Court File No. FM-76-23

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK
TRIAL DIVISION
JUDICIAL DISTRICT OF FREDERICTON

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Applicant (Respondent on motion)

-and-

THE PROVINCE OF NEW BRUNSWICK, as represented by the MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

MOTION RECORD OF GENDER DYSPHORIA ALLIANCE AND OUR DUTY CANADA

(Motion for leave to intervene as an added party, April 18, 2024 at 9:30 am)

April 15, 2024

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Tab 1

Court File No.: FM-76-2023

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Applicant (Respondent on motion)

-and-

THE PROVINCE OF NEW BRUNSWICK, as represented by the MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

NOTICE OF MOTION

COUR DU BANC DU ROI DU NOUVEAU-BRUNSWICK

DIVISION DE PREMIÈRE INSTANCE

CIRCONSCRIPTION JUDICIAIRE DE FREDERICTON

DANS L'AFFAIRE d'une requête en revision judiciare et de jugement déclaratoire en vertu de la règle 69 et la règle 38 des *Règles de procedure* du Nouveau-Brunswick

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Requérant (intimé â la requête)

-et-

LA PROVINCE DU NOUVEAU BRUNSWICK, représentée par le MINISTRE DE L'ÉDUCATION ET DU DÉVELOPPEMENT DE LA PETITE ENFANCE

Intimée (intimé â la requête)

-et-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Intervenants eventuelles (parties requérantes)

AVIS DE MOTION

TO:

THE CANADIAN CIVIL LIBERTIES ASSOCIATION
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AND:

THE MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT
c/o Steve Hutchison, K.C.
Lara Greenough
Stewart McKelvey
Suite 1000, Brunswick House
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Saint John, NB, E2L 2A9

DESTINAIRE:

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

ET:

le MINISTRE DE L'ÉDUCATION ET DU DÉVELOPPEMENT DE LA PETITE ENFANCE

Gender Dysphoria Alliance and Our Duty Canada (collectively, the "**Proposed Intervenors**") will make a motion to the Court at 427 Queen Street, Fredericton, New Brunswick, on a date to be determined for:

(a) an order that the Proposed Interveners be granted leave to intervene in this proceeding: as added joint parties or, in the alternative, as friends of the Court;

(b) an order abridging the time for service and filing of the Notice of Motion and materials filed on this motion, if necessary;

(c) an order that no costs be awarded on this motion for leave to intervene; and

(d) such further relief and other relief as this Honourable Court may deem just.

Gender Dysphoria Alliance and Our Duty Canada (ensemble, les "**Intervenants proposés**") présenteront une motion à la Cour, au 427, rue Queen, Fredericton (Nouveau-Brunswick), à une date à determiner, en vue d'obtenir ce qui suit:

(a) une ordonnance autorisant les intervenants proposés à intervenir dans la présente instance comme parties communes additionnel ou, subsidiarement, à titre d'amis de la cour;

(b) une ordonnance abrégeant, au besoin, le délai de signification et de dépôt del'avis de motion et des documents deposes à l'appui de cette motion;

(c) qu'il n'y a pas lieu d'accorder de dépens pour ou contre eux dans cette requête; et

(d) toute autre mesure de redressement ou reparation que cette honorable Cour peut juger juste.

The grounds for the motion are as follows:

1. This is a motion to intervene in the application brought by the Canadian Civil Liberties Association (the "**CCLA**") challenging recent amendments to the New Brunswick Department of Education and Early Childhood Development's Policy 713, entitled "Sexual Orientation and Gender Identity." The current version of Policy 713 is the product of amendments made August 17 and 23, 2023. The amendments require parental consent before school personnel are permitted to formally use students' preferred names (and pronouns) other than their legal name if the students are under 16 years of age (the "**Notification Requirement**"). Among other remedies, the CCLA seeks a declaration under s. 52(1) that Policy 713 is contrary to the *Canadian Charter of Rights and Freedoms* (the "***Charter***") and not reasonably and demonstrably justified.

2. The Gender Dysphoria Alliance ("**GDA**") and Our Duty Canada ("**ODC**") (collectively, the "**Proposed Intervenors**") have a direct interest in the subject matter of the application as organizations that serve and promote the rights of people with gender dysphoria and the parents of children with gender dysphoria in New Brunswick and across Canada.

3. The Proposed Intervenors seek to intervene as parties to:

    a. represent the interest of people (both adults and children) with gender dysphoria and the parents of children with gender dysphoria or transgender ideation;

    b. represent the organizational interests of the Proposed Intervenors which would be adversely impacted by a finding that Policy 713 is unconstitutional;

    c. adduce evidence of the importance of the Notification Requirement to protecting the rights and interests of children with gender dysphoria and their parents;

    d. make submissions on how Policy 713 protects the rights of children with gender dysphoria and their parents by ensuring that parents are involved in the care and development of their children.

4. GDA is led by transsexual adults and is advised by a panel of researchers, academics, psychiatrists, psychologists, physicians and other experts. Its primary purpose is to promote evidence-based discussion about gender dysphoria so that fair and reasonable accommodations and treatment can be provided.

5. ODC provides support for parents of children experiencing transgender ideation and undergoing psycho-social or medical transitions. ODC has members and provides support to parents across Canada, including in New Brunswick.

6. Many of the individuals GDA represents would be harmed if the Notification Requirement were overturned as they would be left without the benefit of parental oversight while being permitted to embark on serious interventions, such as social transitions.
7. The New Brunswick parents, including members of ODC, that ODC represents and supports would be harmed if the Notification Requirement were overturned as they would be left without a right to be involved if their children are undergoing formal social transition at school. Without being informed, the parents would be unable to fulfill their responsibilities to care for and protect their children and would be unable to guide their children through the difficulties they face in relation to gender dysphoria and transgender ideation.
8. The Proposed Intervenors ability to carry out their organizational mandates to inform and support persons with gender dysphoria and their parents would be directly adversely affected if the CCLA's requested relief is granted. Parents who are not informed that their children are undergoing a formal social transition in school will be hindered in accessing the resources, programming, and community support that the Proposed Intervenors provide.
9. The Proposed Intervenors:
    a. have a direct interest in the subject matter of these proceedings and in protecting the rights of children and their parents in New Brunswick experiencing gender dysphoria and transgender ideation;
    b. would be adversely affected by a judgement in this proceeding if the Notification Requirement in Policy 713 is declared to be of no force and effect; and

c. possess institutional knowledge and experience concerning the experiences of gender dysphoric youth and the parents of children with gender dysphoria and transgender ideation which will assist the Court in understanding the issue of parental involvement prior to a formal change of a child's name and pronouns.

10. The Proposed Intervenors are prepared to comply with the terms of any timetable established by this Court in this Application.

11. In advancing their submissions and evidence, the Proposed Intervenors will consult with the parties and any other intervenors to avoid duplication.

12. In summary, the Proposed Intervenors should be added as parties because:

    a. they have direct interests in the outcome of this Application;

    b. the Court's truth-seeking function will be assisted by the perspective of the Proposed Intervenors;

    c. the Proposed Intervenors will not seek to increase the number of issues in dispute in the Application;

    d. the participation of the Proposed Intervenors will not unduly delay or prejudice the determination of the rights of the parties to the proceeding;

    e. the benefit of the Intervenor's perspective will outweigh any limited impact to the efficiency of the hearing of the Application that may result from their addition as parties.

13. In the alternative, the Intervenor's request that they be permitted to intervene as friends of the Court for the purpose of rendering assistance by way of argument.

14. Such further and other grounds as counsel may advise and this Honourable Court may permit.

The Proposed Intervenors intend to reply on the following statutes and rules:

The *Rules of Court* of New Brunswick, including Rules 15.01, 15.02, and 15.03 and such further and other rules and statutes as counsel may advise.

Upon the hearing of the Motion, the following affidavits or other documentary evidence will be presented:

(i) The affidavit of Aaron Kimberly sworn November 28, 2023; and

(ii) The affidavit of Karin Litzcke sworn November 28, 2023.

You are advised that:

(a) you are entitled to issue documents and present evidence at the hearing in English or French or both;

(b) the Community Interveners intends to proceed in the English language;

(c) if you intend to proceed in the other official language, an interpreter may be required and you must so advise the Clerk at least 5 days before the hearing.

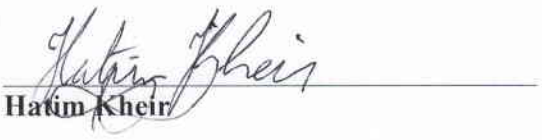
Sachez que:

(a) vous avez le droit demettre des documents et de presenter votre preuve a l'audience en francais, en anglais ou dans les deux langues;

(b) le a l'intention d'utiliser la langue anglaise; et

(c) si vous avez l'intention d'utiliser l'autre langue officielle, les services d'un interprete pourront etre requis et vous devrez en aviser le greffier au moins 5 jours avant l'audience.

DATED at Hamilton, Ontario this 29th day of November, 2023.



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Tab 2

Court File No.: FM-76-2023

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

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Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

AFFIDAVIT OF AARON KIMBERLY

COUR DU BANC DU ROI DU NOUVEAU-BRUNSWICK

DIVISION DE PREMIÈRE INSTANCE

CIRCONSCRIPTION JUDICIAIRE DE FREDERICTON

DANS L'AFFAIRE d'une requête en revision judiciare et de jugement déclaratoire en vertu de la règle 69 et la règle 38 des *Règles de procedure* du Nouveau-Brunswick

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Intimée (intimé â la requête)

-et-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Intervenants eventuelles (parties requérantes)

AFFIDAVIT DE AARON KIMBERLY

I, Aaron Kimberly, of the City of Oak Lake, in the Province of Manitoba, MAKE OATH AND AFFIRM:

1. I am the Executive Director and one of the founding members of Gender Dysphoria Alliance ("**GDA**"), one of the proposed interveners in the Notice of Joint Application For Leave to Intervene, and as such, have personal knowledge of the matters and facts herein deposed to, except where stated to be on information and belief, and where so stated I verily believe the same to be true.

2. As Executive Director of GDA, I am duly authorized to swear and submit this Affidavit in support of GDA's application to intervene in this proceeding.

Gender Dysphoria Alliance

3. GDA was registered in February 2021 and has been influential in bringing awareness to the facts about gender dysphoria ("**GD**") internationally since its inception. GDA's leadership board consists of transsexual adults, and our advisory board is a panel of leading researchers academics, psychiatrists, psychologists, physicians and others with relevant expertise. Attached hereto to this my Affidavit as **Exhibit "A"** is a list of the individuals on our leadership board and our advisory board.

4. GDA's primary goal is to inform the conversation about GD from an evidence based-model, so that fair and reasonable accommodations can be made for those with GD, while balancing the rights of others. We are also advocating for reforms to our healthcare system. We believe that departures from sound evidence have led to missteps in policy and healthcare in ways that are harmful to persons with GD and society generally. Attached hereto to as **Exhibit "B",** is GDA's registration info.

5. Our activities include production of educational content such as a podcasts, short videos, printable materials and essays. We are regularly interviewed by journalists and have built relationships with other organizations such as LGBT Courage Coalition, Genspect, Foundation Against Intolerance and Racism and The Gender Exploratory Therapy Association. We have advised politicians at a national and provincial/state level. For example, I provided testimony in support of the Georgia Green Party's commitment to balance trans rights and women's rights. I also provided testimony in an Ontario human rights case against an Ontario school board after a teacher informed a class of 6-year-old students that "there are no such things as girls and boys."[1] GDA also lobbied for changes to Canada's poorly crafted conversion therapy legislation, as it applies to GD. And we have briefed policy-makers on flaws in the provision of health care to persons with GD. We have also attended clinical conferences as guests and speakers, including a recent clinical conference in Finland regarding the competent, safe and ethical treatment of GD in youth. I was a panelist on the topic of aetiologies of GD.

6. In October 2023, we were granted intervenor status in a similar case between the Government of Saskatchewan and UR Pride Centre for Sexuality and Gender Diversity.[2] The Government of Saskatchewan had implemented a policy similar to Policy 713 which is at issue in the case at bar (the "**Saskatchewan Policy**"). GDA intervened to assist the Court with submissions on the flaws with the prevailing model of care for gender dysphoria and the potential harm of excluding parents from important care decisions.

[1] *N.B v. Ottawa-Carleton District School Board*, 2022 HRTO 1044.
[2] *UR Pride Centre for Sexuality and Gender Diversity v Saskatchewan (Minister of Education)*, 2023 SKKB 197.

7. Also in October 2023, GDA was invited to provide submissions to the Saskatchewan Human Rights Commission on the Saskatchewan Policy. Attached hereto to as **Exhibit "C",** is GDA's submissions to the Saskatchewan Human Rights Commission.

8. As a group of members of the gender dysphoric community (inclusively those of the non-transition, pre-transition, mid-transition, post-transition, and de-transitioned states of surgical and hormonal intervention) we are concerned about the direction that gender medicine and activism has taken. The GDA platform was created to give those with GD who share our concerns a place to learn, network, teach, and tell their own stories.

9. GDA believes that GD is a multi-faceted, multi-causal and multi-correlative condition. GD is associated with homosexuality, autogynephilia, certain intersex conditions, sexual abuse and autism.

10. As a transsexual person myself, and someone who is connected to many transsexual people as part of my livelihood, I am aware that treatment of GD can involve psychotherapy, hormonal treatment, and surgical intervention. GDA believes that counselling can be helpful to:

a. improve coping skills and reduce distress;

b. explore an individual's cross-sex identity and how it developed;

c. discuss non-medical options for managing GD;

d. explore whether or not GD can be integrated into an individual's identity without needing to change the body medically;

e. identify things that may be contributing to an individual's GD;

f. improve social skills and supports;

g. address any other concerns an individual with GD has with their over-all mental health;

h. help with family or social conflicts; and

i. to prepare you for medical treatment, if needed.

GDA's Interest in this Litigation

11. GDA is interested in, and applies to intervene in this proceeding, because of the significant implications this case has for the rights and responsibilities of parents and guardians across New Brunswick to care for and give guidance to their minor children. Further, this case will likely have persuasive implications that will affect parents and children across Canada.

12. GDA is concerned that the arguments of the Applicants will lead to clinical interventions such as social transition without appropriate and competent clinical and parental oversight at crucial times in young children under the age of 16. Additionally, GDA is concerned that this case will have broader implications across the country to the endangerment of gender dysphoric children.

13. As members of the gender dysphoric community who are concerned about the direction that gender medicine and activism has taken, GDA takes a significant interest in the outcome of this matter. In our experience and knowledge, the Affirmative Care model, which exclusively recommends social and then medical transition for individuals experiencing GD, creates a significant risk of considerable harm to children. The situation

becomes exceedingly dangerous when coupled with an approach that removes parents and guardians out of the picture. As a group of gender dysphoric individuals who each have their individual experiences and concerns, and some of whom, like myself, have children, we hope to find a sensible outcome to this matter.

Submissions of GDA

14. I have reviewed the materials filed by the Applicant, The Canadian Civil Liberties Association in support of its application for injunctive relief against the Government of New Brunswick's newly implemented 2023 "Policy 713 – Sexual Orientation and Gender Identity" (the "Policy").

15. GDA endorses the following positions relevant to this case:

a. Canadian law recognizes parents as the primary decision makers of their children for all significant decisions, including being charged with the responsibility for the education and moral upbringing of their children.

b. A parent's right to exercise decision making authority regarding their children involves being informed and involved in important decisions or any significant developments in their children's social behaviour at school, absent demonstrable risk of harm from the parents on a case-by-case basis.

c. School personnel lack the jurisdiction and expertise to change a child's name and pronouns, which is a significant intervention in a child's development that should not be done without the involvement of parents and, if necessary, clinicians.

d. The best interests of children, including their legal and constitutional rights, are protected by the informed involvement of their own parents.

16. If granted the ability to intervene, GDA is able to provide meaningful submissions to this Honourable Court on the irreplaceable role of parents in understanding the unique underlying potential causes of GD in their children, which others, including educators and school personnel may not be privy to. GDA is also able to provide information about gender diversity with respect to evidence, best clinical practices and multicultural understandings of gender non-conformity. This information is crucial to understanding why parents and competent clinicians must be involved in decision-making regarding a given child's treatment of GD, gender non-conformity, or gender-related distress of various origins, as it could have life-long implications for the child's wellbeing. A meaningful decision-making process must begin with an accurate understanding of the condition, at different developmental stages which necessitates the involvement of children's primary caregiver(s): their parent(s)/guardian(s).

17. When combined with a broader and more nuanced examination of the available relevant data, scientific and other discourses in relevant fields, GDA's collective lived experiences and perspective will provide the Court with critical and understandable perspective on the multi-causal issue that is GD, which is a matter of significant importance to the resolution of this litigation.

18. GDA's submissions will be informed by its unique insight as an organization organized and operated by transsexuals, with experience working to protect the rights of those with GD in Canada and internationally by providing evidence-based information

about the condition and its known pathways. This insight and experience will assist in providing the Court with a useful perspective on the implications of the legal issues at stake in the matter.

My story as a person with gender dysphoria

19. Besides my role as Executive Director of GDA, I am a Registered Nurse with a specialization in mental health and have worked within youth gender medicine. I live in Manitoba. Attached hereto to this my Affidavit as **Exhibit "D"** is verification of my status as a registered nurse. I am a surgically transitioned transgender man. I was born female with a rare ovotesticular disorder of sex differentiation (DSD).

20. I am familiar with much of the scientific, political and philosophical literature that relates to transgenderism, GD, Queer Theory and other related topics.

21. I am a begrudging but perhaps necessary exemplar of my community. I was born as a biological female in 1973 and grew up in a small farming community. From an early age, I perceived myself as a boy. My parents would buy me "girl" toys, which I would mostly ignore in preference to my brother's toys. I look miserable in my kindergarten class photo because my mom made me wear a frilly shirt. When swimming, I wanted to wear swim trunks, not a swimsuit. My Halloween costumes included characters like Smurf, Superman, Michael Jackson, and Gene Simmons. I looked and acted so much like what others expect of boys that I was accidentally put onto a boys' baseball team one summer – which I thought was great! When we played Star Wars in the playground, I was Luke Skywalker – never Leia – which no one seemed to mind. I was one of the boys. This social arrangement lasted until puberty, and then all the rules changed. I was attracted to girls,

none of whom took any notice of me. My guy buddies started to either flirt with or ignore me. I had no idea why I perceived myself as male. It was confusing and embarrassing, a sentiment that is echoed with many of our members in their formative years.

22. At age 19, I had surgery to remove a grapefruit-sized cyst from one of my ovaries. The surgeon said that my ovary was unrecognizable as an organ, so it was sent for biopsy. It was discovered to be a mix of ovarian and testicular tissue, an intersex condition known as an ovotesticular disorder of sex development. The surgeon seemed embarrassed for me and reassured me that the offending organ was gone, so I should just forget about it. This both validated and further confused my perception of myself. I did not tell anyone about this at the time. I've since learned that most people with an OT-DSD live as men due to the masculinization caused by our natal testosterone levels.

23. I tried to live with my GD as a young adult, and identified as a lesbian, though it never felt right to me, and I was not happy. I experimented with ways to express my masculinity. I changed my name to Aaron when I was 22.

24. I did not even know how to explain what I felt to people and felt ashamed of it. I also did not know back then that medically transitioning was possible, and when I did learn about it years later, it seemed far-fetched and risky.

25. In the early 2000s, I moved to Vancouver and met a few trans people. Then around 2007, I saw a documentary on TV about trans kids which resonated with my experience of GD, so I decided to transition. I do not really regret that decision, because I do feel a lot more comfortable living as a man, but it has not been easy. As I have gotten older, I care

less about whether I am male or female. I do not believe in radical gender politics or Queer Theory.

26. Even if people do decide to transition, people with GD need counselling to help them understand GD and deal with it in reality-based ways. "Affirmation" is not the same as giving us answers about why we feel the way we do as transsexuals. When I went to see doctors for help, I assumed they understood exactly what this condition is, how it manifests and what treatment is most helpful. I have learned that the truth is far different: doctors often are guessing, and do not have concrete answers regarding GD. I was not informed by the physicians I saw about the vast amount of research by psychologists like Dr. Blanchard and Dr. Zucker; the doctors I encountered presented medical transition as the only real option, which was a disservice to me, and to many other people with GD. The failure to apprise patients, especially children, of all viable treatment options on the medical side, is mirrored by the one-size-fits-all orthodoxy pushed on children regarding social transitioning. Children are often told by activists and those who believe Queer Theory that they *are* in the wrong body, and that the *only* way to address this "fact" is to socially transition to a different gender. The reality is that there are many reasons why a given child may be experiencing GD, and there are many different options for treatment that do not involve social transitioning and genital surgery.

27. Because of the one-sided narrative that is often pushed on young people with GD, GDA's position is that parents absolutely need to be involved and aware of behavioral changes in their children.

28. Knowing what I know now, if I were back in my pre-transition state, I would have gone to more counselling first and learned more about what GD is and what all of my

options were. Unfortunately, it is even harder to get that kind of information today given the prevalence of the Affirmative Care model. I thought I knew everything I needed to know when I decided to undergo surgery, but I did not. I was just so desperate to feel better and fit in that I was not really thinking straight.

29. I feel okay about my choices now, but I am not sure they were all necessary. Of the transitional procedures and hormonal regimens that have been performed on me, I do regret getting bottom surgery done because I had complications and the outcome is not what I expected. Bottom surgery is the surgical creation of a pseudo-phallus using tissue removed from other areas of the body. I feel I was misled about what to expect. The bottom surgery actually made my dysphoria worse not better; better and more realistic pre-surgery clinical care could have prevented this issue. I have learned my disappointment and experience is hardly unique.

30. It is great that people value diversity but, by embracing the militant transgender narrative espoused by The Canadian Civil Liberties Association, people are embracing and promoting practices that objectively harm others, especially children such as:

a. embracing and promoting the idea and reality of traumatized girls altering their bodies to feel safer as transmen;

b. celebrating people fleeing homophobia via transition;

c. praising people who use the medical system to manufacture imaginary personas of all kinds;

d. applauding people who are using those of us with a medical condition to advance their own political and capitalist agendas; and

e. institutionalizing the recruitment of children into this movement, many of whom will alter their healthy bodies needlessly.

31. I do not want my own kids to be captured by this. There are many stories that are like mine and yet are unique. Attached as **Exhibit E** to this affidavit are the stories of three gender dysphoric individuals from GDA's website. I personally know all three individuals. I have been informed of and verily believe the contents of their accounts.

32. There are many other stories and lived experiences on the website. And we are privy to many other non-public stories that, along with our knowledge of the academic literature, inform our views and expertise. We trust that these views and expertise will be meaningful to this Court.

Different Submissions

33. If admitted as an intervenor, GDA will provide submissions from its unique perspective as a third-party entity comprised of GD persons that is concerned with:

a. the broader implications of the special vulnerability of young persons experiencing GD or who are susceptible to experiencing GD;

b. the single-minded treatment options promoted under the Affirmative Care model; and

c. the practice of exclusion of and isolation from parents that some schools, school districts, and individual teachers have chosen for young persons with GD.

34. I swear this Affidavit in support of the Joint Application to Intervene, and for no improper purpose.

SWORN by Aaron Kimberly
at the City of Oak Lake
in the Province of Manitoba,
on the 28th day of November, 2023.

Name: ROCHELLE OLIVER
A commissioner for taking oaths
in the Province of Manitoba

A COMMISSIONER FOR OATHS
IN AND FOR THE PROVINCE OF MANITOBA
MY COMMISSION EXPIRES Jan 23, 2025

Aaron Kimberly

This is **Exhibit "A"** referred to in the Affidavit of **Aaron Kimberly** sworn before me this 28th day of November, 2023.

Name: Rochelle Oliver

Commissioner

Gender Dysphoria Alliance

Dysphoria without ideology

Donate

Search...

Leadership Board

Aaron Kimberly
Executive Director

Aaron has been a mental health clinician since 2008 after 15 yrs as a graphic designer. He lives in Canada, with a banjo on his knee. He medically transitioned in 2006.

Aaron Terrell
Director, Operations

Aaron Terrell is an American transman interested in the causes of gender dysphoria as well as the sociopolitical trends that facilitate medical transition.

Kellie Pirie
Director, Transition Regret

Kellie (formerly Kenneth) transitioned from female to male in 2004, which she later regretted. She has a background in criminology and long haul trucking.

Janet Scott
Director, Education

Janet "Cat Lady" Scott has worked in education for over 20 years. She lives in the US with a small herd of cats. She medically transitioned in 2016-2017.

TBA
Is this you?

Our team is expanding and diversifying. If you think you'd be a good fit for a leadership role with us, be in touch! We are especially looking to add transwomen to our team.

Advisory Board

Dr Ray Blanchard

Professor of Psychiatry at the University of Toronto. He was a member of the Sexual and Gender Identity Disorders Work Group for the DSM-5 and has made significant contributions to research of gender dysphoria.

Dr Oren Amitay

Clinical psychologist and university lecturer of 20 different psychology courses approximately 200 times since 2000, including Human Sexuality, Gender, Clinical Psychology, Personality, Research and Statistics.

Dr Lisa Littman

Dr. Littman is a physician-scientist and currently the President and Director of the Institute for Comprehensive Gender Dysphoria Research. Her research is focussed on GD and desistance/detransition.

Severus Hama-Owamparo

Severus is an African trans man and community psychologist His work focuses on addressing mental health challenges and human rights violations faced by gender and sexual diverse individuals in Africa.

Pam Buffone

Pam is a software executive in the field of data analytics and a part of the leadership team at Genspect, an international organization representing parents of gender questioning youth.

Levi Pay

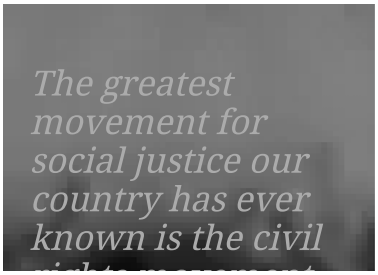
Levi is a policy, strategy and higher education specialist with experience in a range of UK organisations, including several universities, the Scottish Parliament, Stonewall and the Equality Challenge Unit.

Sinead Watson

Sinéad is a detransitioned woman from Scotland who underwent medical transition between 2015-2019. She is an advocate for balanced care of gender questioning youth.

Christina Buttons

Christina is an independent journalist who writes about gender, pseudoscience, mental health, autism & critical thinking. She advocates for early autism screening & transition care that prioritizes thorough, individualized assessments.



Gender Dysphoria Alliance (GDA) was formed in 2021 as a small group of community members who are concerned about the direction that gender medicine and activism has taken. We've created this platform to give others who share our concerns a place to learn, network, teach, and tell their own stories. Our network is quickly growing and partnering with other similar groups and individuals around the world.

Though our members come from diverse cultural backgrounds, hold various political and spiritual beliefs, and different professional designations, GDA is not

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This is **Exhibit "B"** referred to in the Affidavit of **Aaron Kimberly** sworn before me this 28th day of November, 2023.

Name: ROCHELLE OLIVER

Commissioner

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GD ALLIANCE CANADA

Business number: 778483149
Active • Sole Proprietorship

ACTIVE

Registration Relationships Credentials

Show all Credential statuses

Registration

Authority
BC Corporate Registry
Credential verified
Effective: Feb 26, 2021

GD ALLIANCE CANADA is a
Sole Proprietorship

Registration number: FM0834876
Registered on: Feb 26, 2021
Business name effective: Feb 26, 2021

Credentials

Sort by date

Authority

- [x] BC Corporate Registry 2

Credential type

- [x] Registration 1
- [x] Business number 1

Registration type

- [x] Statement of Registration of General Partnership or Sole Proprietorshi 1

Date effective

Show Inactive Credentials

- [x] Show Inactive Credentials

BC Corporate Registry ✕ | Registration ✕ | Business number ✕ | Statement of Registration of General Partnership or Sole | Show Inactive Credentials ✕

Feb 26, 2021 - Present

Statement of Registration of General Partnership or Sole Proprietorship
GD ALLIANCE CANADA
Registration number: FM0834876

Authority
BC Corporate Registry

Reason
Statement of Registration of General Partnership or Sole Proprietorship

Credential verified

How was your experience?

What do you think about OrgBook BC?


About this site

OrgBook BC is a public directory of organizations legally registered in BC, Canada. It's a Digital Trust initiative from the Ministry of Citizens' Services.

This is **Exhibit "C"** referred to in the Affidavit of **Aaron Kimberly** sworn before me this 28th day of November, 2023.

Name: Rochelle Oliver

Commissioner

Submissions to the Saskatchewan Human Rights Commission

Regarding: Ministry of Education "Use of Preferred First Name and Pronouns by Students" Policy/Bill 137

Aaron Kimberly, Executive Director, Gender Dysphoria Alliance

Oct 20, 2023

Note: For clarity, the use of the term Gender Dysphoria, is in reference to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), published by the American Psychiatric Association in 2013. This diagnostic manual is in current use, and outlines several pathways to the cognitive development of a gender identity of the opposite sex: (1) early onset, which is highly correlated with developing homosexuality, (2) transvestic disorder with autogynephilia, and (3) intersex conditions.

In most cases, when we are discussing children, we are referring to the early onset subtype of Gender Dysphoria, which many gay and lesbian people experience as children.

The Gender Dysphoria Alliance (GDA) is in agreement with not allowing children under the age of 16 to be socially transitioned without the consent of their parents/guardians on the following grounds:

1) The human rights framework, which lists "gender identity" as a protected class, can create conflict with the clinical framework and evidence about the multifactorial, multicausal, and often transient nature of childhood Gender Dysphoria, and best clinical practices. While gender identity and sexual orientation are protected classes, the international human rights frameworks (see for example the Yogyakatha Principles described in Appendix I: Gender Identity Framework) were written by human rights scholars who failed to take into consideration the decades of clinical research about Gender Dysphoria and how it relates to sexual orientation. Nor does it take into account what is considered best clinical practices, especially with regard to children. This is a political overstep with significant clinical consequences.

2) "Queer" is a political identity based on the academic discipline of rhetoric, called "Queer Theory" (See Appendix II: Queer Theory). Political movements or academic disciplines are not protected classes under human rights law. The words "transgender", "gender queer" and the hundreds of new genders like "cake gender" and "frog gender" are branches of Queer Theory and a youth subculture. It is for this reason that those associated with GDA use the clinical term, "transsexual" to indicate that we have medically and legally transitioned to live as the opposite sex as a form of treatment for Gender Dysphoria.

3) The general public, including children, parents, teachers, and even clinicians, are being taught a political framework and are being misinformed about Gender Dysphoria (see Appendix III: Impact on Children).

4) Social transition (changing name, pronouns etc) is step one of a medical pathway (see Appendix IV: Transgender Experiences and Outcomes). It is a clinical intervention that requires clinical oversight.

5) Mature minors do have the legal right to consent to medical treatment, even without parental consent provided that they have the capacity to understand the nature and consequences of the treatment. However, models of care for the treatment of Gender Dysphoria, as with any other condition, require adequate assessment, diagnosis and treatment recommendations by a qualified practitioner. It is not a human right to self-diagnose and initiate our own medical treatment, which is why the Yogyakatha Principle relating to bodily autonomy does *not* say that clinical interventions are required on demand. Social transition is a clinical intervention.

6) Gender Dysphoria is frequently associated with comorbid mental health conditions such as autism and ADHD. If parents aren't notified of their child's Gender Dysphoria, it may prevent parents from obtaining proper mental health support, and leave the child on a path they might later regret.

   New studies indicate that early social transitions *do not* improve mental health in most cases: Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria? | Archives of Sexual Behavior (springer.com)

7) The fear of suicide is frequently being misused. For example, parents are often being told "would you rather have a dead son or an alive (trans) daughter. This is a false and detrimental proposition. There is no evidence that children will commit suicide if not immediately affirmed and medicalized. Though trans identified youth do report higher than average suicidal thoughts, there is no evidence of a direct relationship between Gender Dysphoria and suicidality. The suicidality rates reported by this population are consistent with the rates associated with other mental health conditions and the gay and lesbian population. Suicidal ideation is not the same thing as suicide completion. Looking at various models of care for children with Gender Dysphoria: The Dutch Model, Watchful Waiting Model, and the psychotherapeutic models currently being developed in Europe, all of which urge caution and do not immediately confirm that the child's gender identity is a fixed and permanent entity, there is no indication that those children are more at risk of suicide.

8) Studies do show that the best predictor of childhood mental health is parental support. However, "support" can take many forms, not just confirmation that a child's identity is permanent. Clinical models for children typically involve the entire family.

Discussion

It is GDA's view that the policy in question about parental involvement is not really about "parental rights" in of themselves, but rather is more appropriately better understood as a necessary child safeguarding measure, in light of the Queer Theory conundrum in North America, where it originated.

I'm familiar with the UN's guidelines for the social inclusion of gender diversity, in particular the *Yogyakatha Principles* and the reports by the Special Rapporteur on LGBT rights. As a representative of GDA, an organization led by adult transsexuals, I value social inclusion, diversity and human rights. However, human rights scholars aren't clinical experts, and they've made some errors in writing guidelines that don't take into account the decades of research on Gender Dysphoria, especially in children. The implementation of the *Yogyakatha Principles* is having unintended consequences, which need to be re-examined and corrected.

To date, there are 12 studies which followed cohorts of children with early onset Gender Dysphoria (or the older term Gender Identity Disorder "GID"). They all have come to the same conclusions – that the vast majority of children with GID resolve it through pubertal awakening of sexual orientation. It's quite common for gay and lesbian children to experience some degree of gender confusion, gender non-conformity and distress. Many gay adults recall this from their own childhoods. Prematurely labelling these children simply as "trans" risks the medicalization of an entire generation of gay children, with sometimes-severe lifelong consequences.

Studies worth noting:

> https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Other/Rebekah_Murphy_20191214_JamesCantor-fact-checking_AAP-Policy.pdf
>
> https://journals.sagepub.com/doi/10.1177/1359104510378303
>
> https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full

Post-modern (Queer Theory) explanations of "gender" being taught to children and families are misleading many to prematurely label children "trans". As researchers like Dr Kenneth Zucker have warned, hasty social transition of children (i.e. changing name and pronouns) concretizes their self-perception during a time when it should be flexible. This then makes it harder to walk back, even once the child begins to doubt their earlier perception. Social transition is the first step of the medical pathway, and every model of care expects assessment by a qualified clinician prior to any clinical intervention. It's not

our position that “trans” is a bad thing, but overmedicalizing gay and lesbian children without properly informing them about the developmental process is concerning and harmful. The children aren’t being given an opportunity to understand themselves and become healthy gay adults. There is a medical burden. Hormone therapy and surgery aren’t neutral acts. There are risks. Genital surgeries in particular have high complication rates. The Province of British Columbia sent me and a number of other trans men to Dr. Crane in Austin, Texas a few years ago. About 80% of us had complications. Some severe.

Teachers and schools are being informed of the human rights framework, but not the clinical frameworks. By agreeing to socially transition children, they mean to be supportive, but they are in fact initiating a clinical intervention without a license or qualifications to do so.

It’s not necessary to socially transition children to love and support them. What I and my family would have benefited most from is accurate information about what I was experiencing. At that time, we didn’t know that I had an intersex condition. Nor did we know that it’s common for pre-gay/lesbian children to wrestle with gender and some degree of cross sex identification.

Families who are simply told “you have a trans kid” versus those who are given accurate info, i.e. “these experiences are a developmental aspect of sexuality which will most likely resolve through puberty”, are likely to make very different choices about what to do.

There’s another issue that’s even more concerning. There’s emerging evidence that many of the girls self-identifying as “trans” don’t have a history of early onset Gender Dysphoria. “Trans” has become a youth subculture with social currency. Many young people, especially those who struggle socially, like kids with autism or ADHD, find a welcoming community through a trans identity. That in itself isn’t a bad thing. Every generation has its youth subcultures like goth, punk and hippie, and it’s not unusual for parent/child conflicts to arise from a child’s strong subcultural convictions. However, unlike youth subcultures of the past, the “Queer” one involves somtimes severe and permanent bodily modification while protecting the path as a human right under “gender identity”. Parents are in a unique position of knowing the child’s history. Their accounts of whether or not the child showed signs of early onset Gender Dysphoria is crucial to making a proper diagnosis and protecting the children and adolescents, whose identity is socially influenced, from medical harm.

Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria | PLOS ONE

Concerns about the policy

I think that as policies like this are implemented, it's very important that they're followed by educational campaigns to help staff and families understand that this path is not led by anti-LGBT hate. It's a child safeguarding measure and a necessary correction of political overreach. I and other members of GDA would be happy to work with the government and schools to help with the delivery of the messaging to staff and families. The very purpose of the Gender Dysphoria Alliance is to educate about the several types of Gender Dysphoria.

We do believe in concepts like personal autonomy, but that can only be achieved when people are equipped with accurate information. We are not confident that many people understand what Gender Dysphoria is, unfortunately including some medical professionals.

There is reasonable concern that some parents are hostile or abusive towards their children. In those cases, steps can be taken by teachers to involve authorities such as Child Protection Services and family therapists. These are critical opportunities to therapeutically support families through conflict.

Hiding information from parents has the potential to escalate conflict within the family, and breaks trust between families and teachers/schools.

Parents and Teachers

I am myself a parent and share the concerns of many parents.

Many parents and teachers throughout North America have reached out to GDA with questions and concerns about what they're seeing in their homes and classrooms. One Canadian middle school teacher contacted us last year to say that half of her class identified as something other than "cis". It should be seen for what it is – experimenting with the political ideas, identity, sexuality, and social inclusion, which is normal for that age group. But it shouldn't be assumed to be permanent expressions of self, and care is needed to not lead kids to a medical pathway that might not be in their best interest. Teachers and parents need guidance about how to best respond. We have partnered with other organizations to create a guidance booklet for schools that are based on best evidence. I've attached that document for your consideration:

https://www.genderdysphoriaalliance.com/_files/ugd/712544_864256e0f9c64f98bb8a64ae64dec67b.pdf

We have been talking to many parents and teachers about these issues generally, and this policy specifically. Most are in favour of safeguarding measures. Most teachers and parents are frightened and don't feel well equipped to know how to best respond. They don't want to upset anyone, and are afraid of disciplinary action if they don't do the right thing. But many also sense that something new is happening to children and adolescents over the past few years. Indeed there is something new happening that has nothing to do with clinical Gender Dysphoria.

Though I don't have first-hand experience as a teacher, I can speak to similar concerns as a nurse.

I used to work for the BC Provincial Adult Eating Disorders Program in Vancouver, about 9 years ago. While there, we didn't have a single trans patient in the program that I'm aware of. Now, I'm told by nurses still working there that the program is flooded with (mostly) young women who change their pronouns frequently and have meltdowns if the nurses can't remember which pronoun they've chosen that day. Eating disorders are often co-morbid with personality disorders. The program is designed to contain the boundary-pushing nature of those disorders but, the staff do not know how to therapeutically contain the boundary-pushing when it comes in the form of "identity" because it's a protected class. Hundreds of new "gender" categories like "cake gender" and "frog gender" have emerged. Do we affirm that a child is actually a frog? I don't believe that's what our human rights legislation is meant to do, but teens (and those with personality disorders) will attempt to push those boundaries until we have greater clarity on what it means to protect "gender identity".

Human Rights Code

I understand that "gender identity" and "expression" are protected under both federal and provincial law. As a transsexual man myself, I am grateful for protections. I believe the intent is to protect gay, lesbian and bisexual individuals. And, it's meant to protect transsexuals like myself who have legally and medically transitioned.

My understanding of transition is this: it's an accommodation for and treatment of Gender Dysphoria, which has been consistent, persistent and causing significant functional impairment. It's the creation of a legal fiction. I do agree that once someone is assessed and granted this legal fiction, it should be protected, but with consideration to biological sex. I am now *legally* male. It has been a helpful intervention for me, but I am not and never can be biologically identical to natal males. That reality has to be integrated into my self-concept because it has implications such as healthcare decisions. Though I've adapted well to legally changing to male, it's still important that my medical records indicate that I'm not biologically male, otherwise my health could be

at risk if something is missed. Gender Identity must remain separate from sex and sexual orientation.

Sex and sexual orientation are also a protected classes, and sometimes conflicts arise between the rights of one group over another.

By understanding trans as a legal fiction, we can discuss it, negotiate it and write it into law and policy in reality-based terms as its own entity, while also weighing in on the sex-based rights of women, and homosexuals (who are attracted to the same sex). We can find fair solutions and resolve conflicts when the rights of one group conflicts with another group. The rights of young gay and lesbian people are being compromised by the over medicalization of early onset Gender Dysphoria, since it is most often a developmental stage for emerging homosexuality.

Legal fictions don't need to be pathologizing. There is precedent for it among some intersex people like myself. The sex assignment of those with atypical genitals used to be common practice, and not necessarily biologically true (e.g. a child with XY chromosomes being assigned female because it was an easier operation to perform), but it wasn't causing societal problems and most of those children adapted well to their assigned sex, if done early enough.

Further Consulation

We are fortunate to have some of the leading experts on Gender Dysphoria here in Canada. I recommend that you speak with:

> Dr Kenneth Zucker, world-renowned researcher and psychologist who specializes in childhood onset GD. https://www.kenzuckerphd.com/
>
> Dr James Cantor, sex researcher and GD expert. http://www.jamescantor.org/
>
> Dr Joey Bonifacto, pediatrician with a specialization in childhood GD. https://www.drjoeybonifacio.com/medicine

Appendix I

The Gender Identity Framework

In 2006 the UN assembled a panel of human rights specialists who met in Yogyakarta, Indonesia to outline a set of international principles relating to sexual orientation and gender diversity. The resulting document, called the *Yogyakarta Principles* outlines binding international standards for the state inclusion of same-sex attracted and gender non-conforming people. Ten additional principles were added in 2016.

In 2016, the UN launched a mandate to reduce violence and discrimination against people of diverse sexual orientations and gender expression globally. Madrigal-Borloz was first appointed as UN Independent Expert on sexual orientation and gender identity. He was replaced by Victor Madrigal-Borloz in late 2017.

In 2019, the World Health Organization, reclassified the condition of Gender Dysphoria from their *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). The previous classifications of "transsexualism" and "gender identity disorder of children" were replaced with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood" and moved them from the section on mental disorders to a section on sexual health. They noted that inclusion in the IDC ensured insurance coverage for medical interventions but, by reclassifying the condition, they hoped to destigmatize it.

In 2022 the UN Independent Expert on Sexual Orientation and Gender Identity Victor Madrigal-Borloz, released a report in which he referred to the international human rights strategy as the "Gender Identity Framework". Working in tandem with the WHO's efforts to destigmatize gender nonconformity and the condition of Gender Dysphoria, they've devised a framework that's being implemented and enforced by federal, provincial and institutional systems.

A full analysis of these mandates and their impact is beyond the scope of this statement. We do agree that many LGBT people worldwide experience violence and exclusion. We value human rights and social inclusion for ourselves and others.

However, the "Gender Identity Framework" is having unexpected consequences. Rather than educate clinicians, patients and policy makers about the multifactorial nature of Gender Dysphoria, clinical knowledge has been almost entirely replaced with the political narrative, "everyone has a gender identity, which may or may not match one's sex". Gender identity, in these terms, becomes a mystical, elusive entity, removed from the cognitive-developmental processes for which psychologists coined the phrase.

"Gender Identity" was a term coined by Dr Robert Stoller in the context of intersex (DSD) research being done in the 1950s. It had been routine practice to "sex assign" children born with atypical sex anatomy, usually made female simply because surgical procedures to create a neovagina is less complicated than the creation of a neophallus. Because most of these intersex kids did adjust well to their sex assignment, regardless of their genetic sex, Stoller and sexologists after him theorized that "gender identity" isn't the result of any biological mechanism but the result of a cognitive and social learning process.

This term was later applied to research about Childhood Onset Gender Identity Disorder, believed to be an early life error in the unconscious cognitive categorization and social learning process, resulting in a child's perception of themselves as the opposite sex. During childhood, this cognitive process is typically flexible and able to integrate new information. Indeed, research has shown that the vast majority of kids who experience a sense of sex incongruence do resolve it by adolescence or early adulthood under the "Watchful Waiting" model.

Unfortunately, the well-intended human rights framework that has adopted the term "gender identity" is an oversimplification and misrepresentation of that term, presented not only to the general public, but also among clinicians who have become activists, not science informed.

Of note, nowhere in the *Yogyakarta Principles* does it say that any individual must be guaranteed medical interventions. Principle 32 - The Right to Bodily and Mental Integrity - outlines bodily rights such as being free from physical torture or medical interventions to change sex characteristics against ones will. It does not say that medical transition

itself is a right, since that would eliminate clinical judgement on a case by case basis. Principle 17 - Relating to the Right to the Highest Attainable Standard of Health - states that gender affirming medical interventions should be included in the public healthcare system. But it does not say that every individual is entitled to those interventions on demand. Principle 31 - The Right to Legal Recognition - does state that each state shall "Ensure that no eligibility criteria, such as medical or psychological interventions, a psycho-medical diagnosis, minimum or maximum age, economic status, health, marital or parental status, or any other third-party opinion, shall be a prerequisite to change one's name, legal sex or gender". We believe this principle in particular is a misstep and demonstrates a lack of evidence-based clinical knowledge and foresight of the committee. On this point, it's important to remember that this was a committee of human rights strategists, not clinical experts or researchers. One of the authors of the *Yogyakarta Principles*, Professor Robert Wintemute, has since spoken publicly about some of their shortcomings, such as how the concept of self-identification poses risks to girls'/women's safety.

Appendix II

Queer Theory

From 1995-2000 I studied visual art at the Nova Scotia College of Art and Design (now called NSCAD University) in Halifax, NS. Across the city, St Mary's University's Department of Literary Criticism was offering a new graduate level class called "Queer Theory". This was a new academic discipline at that time. Judith Butler's second book, *Bodies That Matter*, had just been published. A few of us from NSCAD took the class as an elective.

At the foundations of Queer Theory is the work of French philosopher Michel Foucault who, in his 1978 book *The History of Sexuality*, asserted that the category of "homosexual" was an invention of the ruling class for the purpose of identifying and oppressing individuals who engaged in same sex behavior.

Building upon Foucault's premise - that categories are for the purpose of oppression - the goal of academics like Judith Butler was to disrupt and dismantle social categories such as gay/straight and male/female. The central theme of Butler's work was what she called the "performativity" of gender - meaning that what we consider manliness or womanliness are learned performances and, as such, could be performed by either sex equally well. Manliness, for example, was meant to be an understated performance, rehearsed to such perfection, and enforced by society in ways that made it appear effortless and non-artificial. By contrast, womanliness retained a distinct quality of effort and artifice. Drag queens and kings became icons of the Queer Theory movement, intended to be both homage and parody of the performative nature of sex categories.

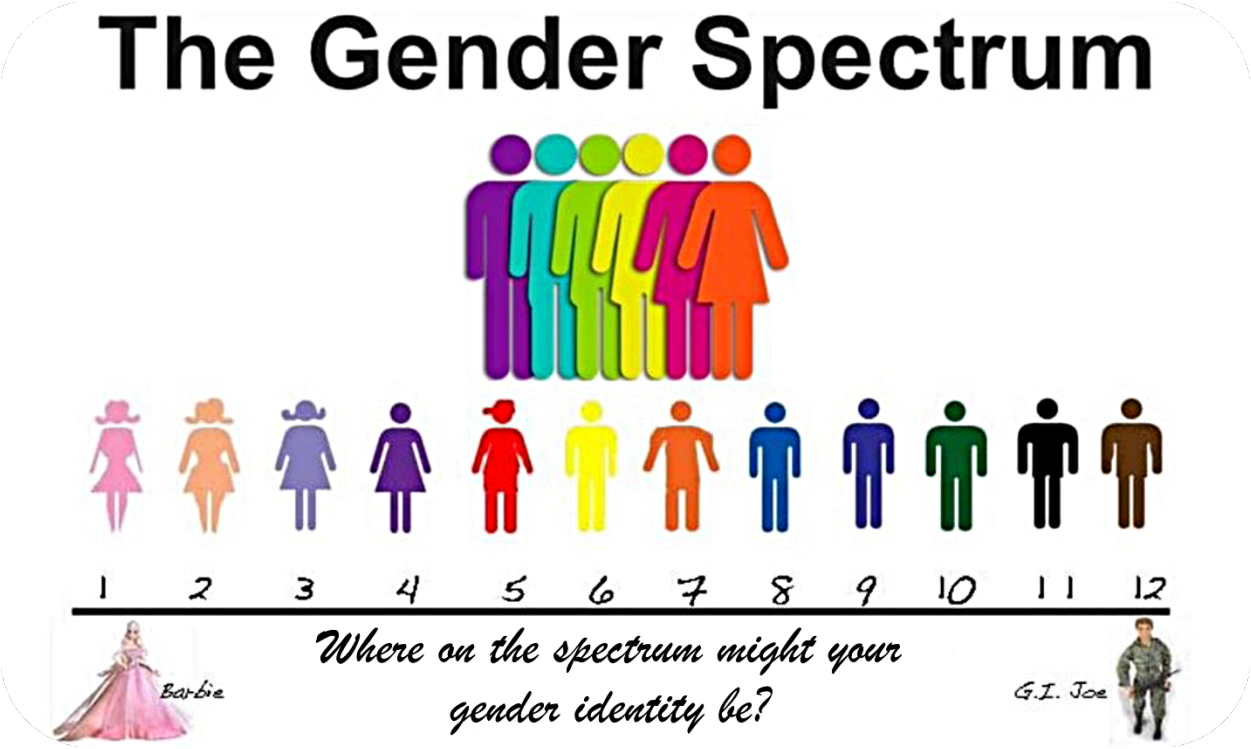
I believe it's important to understand that the central purpose of Queer Theory is the creation of a perpetual smoke and mirrors show to intentionally confuse boundaries between defined categories and, as a branch of post-modern philosophy, aims to dismantle the institutions which uphold those categories, including traditional families. "Queering" a space or community means to apply these political strategies, which is achieved primarily by the subversion of language. A "queer" person is not a sexual orientation but an adherence to the Queer Theory worldview in which men, women, gay,

straight and other sexual orientations and identities co-exist without delineations. American transwoman Martine Rothbladt, in her 1995 book *Apartheid of Sex: A Manifesto on the Freedom of Gender* considers the delineations of male and female a type of oppressive and artificial separation, no different than the South African segregation of white and black.

The words “transgender”, “genderqueer” and “non-binary” come out of Queer Theory, referring to the political transgressions of sex categories, whereas the term “Transsexual” comes out of the clinical literature. In recent years, dozens of new social categories have been created such as "cake gender" and "demisexual" each with their own neopronouns. In concept, the creation of an infinite number of gender or sexuality categories will eventually mean that each individual has their own unique gender, thus making gendered groups obsolete.

In a pluralistic society such as Canada, I respect the right of anyone to believe and study post-modern philosophies. However, since it's a political framework, Queer should not be considered a protected class of personhood immune from criticism.

These concepts are being taught to children in public schools, as early as kindergarten, presented as facts about sexuality and gender. For example, many teachers are using a popular illustration of a "gender spectrum" with GI Joe on one side and Barbie on the other, then asking kids to consider where on the spectrum they place themselves. This diagram conflates gender expression with biological sex because, unless a child is an extreme stereotype of their sex, they are plotted on the diagram towards the opposite sex. This is (intentionally) misleading and bears no resemblance to the evidence-based understanding of Gender Dysphoria, Disorders of Sex Development (DSD) or sexual orientation. A highly effeminate gay man is no less male. A woman with a DSD may still be highly feminine.



I think it's highly inappropriate for a political movement aimed at deliberately confusing society about sexuality and sex categories to have developed sex education curricula for our public school system. These theories are likely to confuse children and, given the deconstructive nature of post-modernism, divide families and communities. Indeed, it has been the case that families who object to these concepts are quickly labeled as “anti-LGBT” and deemed unsupportive of their children.

Furthermore, Queer theorists who are using their professions to advance Queer Theory (e.g. physicians, psychologists, counsellors, social workers, lawyers, educators) are in fact using rare conditions like Gender Dysphoria and DSDs as props in their political movement, and have replaced scientific, clinical knowledge about these conditions with Queer rhetoric. This is alarmingly unethical.

At GDA, we object to being represented and used by this deceptive and divisive framework, and had we been presented with these ideas as gender dysphoric children, it would not have helped us to understand our experiences.

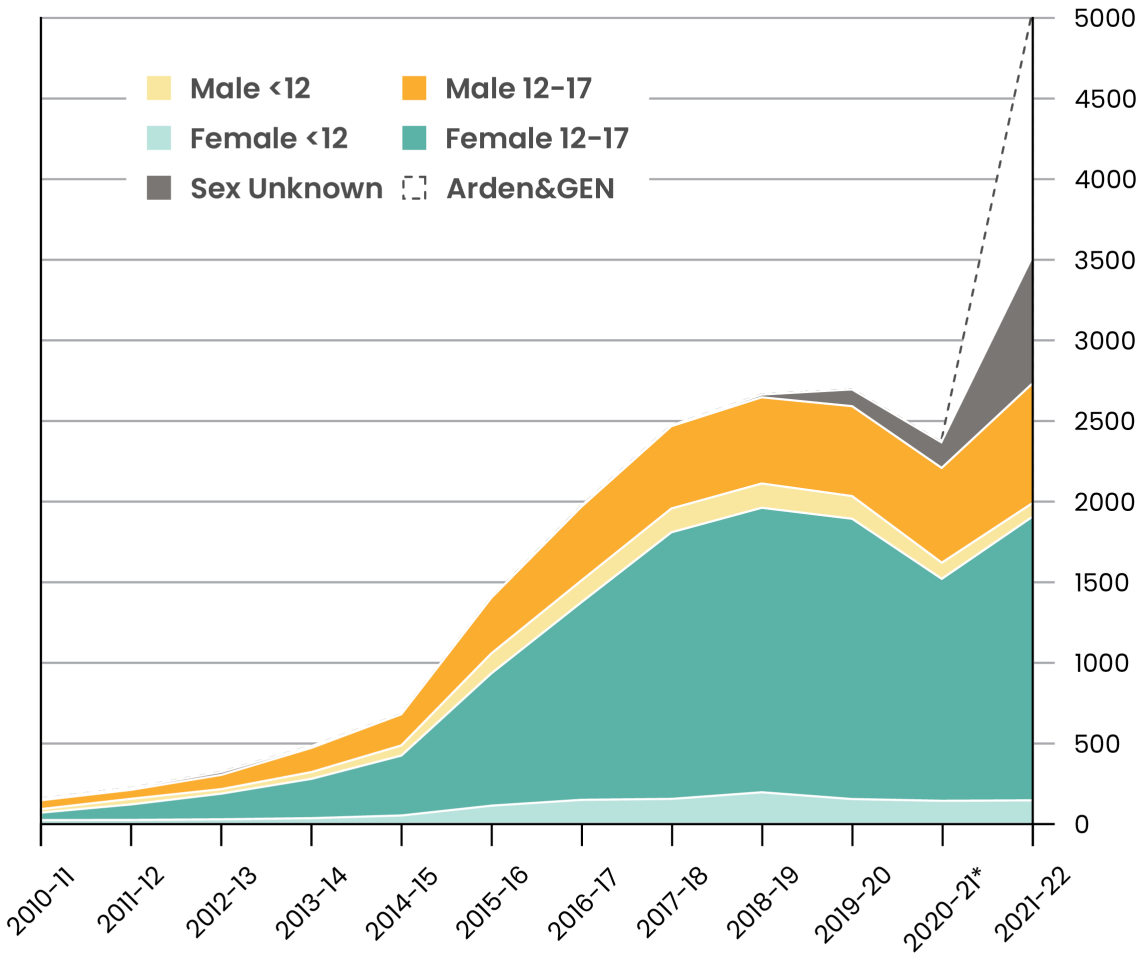
Appendix III

Impact on Children

A Queer Theory based youth subculture has emerged in recent years, which should be regarded as this generation's "goth" or "hippie". But, it's found shelter under the LGBT umbrella and institutions are systematically granting it status as a protected class. Youth in this subculture identifying as transgender are being medicalized along with those with legitimate conditions. The public school SOGI lessons about concepts like "100 genders" is persuading kids to consider that maybe they're not actually girls or boys at all, just as our healthcare system has been eliminating careful, comprehensive assessment, as though safeguarding and clinical oversite is a violation of our human rights. We are very concerned about the wellbeing of children under these perfect storm conditions.

A marriage of Queer Theory and the UN's activist framework ("Gender Ideology") is interfering with the natural healthy development of children's relationships with their biological realities, rendering clinical systems unable to recognize and respond appropriately to the explosion of childhood/adolescent transgender identities. Pediatric gender clinics throughout the western world are reporting a 4000% increase of referrals mostly consisting of teen girls who don't fit the childhood onset Gender Dysphoria criteria. You would think that clinicians would be qualified to properly diagnose and screen out inappropriate candidates for medical interventions, but many have adopted an informed-consent only stance and no longer require any diagnosis, because per the WHO and the UN, that would be "pathologizing".

Child and Adolescent Referrals for Gender Dysphoria
United Kingdom



*Referral activity was sharply limited in 2020-2021 due to COVID-19.
Additional Notes: Beginning July 2021, referrals made directly to GIDS are reported separately from those handled by the Arden & GEN referral management service. The Tavistock reports that Arden & GEN handled over 1500 referrals in 2021-22.

Contrary to best clinical practices which sought to help children formulate a healthy relationship with their natal sex while their gender identity is still flexible, the political framework invites more kids to consider that being the opposite sex might be desirable, for a variety of reasons, and appears to concretize the experience of incongruence prematurely. The net result: more kids identifying as trans (or even trans human, such as animal identities), and fewer kids with gender identity distortions reconciling with their sexed bodies. It's not our goal to police identities, but in this case, there is a significant medical burden. It has been well understood for decades that social transition (e.g.

changing names and pronouns to live as the opposite sex) is a part of "triadic therapy" as the real-life test and a part of the medical pathway. Teachers are not licensed or qualified to initiate clinical interventions. While it isn't our position that no one benefits from the medical pathway, we do believe in medical ethics and competency, and the safeguarding of children who by nature are impulsive and tend to have strong but temporary emotions and convictions.

For these reasons, GDA is critical of the Gender Identity Framework and Queer Theory. We disagree with how these ideas are being packaged and taught, especially to children.

The failure of the public education and medical systems to safeguard children places a heavy burden on parents to guide and protect their kids. Their agency to do so should not be undermined.

I, along with the transsexual adults and others with Gender Dysphoria that GDA represents, do not want to be associated with the institutionalized harm being done to children and families, polarized societal divisions, and greater hostility towards the LGBT community.

Appendix IV: Transgender Experiences and Outcomes

Below, I share my own story as natal female with an ovotesticular disorder of sex development (OT-DSD), and the stories of others posted publicly on GDA's website.

I further have received consent to share three additional stories from Canadian members and associates of GDA, for the purpose of illustrating how multifactorial and multicausal the Gender Dysphoria experience is, and the broad range of outcomes of medical transition.

For clarity again, the use of the term Gender Dysphoria, is in reference to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), published by the American Psychiatric Association in 2013. This diagnostic manual is in current use.

My story as a person with gender dysphoria

I am a begrudging but perhaps necessary exemplar of my community. I was born as a biological female in 1973 and grew up in a small farming community. From an early age, I perceived myself as a boy. My parents would buy me "girl" toys, which I would mostly ignore in preference to my brother's toys. I look miserable in my kindergarten class photo because my mom made me wear a frilly shirt. When swimming, I wanted to wear swim trunks, not a swimsuit. My Halloween costumes included characters like Smurf, Superman, Michael Jackson, and Gene Simmons. I looked and acted so much like what others expect of boys that I was accidentally put onto a boys' baseball team one summer – which I thought was great! When we played Star Wars in the playground, I was Luke Skywalker – never Leia – which no one seemed to mind. I was one of the boys. This social arrangement lasted until puberty, and then all the rules changed. I was attracted to girls, none of whom took any notice of me. My guy buddies started to either flirt with or ignore me. I had no idea why I perceived myself as male. It was confusing and embarrassing, a sentiment that is echoed with many of our members in their formative years.

At age 19, I had surgery to remove a grapefruit-sized cyst from one of my ovaries. The surgeon said that my ovary was unrecognizable as an organ, so it was sent for biopsy.

It was discovered to be a mix of ovarian and testicular tissue, an intersex condition known as an ovotesticular disorder of sex development. The surgeon seemed embarrassed for me and reassured me that the offending organ was gone, so I should just forget about it. This both validated and further confused my perception of myself. I did not tell anyone about this at the time. I've since learned that most people with an OT-DSD live as men due to the masculinization caused by our natal testosterone levels.

I tried to live with my GD as a young adult, and identified as a lesbian, though it never felt right to me, and I was not happy. I experimented with ways to express my masculinity. I changed my name to Aaron when I was 22.

I did not even know how to explain what I felt to people and felt ashamed of it. I also did not know back then that medically transitioning was possible, and when I did learn about it years later, it seemed far-fetched and risky.

In the early 2000s, I moved to Vancouver and met a few trans people. Then around 2007, I saw a documentary on TV about trans kids which resonated with my experience of GD, so I decided to transition. I do not really regret that decision, because I do feel a lot more comfortable living as a man, but it has not been easy. As I have gotten older, I care less about whether I am male or female. I do not believe in radical gender politics or Queer Theory.

Even if people do decide to transition, people with GD need counselling to help them understand GD and deal with it in reality-based ways. "Affirmation" is not the same as giving us answers about why we feel the way we do as transsexuals. When I went to see doctors for help, I assumed they understood exactly what this condition is, how it manifests and what treatment is most helpful. I have learned that the truth is far different: doctors often are guessing, and do not have concrete answers regarding GD. I was not informed by the physicians I saw about the vast amount of research by psychologists like Dr. Blanchard and Dr. Zucker; the doctors I encountered presented medical transition as the only real option, which was a disservice to me, and to many other people with GD. The failure to apprise patients, especially children, of all viable treatment options on the medical side, is mirrored by the one-size-fits-all orthodoxy

pushed on children regarding social transitioning. Children are often told by activists and those who believe Queer Theory that they *are* in the wrong body, and that the *only* way to address this “fact” is to socially transition to a different gender. The reality is that there are many reasons why a given child may be experiencing GD, and there are many different options for treatment that do not involve social transitioning and genital surgery.

Because of the one-sided narrative that is often pushed on young people with GD, GDA’s position is that parents absolutely need to be involved and aware of behavioral changes in their children.

Knowing what I know now, if I were back in my pre-transition state, I would have gone to more counselling first and learned more about what GD is and what all of my options were. Unfortunately, it is even harder to get that kind of information today given the prevalence of the Affirmative Care model. I thought I knew everything I needed to know when I decided to undergo surgery, but I did not. I was just so desperate to feel better and fit in that I was not really thinking straight.

I feel okay about my choices now, but I am not sure they were all necessary. Of the transitional procedures and hormonal regimens that have been performed on me, I do regret getting bottom surgery done because I had complications and the outcome is not what I expected. Bottom surgery is the surgical creation of a pseudo-phallus using tissue removed from other areas of the body. I feel I was misled about what to expect. The bottom surgery actually made my dysphoria worse not better; better and more realistic pre-surgery clinical care could have prevented this issue. I have learned my disappointment and experience is hardly unique.

Meet Aaron Terrell

I had what we would consider early onset childhood gender dysphoria; a self-conception of being a boy despite a body that contradicted that. I don’t think I was born with it though; I think it was a response to restrictive female gender roles and a sense that boys had a freedom that shouldn’t be withheld from me. I was a tomboy who grew up in

a conservative Evangelical Christian environment and was regularly reminded how girls behave and dress, with the explicit message being I was acting like a boy and that was inappropriate. From my earliest memories the wish to be a boy, or the self-conception of myself as a boy, was inextricable from a sense of shame at feeling that way.

I began to tell myself stories to explain why I felt the way I did. When I was a toddler my infant brother died from SIDS and a few years later I became convinced that his spirit passed into me. That was why I felt like I was a boy; I was carrying my brother's spirit with me. This story also gave me permission to 'act like a boy', because I was doing it for my brother, not for me. I eventually outgrew this story and around age 11 or 12 my internal story shifted to something a little more realistic, which was that puberty would take away my 'boy' feelings and turn me into a real girl. I convinced myself that would fix me. It didn't.

The shame I felt as a small child for wishing I was a boy only increased in adolescence along with the "dysphoria". I didn't know that word at the time, but that's what I would come to understand it as. The older I got, the more intense the dysphoria got and the more intense the shame at still feeling that way. I kept telling myself I would outgrow it. I wouldn't feel this way at 16. Then when I still felt that way at 16, I knew I would outgrow it by 20. On and on it went.

It was further confounding and embarrassing because I wasn't attracted to girls. My peers thought I was a lesbian but in reality the thought of touching another girl's body was repellent to me. My own female body was grotesque, why would I find pleasure in duplicating it? I wasn't attracted to boys until my late teens and when that attraction manifested it was indistinguishable from envy. I found gay men most attractive, and fantasized about being one. I now realize gay male relationships were appealing because they didn't involve any female anatomy and was therefore erotically pure in my estimation. I certainly never told anyone this.

By 26 I hadn't outgrown the dysphoria, and in 2010 I started exploring the possibility of transition. Medical transition wasn't nearly as daunting as the prospect of telling my friends and family my shameful secret that I had carried with me as long as I could

remember. However, once I had vocalized it, the shame disappeared. As if all my life I had been carrying a heavy burden, when all I had to do was put it down. The dysphoria indeed persisted and I went on to transition in 2011 at the age of 27.

Important to note because I know this is a contentious issue right now between trans people and gay people: I did not transition to have sex with gay men. I anticipated being celibate the rest of my life. I did not believe actual gay men would be interested in me, and I wasn't interested in women. Spending the remainder of my life single was a sacrifice I was more than happy to make to be rid of the dysphoria. I saw it two ways: I could be single as a man or partnered as a woman. The choice was simple for me.

Transition was an unequivocal relief for me. Testosterone brought on physical and psychological changes that allowed me to feel comfortable in my body in a way I didn't know was even possible. The dysphoria dramatically reduced as my face and musculature began masculinizing. My sexuality ceased to be focused on gay men and instead, very surprisingly to me, turned primarily toward women. I later concluded my previous repulsion to the female form was a projection of my dysphoria, and my attraction to men was primarily envy. With the relief from dysphoria that repulsion and envy faded away. Two years into my transition I got "top surgery" and my dysphoria was mostly eradicated. As disturbing as this may sound to people who do not suffer from gender dysphoria, the day I had my double mastectomy remains the greatest day of my life. Dysphoria had been such a constant and seemingly interwoven sense of who I was, I wasn't able to fathom what I would feel like without it. Immense relief and contentment is what I felt.

After transition I didn't spend much time in trans communities. I lived mostly stealth. I went back to college and got a Bachelor's degree. I started a new job where no one knew of "my female past" (as I would refer to it at the time) and generally embraced life as a man and didn't spend much time dwelling on the trans part of my life. Transition worked wonders for me, and I got on with life. Occasionally I would wander into online trans communities where I would read young people, often teenagers, expressing they

thought they were trans. I was team transition all the way. I mistakenly assumed gender dysphoria was one thing, and that transition was the only solution.

In 2017 I learned gender dysphoria is not one thing, and that plenty of people are transitioning despite never even experiencing dysphoria of any variety. I became aware of this shift in understanding when I befriended a number of transmen in my city. Initially I was glad to learn there were other people with whom I had such a fundamental commonality, but quickly learned our experiences were starkly different. Some of the things I learned from these young transmen:

1. Being ‘trans’ is separate from gender dysphoria
2. Transition is something you do to demonstrate you are ‘trans’
3. Assuming dysphoria should be a prerequisite to transitioning is inherently transphobic because it ‘pathologizes transness’
4. Lying about having dysphoria is a normal part of accessing trans healthcare, as is necessary because doctors and clinicians are by and large transphobic

Upon hearing multiple variations of all of the above, I was dumbfounded and angry at what I perceived as a cruel appropriation of an ailment I had suffered my entire life. When I expressed disagreement at this framing of ‘trans’ as an identity independent from any mental turmoil at one’s sexed body, I was told that as a fellow trans person I shouldn’t be invalidating anyone else’s ‘transness’ because trans people are invalidated enough by ‘cis transphobes’, and therefore don’t need it from fellow trans people as well.

After distancing myself from my short-lived friendship with these transmen, my anger and confusion only grew. I started lurking in online communities for transmen and learned the cohort I had known in person were not an anomaly - they were expressing the currently pervasive view of ‘trans’ as an identity. An identity that must be validated by surgeries and hormones. My anger at the appropriation melted into terror at what was happening. I read a lot of their stories, I asked a lot of questions, and eventually developed a sense of what was happening. Loneliness is driving young people to

drastic measures to find community, purpose, and distinction. Trans is a religion and a youth subculture rolled into one. It is especially appealing to girls who have been sexually abused or who are on the Autism spectrum. In females it appears to be unrelated to sexuality (apart from fleeing male attention). What we now know as ROGD has little to do with GD as we previously understood it and more to do with tragically normal adolescent struggles being funneled into ‘trans’.

While casually researching the turn within the trans community I came upon a number of stories of detransitioners, mostly women (former transmen). I was not surprised that there were many detransitioned women now. What did surprise me is their stories of dysphoria sounded much more familiar and relatable to me than what I was hearing from the current ‘trans’ population. For these women transition did not relieve their dysphoria. Sometimes it made it worse. In other cases it just came with the nagging reality that they were lying to others and deluding themselves. It would seem many experiences common in girls upbringing, especially masculine girls, can easily be interpreted as an intense, unrelenting feeling that we should have been boys.

All these revelations led me to re-examine my transition and the stories I told myself as a child and as an adult about why I felt the way I did. I’ve realized ‘gender dysphoria’ is just another story I use to explain to myself why I feel the way I do about my female sex and where that positions me in the world. While transition did provide significant relief, and I stand here a decade later without regret, I do wonder if had I been given a different story or tools to explain my discomfort with my sex, would I have found the relief I needed without such drastic and invasive measures? After all, no one is born in the wrong body and I was not supposed to be male. What we are currently doing is solving software issues by carving up hardware. We are treating normal female adolescence with blunt force transition. We should be identifying the root issue before trying to solve vague and nebulous anxieties - body dysmorphia, social anxiety, fear of loneliness - with irreversible hormones and surgeries.

Meet Janet Scott

Most of my strongest childhood memories revolve around my desire to be a girl or at least the knowledge that I did not “fit” as a boy. We now call that gender dysphoria. I remember distinctly going to bed for several years with the constant secret wish that I would wake up and be a girl. From preschool through high school you were likely to find me as the lone boy among a group of girls. While I did have the occasional boy in my neighborhood that I was friends with, other boys tended to confuse me. They didn’t tend to like what I liked, they didn’t play the games I liked to play. At recess, I was often playing jump rope or learning the latest rhyming game with the girls, while the boys learned to play basketball or football or just chased around after each other.

Children tend to be strict enforcers of “gender”. “Boys do this.” “Only girls do that.” Most young children don’t really know about the sex differences between boys and girls, so what makes them different becomes other factors. When I was wishing to be a girl at 6 and 7, I didn’t understand that that would require a change of my sexed body. What I did know is that I was different and that difference was not OK with some people. My parents were loving. They never tried to force me to “be like the other boys” but there were always limits on just how far I was allowed to go in the other direction. I could talk them into some “girls’ toys” but dolls and Barbie were a no go. I’d get the occasional lecture about how “Boys don’t do that. Boys don’t stand that way. They don’t carry their books like that.”

I was around 9 the first time I learned that people could actually have a “sex change”. From that moment on, I knew that’s what I wanted when I got older. (It was still very much an adult issue back then) Shortly after, I learned the word transsexual and began trying to find out everything I could. I was probably the only one in elementary school that knew who Christine Jorgenson and Renee Richards was.

Middle school and high school became very confusing. The friendships I had always enjoyed with girls became complicated. I lost one friend in middle school because a rumor started that we had “done it” in the girls’ bathroom. I didn’t even know what “it” was. Other friends became disappointed when I showed no interest in being their

boyfriend. I never had crushes on boys my own age. I did however have crushes on male teachers, Being gay in middle school or high school wasn't really a thing back then. Besides, it didn't occur to me to consider the attraction I had to these men as "gay", because the men weren't gay and I had already convinced myself that I'd be a woman when I grew up. I became obsessed with transsexuals and "gender", watching and reading everything I could find. Not the easiest thing to do in the early 1990s.

Unlike a lot of dysphoric children and teens of that time, I actually do have proof of these feelings and experiences. At 16, I called a cable talk show that was doing a story on transsexuals. The cohost was a young Dr. Drew. I also came out to one of my teachers because an assignment asked us to visualize how we saw ourselves in the future. I became paralyzed because how could I explain that in the future I saw myself as a woman? Coming out led to talks with the school counselor and then to my parents. My parents took me to a therapist, who did eventually diagnose me with what was then called Gender Identity Disorder. She told them that I was a "likely transsexual".

Right after turning 17 my family and I moved to the southeast United States and I started college. My parents had made me promise to stop all this talk about being a woman and asked me if I was sure I wasn't "just gay". Despite that, I maintained the idea that I would transition after college. I grey my hair out and even frequently "passed" as a woman, even though that wasn't my intent. After college (and more time on the internet) I decided to see if maybe everything else people said about me was true, maybe I was a gay man. I went on my first date with the man that would become my husband of 19 years. The dysphoria didn't disappear, but it became tolerable. I had a relationship and a career to focus on, "gender" took a back seat.

In 2016 the dysphoria started getting stronger again. After discussion with my husband, I began socially transitioning and seeking a therapist and medical transition. My transition was from April 2016-July 2017 when I completed SRS. During my transition and after, I realized that things had changed from my initial ideas in the 90s. Gender Identity Disorder was out, gender dysphoria was in. Transsexuals were out, trans men

and trans women were in. Therapy focused more on how you felt about the transition process than your dysphoria.

I spent the first few years after my transition saying a lot of the things gender ideology says. Even if I didn't fully believe some of it, you start to trust those with more knowledge and experience. Slowly though I started listening to more voices and asserting my own views. "Trans" is not something you innately are, it's something you become with transition. Transition is not a blanket solution for everything. Those of us that choose to transition need to understand the limitations of the process.

Meet Lauren Black

"I am a butch lesbian. I live with gender dysphoria. I do not believe my deep discomfort with my female body means that I should take steps to change it."

I am a butch lesbian. I live with gender dysphoria. This is the condition which, according to mental health professionals, means I am transgender. However, I do not define as transgender. I do not want to take hormones or have surgeries. I do not accept that it is possible to live "as a man", without believing in old fashioned gender stereotypes. I do not believe my deep discomfort with my female body means that I should take steps to change it. This is my story.

In many respects, I live "as a man," if you want to put it like that. I don't want to put it like that, which is part of the problem I face. But I work in a warehouse. I shop in the men's department. I have a wife and children, who I work to support. I am at ease in the company of men. My hobbies include turning wood, and fixing things. If I could click my fingers and be rid of my womb and my breasts, and not face lifelong medicalisation, I probably would. I have regularly felt, like Lady Macbeth, "unsex me here." I am often "misgendered." People call me "lad" or "sir," until they hear my voice. It bothers me not at all.

I meet the criteria, set out in the DSM 5, for medical transition. That is, if I went to a gender clinic and told them how I feel, and about my experiences, they would prescribe me testosterone and a double mastectomy. I choose not to transition. Instead, I am

learning to love the skin I'm in. I have my own struggles with that skin, with my female body. Those struggles are not because my female body is wrong, but because my negative thinking around my body and my sexuality, which started in childhood, was not explored through therapy soon enough. I do not think it is in my interest to treat a condition that is in my head by making changes to my body. Psychiatry does not have a good history in this regard.

I'm not hard line about transition. I support the right of adults to take what course of action they feel they need to take. However, I believe it is the responsibility of the medical establishment to explore options with individuals, before going 'nuclear'. If counselling, feminism, learning to accept your sexuality shame free (which for me is butch femme dynamics), or even just growing into yourself can help you, why take life changing drugs and have life changing surgeries? It is not the job of clinicians to prescribe unthinkingly to satisfy another person's desire to be validated; it is the job of clinicians to explore the reasons for an individual's distress.

The affirmation model, the rush to the nuclear option first, is not good for individuals like me, who live with dysphoria. It closes down my options. I am less able, not more, to seek help for my distress, as the only help now widely available would, I believe, be damaging to my health and my life. The side effects of testosterone on women include, and may not be limited to – painful orgasm, vaginal atrophy, clitoromegaly, suicidal tendencies, violence, panic attacks, rage, jaundice, severe allergic reaction, nausea, vomiting, liver failure, cancer, kidney or urinary problems, infection of the injection site, stroke, or heart attack. Learning to love the skin I'm in sounds like a much better option to me.

Affirmation also solidifies a trans identity. Dysphoria is a condition affecting individuals; transition is only one treatment for that condition. "Being" trans seems as though it attaches an identity to a condition, and I don't think that's a helpful way to think. Individuals live with a variety of conditions, without letting those condition define them.

It is particularly important not to “affirm” children in identities which may take them down unhelpful routes in their lives. Telling a child they “are” anxious, for example, is less helpful than giving them support and strategies to deal with their worries.

How much more important is it, then, not to consolidate the identities of people in ways that will make them life long medical patients, reduce their choice of sexual partners, and may ruin their future fertility and sex life? If I had been “affirmed” as transgender as a child, when I was a tomboy, if that option had been open to me, I would have taken it. It was not an option. I am glad it was not. I now have a life that I never thought was open to me.

I still have difficulties with my sexed body. Periods are particularly difficult for me. But instead of seeking a hysterectomy, I tell myself, “Lauren, you’re a butch lesbian, are you really so afraid of a little blood?”, and then I get on with my day. My wife loves me, just how I am, with all my oddities. I’m very glad that I’m in a lesbian relationship. I would not want to be in a heterosexual relationship with a woman. That would wreck something important for me about who I am, and what I stand for and I could never have discovered that on my own if I had been transitioned young.

I stand for trashing the old fashioned, regressive stereotypes that say “if you can drive a forklift and operate a lathe, you must be a man.” No. I stand for a celebration of the amazing diversity that women are. I stand for smashing the nonsense that is the gender binary. I stand for loving the skin you’re in, and embracing who you really are, not for altering healthy bodies with drugs and surgeries in an endless quest to become someone that, in the end, you biologically can never be.

And so, I will put on my high vis vest, and my steel toe caps, and go to work with the lads, and I will hug my wife a little tighter when I’m suffering. I will clad my female body with muscle, and my female voice with chivalry, and I will know that this is who I am. And that it is good enough.

Meet Kellie Pirie

I am a 57-year-old woman and a medical transition regrettor, though I haven't taken steps to medically detransition, since most of the changes to my body are permanent. I pass as male in society and work full time as a truck driver. Since 2004, when I first started taking testosterone, I've reflected a lot about what's happened to me and why I made the decisions I did.

In 1966 my mother married a convicted pedophile who sexually exploited me for many years as a child.

I moved to Vancouver BC, as an adult during the early 2000's. There I encountered trans-ideology and was completely enchanted by the fantasy that living my life as a man would make me feel safer.

In 2004 I began to attend Vancouver Coastal Health's Trans Health Program peer counselling services, peer support group and FTM Etcetera, all led by members of the community, not clinical experts. My peer support group told me of someone who would prescribe hormones based on a family doctor's referral, and coached me to "navigate the system". They were hyper-focused on the process, and minimized the risks.

I obtained the necessary referral and was prescribed testosterone on my second visit. I was told to expect male normal health risks. No one talked about how cross sex hormones are like burning gas in a diesel engine. Rates of type 2 diabetes are higher in women taking testosterone. In December 2017 I was diagnosed with type 2 diabetes. My peer support cheering squad encouraged me to celebrate abdominal pain, soft tissue injuries, joint pain and ligament strain as proof the testosterone was working. My family's grief, remorse, shock and confusion were all framed by the group as manifestations of lack of acceptance, transphobia, and intolerance of my autonomy.

The surgeon who started me on testosterone, performed my complete hysterectomy. After three days in hospital I was sent home. Routine post hysterectomy examinations were not done, so the abdominal pain and discomfort I began to experience was missed.

In 2008 I had a double mastectomy at the UBC Hospital where I had a complication recovering from the anesthetic and was discharged late.

Early the following day I woke up in severe agony. It felt like someone was ripping the left side of my chest apart. I groped my dressing and there was a huge bulge. I was taken to Vancouver General Hospital where doctors determined that an artery had burst and I was bleeding internally. I had to wait a day and a half for emergency surgery.

Because of my earlier reaction to anesthetic, a milder sedation was used. I woke up on the surgical table while they were closing up the incision area. Screaming obscenities at hospital staff, I tried to get up to leave. They gave me something to knock me out. When I came to they had me completely restrained. I was kept in hospital for an additional two nights. About a week later I developed a post-operative infection and was put on several rounds of antibiotics.

As a truck driver, wearing a seatbelt is still uncomfortable due to scar-line adhesions and sensitivity.

In 2009, I experienced increasing levels of abdominal pain and discomfort. The peer support cheering section continued to frame this as physical manifestations of transphobia because of my family. Eventually a combination of pain, fever and nausea led me to think I should go to an emergency room. I had developed an abdominal abscess which fistulated into my intestinal tract. Over the next year I was on several courses of extremely strong antibiotics. I was unable to work most of that year and no longer have complete control of my bodily functions.

Late 2010 my world came crashing down as I recognized that despite everything I had done to surgically and chemically alter my social gender presentation, I would never be a man. I realized that my distress and desire to transition was a result of my childhood trauma. None of these interventions addressed the real cause of my distress.

I’ve resigned to the fact that I’ll probably never find a romantic partner, since I’m attracted to lesbians but I’m now invisible and not attractive to other lesbians. I’ve also

lost sexual function as a result of testosterone therapy, because diabetic neuropathy has set in and I have lost sensation in my toes and sex organs.

Between 2010 and 2016, I returned to employment in trucking, a very male dominated profession. Through contact with the men I worked with, the differences between men and women became clear to me. So the realization of being biologically female, and nothing like my male coworkers sunk in.

Between 2017-2018 I've watched the most radical trans activists defend the rights of convicted sex offenders to access women's prisons, and argue for the inclusion of pedophiles in the LGBTQ2S+ umbrella under the term Minor Attracted Persons. As a who's experienced childhood sexual exploitation, I can no longer support the Queer Theory based political movement.

Meet Lois Card

I am a First Nations adult and post op transsexual (male to female) of 14 years from Treaty 6 territory in Alberta. Earlier this year, I applied for MAiD due to the lack of medical resources to help alleviate my extreme and ongoing pain and discomfort from the vaginoplasty I had in 2009. I believe that the current medical system is captured by gender identity ideologues, which made accessing safe therapeutic and medical care impossible. At the end of my first MAiD assessment, it was determined that all I could do was settle for a numbing cream that does not work. The assessors also determined that my application was a human rights concern and thus declined my application. I now must exhaust all current medical resources (likely more surgery) in order to qualify for another MAiD application, which I intend to do in the future. As a First Nations individual and advocate, I am especially concerned for First Nations youth and children in care who do not have a guardian. The institutional undermining of parental authority that happens "in the best interests of the child" echoes our devastating history of the removal of First Nations children from their homes and placing them in residential schools. I'm concerned about the over representation of First Nations youth and youth in foster care among those who are trans identified in Canada and, since medical transition often times involves the stopping of sexual maturation and the removal of sex

organs, that First Nations people are, once again, being sterilized. I am also critical of the ways in which academic post-modern ideas about sexuality and gender (e.g. Queer Theory) are being used to further colonize First Nations people. We have our own cultural and spiritual understandings of these things. The term "Two-Spirit" was coined in Winnipeg in 1990 at a conference of same-sex attracted indigenous people who wished to separate themselves from the European concepts of homosexuality and gender non-conformity. Efforts to "queer" our communities, especially our youth, is erasing our cultures and dividing our communities.

Meet Stefan

In January 2004, I started hormone treatment to transition from a woman to a man. I was a young adult in my mid-20s, living in a large Canadian city, when I embarked on a medical path. My last surgical intervention was in 2010.

I saw the assessing psychologist for a single 90-minute session. The natural next step was hormones and surgery. That was the only treatment option that was presented to me.

Taking my first hormone shot felt very empowering. I felt like I was taking control of my own identity, my own destiny. Initially, my depression lifted, my anxiety subsided. A clear path lay ahead of me: updating legal documents, informing loved ones, and looking into surgical options. It gave me a sense of purpose and direction.

But I had flashes of memories I couldn't deny - moments where I had made choices, not based on the belief that I was a man, but rather on the belief that I was not much of a woman. I recalled moments where I had felt uncomfortable because I didn't like the look of my breasts, or was grossed out by my period, or didn't feel like I had much in common with the women around me.

After my transition, and as I matured, the desire to have children snuck up on me. Prior to that, I had not allowed myself to imagine the possibility of being a parent. Up until then, I had little concept of growing old, let alone growing old as a man. For much of my teen years and early twenties, I had held a belief that I would be dead by the age of

thirty, either by my own hand or by some act outside of my control. As thirty came and went, however, and I continued to live, my views changed - and with it my perspective on my transition.

I no longer consider myself male, though legally that is what I am. When I first transitioned, I thought that gender transition was a cure for my depression and anxiety. Some might say that this was a foolish assumption on my part, and that I am solely responsible for holding it. But this belief didn't come out of nowhere. This is what I was told. What responsibility do the medical and psychological providers have, considering that they had a duty of care and I believed what they were telling me? What duty does the clinical community have to ensure that their treatment protocol is safe and based on evidence. What duty do they have to ensure informed consent?

Medical transition is held up as a very effective treatment for gender dysphoria. Doctors routinely claim that the regret rate is much lower for this type of intervention than virtually any other medical treatment people receive for other conditions. While I wish that were true, I remain skeptical. No one who helped me along my medical transition ever followed up with me to find out how I was adjusting. Just because people don't necessarily detransition doesn't mean they don't grieve or regret. In many cases, there may be no going back. And what of the rising voices of detransitioners? Do their voices not also matter? Perhaps for some people transition is the right choice and it really is that simple. But for me, my transition has raised more questions than it has answered. I see value in acknowledging these complexities, complexities that the clinical community have refused to acknowledge.

As for my gender dysphoria, I still experience it. Only now it's in reverse. Medical transition has complicated my already messy relationship with my body. I mostly like myself when I look in the mirror and see my bearded face, but I also miss the thick, curly brown hair I had as a girl, that at times I wore in a ponytail and sometimes cut short. These days I wear a hat to conceal the hair loss that often accompanies testosterone treatment. I don't mind my deep voice, but I miss my singing voice, the voice my late father loved to hear when I sang carefree in the shower as a teen. I have

grown to like the silhouette of my flat, masculinized chest, but I regret the scars and grieve the loss of sensation that followed the loss of a nipple during surgery. I like that I no longer must worry about monthly periods or have to fear unwanted pregnancy, but I experience deep sadness for the child I'll never bear.

Over the years I have had many theories on what led me to transition. Is my gender dysphoria better understood as an anxiety disorder, the fear of becoming an adult woman in a culture hostile to gender nonconformity? Was it social influence and an obsessive disposition that led me down this path? Am I autistic and mistook my sensory sensitivities and communication difficulties for gender dysphoria? Did my misattunement with my mother drive me to over-identify with my father? I'll likely never know.

Was my medical transition worth it? I'm not so sure.

This is **Exhibit "D"** referred to in the Affidavit of **Aaron Kimberly** sworn before me this 28th day of November, 2023.

Rochelle Lewis

Name: Rochelle Oliver

Commissioner

Nurse Check
Online verification system

Search Results

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Total : 1 record(s), Records : 1-1

Previous • Next

Registration Number	First Name	Last Name	Current Membership Class	Conditions	Notations	Client Population	Expiry Date
406296 View employment information	Aaron	Kimberly	Registered Nurse				2023-12-31

Previous • Next

The following information was obtained from the Employer Verification section of the College of Registered Nurses of Manitoba website www.crnm.mb.ca on 2023-09-13 at 09:33:55 PM CST.

Currency of Information: Verification requests are processed in real-time based on information contained in our registration database at the time of the request. A short processing delay may occur between the time an individual applies for registration until approval is granted and the information is entered into the register. If you believe there are any discrepancies between these results and your records, please contact Registration Services at the College of Registered Nurses immediately at (204) 774-3477 or toll free in

This is **Exhibit "E"** referred to in the Affidavit of **Aaron Kimberly** sworn before me this 28th day of November, 2023.

Name: ROCHELLE OLIVER

Commissioner

GD Alliance Aug 18, 2021 7 min read

Meet Aaron Terrell

Updated: Dec 18, 2021

Part I: Gender Dysphoria & Shame

I had what we would consider early onset childhood gender dysphoria; a self-conception of being a boy despite a body that contradicted that. I don't think I was born with it though; I think it was a response to restrictive female gender roles and a sense that boys had a freedom that shouldn't be withheld from me. I was a tomboy who grew up in a conservative Evangelical Christian environment and was regularly reminded how girls behave and dress, with the explicit message being I was acting like a boy and that was inappropriate. From my earliest memories the wish to be a boy, or the self-conception of myself as a boy, was inextricable from a sense of shame at feeling that way.

I began to tell myself stories to explain why I felt the way I did. When I was a toddler my infant brother died from SIDS and a few years later I became convinced that his spirit passed into me. That was why I felt like I was a boy; I was carrying my brother's spirit with me. This story also gave me permission to 'act like a boy', because I was doing it for my brother, not for me. I eventually outgrew this story and around age 11 or 12 my internal story shifted to something a little more realistic, which was that puberty would take away my 'boy' feelings and turn me into a real girl. I convinced myself that would fix me. It didn't.

The shame I felt as a small child for wishing I was a boy only increased in adolescence along with the "dysphoria". I didn't know that word at the time, but that's what I would come to understand it as. The older I got, the more intense the dysphoria got and the more intense the shame at still feeling that way. I kept telling myself I would outgrow it. I wouldn't feel this way at 16. Then when I still felt that way at 16, I knew I would outgrow it by 20. On and on it went.

It was further confounding and embarrassing because I wasn't attracted to girls. My peers thought I was a lesbian but in reality the thought of touching another girl's body was repellent to me. My own female body was grotesque,

why would I find pleasure in duplicating it? I wasn't attracted to boys until my late teens and when that attraction manifested it was indistinguishable from envy. I found gay men most attractive, and fantasized about being one. I now realize gay male relationships were appealing because they didn't involve any female anatomy and was therefore erotically pure in my estimation. I certainly never told anyone this.

By 26 I hadn't outgrown the dysphoria, and in 2010 I started exploring the possibility of transition. Medical transition wasn't nearly as daunting as the prospect of telling my friends and family my shameful secret that I had carried with me as long as I could remember. However, once I had vocalized it, the shame disappeared. As if all my life I had been carrying a heavy burden, when all I had to do was put it down. The dysphoria indeed persisted and I went on to transition in 2011 at the age of 27.

Important to note because I know this is a contentious issue right now between trans people and gay people: I did not transition to have sex with gay men. I anticipated being celibate the rest of my life. I did not believe actual gay men would be interested in me, and I wasn't interested in women. Spending the remainder of my life single was a sacrifice I was more than happy to make to be rid of the dysphoria. I saw it two ways: I could be single as a man or partnered as a woman. The choice was simple for me.

Part II: Gender Ideology & Gender Reconciliation

Transition was an unequivocal relief for me. Testosterone brought on physical and psychological changes that allowed me to feel comfortable in my body in a way I didn't know was even possible. The dysphoria dramatically reduced as my face and musculature began masculinizing. My sexuality ceased to be focused on gay men and instead, very surprisingly to me, turned primarily toward women. I later concluded my previous repulsion to the female form was a projection of my dysphoria, and my attraction to men was primarily envy. With the relief from dysphoria that repulsion and envy faded away. Two years into my transition I got "top surgery" and my dysphoria was mostly eradicated. As disturbing as this may sound to people who do not suffer from gender dysphoria, the day I had my double mastectomy remains the greatest day of my life. Dysphoria had been such a constant and seemingly interwoven sense of who I was, I wasn't able to fathom what I would feel like without it. Immense relief and contentment is what I felt.

After transition I didn't spend much time in trans communities. I lived mostly stealth. I went back to college and got a Bachelor's degree. I started a new job where no one knew of "my female past" (as I would refer to it at the time) and generally embraced life as a man and didn't spend much time dwelling on the trans part of my life. Transition worked wonders for me, and I got on with life. Occasionally I would wander into online trans communities where I would read young people, often teenagers, expressing they thought they were trans. I was team transition all the way. I mistakenly assumed gender dysphoria was one thing, and that transition was the only solution.

In 2017 I learned gender dysphoria is not one thing, and that plenty of people are transitioning despite never even experiencing dysphoria of any variety. I became aware of this shift in understanding when I befriended a number of transmen in my city. Initially I was glad to learn there were other people with whom I had such a fundamental commonality, but quickly learned our experiences were starkly different. Some of the things I learned from these young transmen:

1. Being ‘trans’ is separate from gender dysphoria

2. Transition is something you do to demonstrate you are ‘trans’

3. Assuming dysphoria should be a prerequisite to transitioning is inherently transphobic because it ‘pathologizes transness’

4. Lying about having dysphoria is a normal part of accessing trans healthcare, as is necessary because doctors and clinicians are by and large transphobic

Upon hearing multiple variations of all of the above, I was dumbfounded and angry at what I perceived as a cruel appropriation of an ailment I had suffered my entire life. When I expressed disagreement at this framing of ‘trans’ as an identity independent from any mental turmoil at one’s sexed body, I was told that as a fellow trans person I shouldn’t be invalidating anyone else’s ‘transness’ because trans people are invalidated enough by ‘cis transphobes’, and therefore don’t need it from fellow trans people as well.

After distancing myself from my short-lived friendship with these transmen, my anger and confusion only grew. I started lurking in online communities for transmen and learned the cohort I had known in person were not an anomaly - they were expressing the currently pervasive view of ‘trans’ as an identity. An identity that must be validated by surgeries and hormones. My anger at the appropriation melted into terror at what was happening. I read a lot of their stories, I asked a lot of questions, and eventually developed a sense of what was happening. Loneliness is driving young people to drastic measures to find community, purpose, and distinction. Trans is a religion and a youth subculture rolled into one. It is especially appealing to girls who have been sexually abused or who are on the Autism spectrum. In females it appears to be unrelated to sexuality (apart from fleeing male attention). What we now know as ROGD has little to do with GD as we previously understood it and more to do with tragically normal adolescent struggles being funneled into ‘trans’.

While casually researching the turn within the trans community I came upon a number of stories of detransitioners, mostly women (former transmen). I was not surprised that there were many detransitioned women now. What did surprise me is their stories of dysphoria sounded much more familiar and relatable to me than what I was hearing from the current ‘trans’ population. For these women transition did not relieve their dysphoria. Sometimes it made it worse. In other cases it just came with the nagging reality that they were lying to others and deluding themselves. It would seem many experiences common in girls upbringing, especially masculine girls, can easily be interpreted as an intense, unrelenting feeling that we should have been boys.

All these revelations led me to re-examine my transition and the stories I told myself as a child and as an adult about why I felt the way I did. I’ve realized ‘gender dysphoria’ is just another story I use to explain to myself why I feel the way I do about my female sex and where that positions me in the world. While transition did provide significant relief, and I stand here a decade later without regret, I do wonder if had I been given a different story or tools to explain my discomfort with my sex, would I have found the relief I needed without such drastic and invasive measures? After all, no one is born in the wrong body and I was not supposed to be male. What we are currently doing is solving software issues by carving up hardware. We are treating normal female adolescence with blunt

force transition. We should be identifying the root issue before trying to solve vague and nebulous anxieties - body dysmorphia, social anxiety, fear of loneliness - with irreversible hormones and surgeries.

GD Alliance Aug 22, 2021 4 min read

Meet Janet Scott

Updated: Dec 18, 2021

Most of my strongest childhood memories revolve around my desire to be a girl or at least the knowledge that I did not “fit” as a boy. We now call that gender dysphoria. I remember distinctly going to bed for several years with the constant secret wish that I would wake up and be a girl. From preschool through high school you were likely to find me as the lone boy among a group of girls. While I did have the occasional boy in my neighborhood that I was friends with, other boys tended to confuse me. They didn’t tend to like what I liked, they didn’t play the games I liked to play. At recess, I was often playing jump rope or learning the latest rhyming game with the girls, while the boys learned to play basketball or football or just chased around after each other.

Children tend to be strict enforcers of “gender”. “Boys do this.” “Only girls do that.” Most young children don’t really know about the sex differences between boys and girls, so what makes them different becomes other factors. When I was wishing to be a girl at 6 and 7, I didn’t understand that that would require a change of my sexed body. What I did know is that I was different and that difference was not OK with some people. My parents were loving. They never tried to force me to “be like the other boys” but there were always limits on just how far I was allowed to go in the other direction. I could talk them into some “girls’ toys” but dolls and Barbie were a no go. I’d get the occasional lecture about how “Boys don’t do that. Boys don’t stand that way. They don’t carry their books like that.”

I was around 9 the first time I learned that people could actually have a “sex change”. From that moment on, I knew that’s what I wanted when I got older. (It was still very much an adult issue back then) Shortly after, I learned the word transsexual and began trying to find out everything I could. I was probably the only one in elementary school that knew who Christine Jorgenson and Renee Richards was.

Middle school and high school became very confusing. The friendships I had always enjoyed with girls became complicated. I lost one friend in middle school because a rumor started that we had “done it” in the girls’ bathroom. I didn’t even know what “it” was. Other friends became disappointed when I showed no interest in being their boyfriend. I never had crushes on boys my own age. I did however have crushes on male teachers, Being gay in middle school or high school wasn’t really a thing back then. Besides, it didn’t occur to me to consider the attraction I had to these men as “gay”, because the men weren’t gay and I had already convinced myself that I’d be a woman when I grew up. I became obsessed with transsexuals and “gender”, watching and reading everything I could find. Not the easiest thing to do in the early 1990s.

Unlike a lot of dysphoric children and teens of that time, I actually do have proof of these feelings and experiences. At 16, I called a cable talk show that was doing a story on transsexuals. The cohost was a young Dr. Drew. I also came out to one of my teachers because an assignment asked us to visualize how we saw ourselves in the future. I became paralyzed because how could I explain that in the future I saw myself as a woman? Coming out led to talks with the school counselor and then to my parents. My parents took me to a therapist, who did eventually diagnose me with what was then called Gender Identity Disorder. She told them that I was a “likely transsexual”.

Right after turning 17 my family and I moved to the southeast United States and I started college. My parents had made me promise to stop all this talk about being a woman and asked me if I was sure I wasn’t “just gay”. Despite that, I maintained the idea that I would transition after college. I grey my hair out and even frequently “passed” as a woman, even though that wasn’t my intent. After college (and more time on the internet) I decided to see if maybe everything else people said about me was true, maybe I was a gay man. I went on my first date with the man that would become my husband of 19 years. The dysphoria didn’t disappear, but it became tolerable. I had a relationship and a career to focus on, “gender” took a back seat.

In 2016 the dysphoria started getting stronger again. After discussion with my husband, I began socially transitioning and seeking a therapist and medical transition. My transition was from April 2016-July 2017 when I completed SRS. During my transition and after, I realized that things had changed from my initial ideas in the 90s. Gender Identity Disorder was out, gender dysphoria was in. Transsexuals were out, trans men and trans women were in. Therapy focused more on how you felt about the transition process than your dysphoria.

I spent the first few years after my transition saying a lot of the things gender ideology says. Even if I didn’t fully believe some of it, you start to trust those with more knowledge and experience. Slowly though I started listening to more voices and asserting my own views. “Trans” is not something you innately are, it’s something you become with transition. Transition is not a blanket solution for everything. Those of us that choose to transition need to understand the limitations of the process.

GD Alliance Mar 28, 2021 4 min read

Meet Lauren Black

Updated: Oct 13, 2021

“I am a butch lesbian. I live with gender dysphoria. I do not believe my deep discomfort with my female body means that I should take steps to change it.”

I am a butch lesbian. I live with gender dysphoria. This is the condition which, according to mental health professionals, means I am transgender. However, I do not define as transgender. I do not want to take hormones or have surgeries. I do not accept that it is possible to live “as a man”, without believing in old fashioned gender stereotypes. I do not believe my deep discomfort with my female body means that I should take steps to change it. This is my story.

In many respects, I live “as a man,” if you want to put it like that. I don’t want to put it like that, which is part of the problem I face. But I work in a warehouse. I shop in the men’s department. I have a wife and children, who I work to support. I am at ease in the company of men. My hobbies include turning wood, and fixing things. If I could click my fingers and be rid of my womb and my breasts, and not face lifelong medicalisation, I probably would. I have regularly felt, like Lady Macbeth, “unsex me here.” I am often “misgendered.” People call me “lad” or “sir,” until they hear my voice. It bothers me not at all.

I meet the criteria, set out in the DSM 5, for medical transition. That is, if I went to a gender clinic and told them how I feel, and about my experiences, they would prescribe me testosterone and a double mastectomy. I choose not to transition. Instead, I am learning to love the skin I'm in. I have my own struggles with that skin, with my female body. Those struggles are not because my female body is wrong, but because my negative thinking around my body and my sexuality, which started in childhood, was not explored through therapy soon enough. I do not think it is in my interest to treat a condition that is in my head by making changes to my body. Psychiatry does not have a good history in this regard.

I'm not hard line about transition. I support the right of adults to take what course of action they feel they need to take. However, I believe it is the responsibility of the medical establishment to explore options with individuals, before going 'nuclear'. If counselling, feminism, learning to accept your sexuality shame free (which for me is butch femme dynamics), or even just growing into yourself can help you, why take life changing drugs and have life changing surgeries? It is not the job of clinicians to prescribe unthinkingly to satisfy another person's desire to be validated; it is the job of clinicians to explore the reasons for an individual's distress.

The affirmation model, the rush to the nuclear option first, is not good for individuals like me, who live with dysphoria. It closes down my options. I am less able, not more, to seek help for my distress, as the only help now widely available would, I believe, be damaging to my health and my life. The side effects of testosterone on women include, and may not be limited to – painful orgasm, vaginal atrophy, clitoromegaly, suicidal tendencies, violence, panic attacks, rage, jaundice, severe allergic reaction, nausea, vomiting, liver failure, cancer, kidney or urinary problems, infection of the injection site, stroke, or heart attack. Learning to love the skin I'm in sounds like a much better option to me.

Affirmation also solidifies a trans identity. Dysphoria is a condition affecting individuals; transition is only one treatment for that condition. "Being" trans seems as though it attaches an identity to a condition, and I don't think that's a helpful way to think. Individuals live with a variety of conditions, without letting those condition define them.

It is particularly important not to "affirm" children in identities which may take them down unhelpful routes in their lives. Telling a child they "are" anxious, for example, is less helpful than giving them support and strategies to deal with their worries.

How much more important is it, then, not to consolidate the identities of people in ways that will make them life long medical patients, reduce their choice of sexual partners, and may ruin their future fertility and sex life? If I had been "affirmed" as transgender as a child, when I was a tomboy, if that option had been open to me, I would have taken it. It was not an option. I am glad it was not. I now have a life that I never thought was open to me.

I still have difficulties with my sexed body. Periods are particularly difficult for me. But instead of seeking a hysterectomy, I tell myself, "Lauren, you're a butch lesbian, are you really so afraid of a little blood?", and then I get on with my day. My wife loves me, just how I am, with all my oddities. I'm very glad that I'm in a lesbian relationship. I would not want to be in a heterosexual relationship with a woman. That would wreck something important for me about who I am, and what I stand for and I could never have discovered that on my own if I had been transitioned young.

I stand for trashing the old fashioned, regressive stereotypes that say “if you can drive a forklift and operate a lathe, you must be a man.” No. I stand for a celebration of the amazing diversity that

women are. I stand for smashing the nonsense that is the gender binary. I stand for loving the skin you’re in, and embracing who you really are, not for altering healthy bodies with drugs and surgeries in an endless quest to become someone that, in the end, you biologically can never be.

And so, I will put on my high vis vest, and my steel toe caps, and go to work with the lads, and I will hug my wife a little tighter when I’m suffering. I will clad my female body with muscle, and my female voice with chivalry, and I will know that this is who I am. And that it is good enough.

Lauren’s story was originally published in Lesbian and Gay News. (Republished with permission).

Tab 3

Court File No.: FM-76-2023

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Applicant (Respondent on motion)

-and-

THE PROVINCE OF NEW BRUNSWICK, as represented by the MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

AFFIDAVIT OF KARIN LITZCKE

COUR DU BANC DU ROI DU NOUVEAU-BRUNSWICK

DIVISION DE PREMIÈRE INSTANCE

CIRCONSCRIPTION JUDICIAIRE DE FREDERICTON

DANS L'AFFAIRE d'une requête en revision judiciare et de jugement déclaratoire en vertu de la règle 69 et la règle 38 des *Règles de procedure* du Nouveau-Brunswick

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Requérant (intimé â la requête)

-et-

LA PROVINCE DU NOUVEAU BRUNSWICK, représentée par le MINISTRE DE L'ÉDUCATION ET DU DÉVELOPPEMENT DE LA PETITE ENFANCE

Intimée (intimé â la requête)

-et-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Intervenants eventuelles (parties requérantes)

AFFIDAVIT DE KARIN LITZCKE

I, KARIN LITZCKE, of the City of Vancouver in the Province of British Columbia, MAKE OATH AND SAY:

1. I am the Legal Projects Co-ordinator of Our Duty Canada ("**ODC**"), a proposed intervenor in this matter and, as such, have personal knowledge of the facts herein deposed, except where based on information and belief, in which case I verily believe the same to be true.

2. I have been authorized by the rest of the leadership of ODC to swear and submit this Affidavit in support of ODC's application to intervene in this proceeding.

Our Duty Canada

3. Our Duty Canada is an unincorporated association serving as an independent chapter of Our Duty International, which is based in the United Kingdom. ODC is primarily a peer support network for parents of children experiencing transgender ideation, undergoing psychological and social transition, or medical transition.

4. ODC was started in October 2022. The group grew to 80 members in its first year and continues to grow. ODC is run on an entirely volunteer basis. Our members are motivated by a pursuit of our children's best interests and to safeguard children's interests generally.

5. As parents with first-hand experience, members of ODC have witnessed the physical and emotional outcomes of the prevailing model of affirmative treatment for gender dysphoria. Members of ODC have seen their children experience declines in physical and mental well-being as a result of such "affirmative" treatment.

6. ODC holds regular peer support meetings and connects its members around advocacy projects. Our members also network with a wider international community of parents facing similar challenges which allows them to share their experiences.

7. While our members are primarily committed to promoting the best interests of our children, we also feel obligated to inform the public and government officials about our experiences and the insights we have gained. To this end, we liaise with organizations and individuals involved in education, medicine, academia, government, law, and the child welfare system. We undertake projects to inform and assist policy formation across these disciplines. For example, we have submitted a brief to the United Nations Periodic Review process. ODC's report identified ways in which the current approach childhood and adolescent transgender ideation in Canada fails to protect children's rights in line with Canada's obligations under the UN Convention on the Rights of the Child. ODC's report is attached as **Exhibit A** to this affidavit.

Our Duty Canada's Interest in this Litigation

8. The majority of ODC's members are parents of children struggling with transgender ideation. Our members come from diverse social, economic, and political backgrounds. What unites them is an intimate, hands-on knowledge of the impact transgender ideation has had on their children. Many of us initially reacted by "affirming" our children in their new chosen identities. However, a common pattern among our members is a decision to reevaluate that approach after witnessing psychological and emotional decline in our children.

9. Approximately 90% of our members with affected school-aged children received no communication from their child's school that the child was undergoing a psycho-social transition.[1]

10. Our members' relationships with their children are often marred by a form of parental alienation syndrome.[2] Among our members' adult children, approximately 30% have become fully

[1] Our Duty Canada uses the term "psycho-social transition" because the term "social" does not adequately reflect the psychological impact of the intervention on the mind of the child.

[2] While recognized in the context of custody disputes, our members have experienced similar behaviour from their children entailing an unjustified campaign of denigration by the child against the parent, often at the urging of outside influences, including peers, school staff, and other adults offering uncritical affirmation of an expressed gender identity.

estranged. The remaining 70% often have tense, conflicted relationships, often made conditional on the parent affirming the child's chosen identity. Parents in those circumstances often report a tension between offering assistance to their children in a manner consistent with their own views and avoiding anything which could lead to further alienation. In cases where the children have desisted[3] or detransitioned[4], the alienation often resolves.

11. As a representative of our members, ODC has a direct interest in this litigation because Policy 713 ensures our members in New Brunswick are kept informed about psychological interventions to which their children are subjected. Our members have an interest in parenting their children in an informed manner. If the Applicant's requested relief is granted, that interest will be impaired by a policy which would keep parents in the dark about significant changes in their children's mental health.

12. As an organization, ODC has a direct interest in this litigation because we assist parents with children struggling with transgender ideation. New Brunswick parents who would benefit from our assistance will be unable to access our resources, support, and community if, as a matter of policy, they are prevented from learning that their children are struggling.

Submissions of Our Duty Canada

13. ODC supports the parental notification requirement which was added to Policy 713 and would seek to make submissions rooted in our organization's experience and scientific evidence supporting the importance of parental involvement when children are struggling with transgender ideation.

[3] Desistance is the name given to the process of ceasing to identify as transgender before any medical steps have been taken.
[4] Detransition is the name used for the process of rejecting a transgender identity after a medical transition, including cross-sex hormones and/or surgery, has begun.

Perspectives of New Brunswick Parents of Children with Transgender Ideation

14. The August 2020 version of Policy 713, which did not require parental notification when children wanted to use different pronouns or names at school, was premised on the "gender affirming" model of care. However, the experience of ODC's members contradicts a number of assumptions of the "gender affirming" model of care. It is the experience of our members that:

a. often transgender ideation is the result of outside influence to which certain children are particularly susceptible due to their personal circumstances;

b. rather than being a neutral act, psycho-social transition is an intervention which makes risky medical transition more likely; and

c. there are serious risks associated with psycho-social transition followed by medical transition.

15. **First**, the experience of our members shows that some children may be particularly susceptible to transgender ideation due to personal circumstances unrelated to a fixed, innate sense of gender. Children who appear particularly susceptible to outside influence include those:

a. who have had traumatic experiences including sexual abuse or loss of a parent;

b. with traits or conditions that create social or bodily discomfort, such as autism, obesity, or early or delayed maturation;

c. with psychological co-morbidities including anxiety and depression; and

d. struggling with latent or emerging same-sex attraction about which they may have conflicting feelings.

16. Our members have seen that their children who suffer from one or more of the above-noted vulnerabilities are more susceptible to outside influence which may propose gender transition as a potential solution to the child's perceived distress.

17. **Second**, the experience of our members as confirmed by research is that psycho-social transition is an intervention which makes medical transition more likely relative to other interventions aimed at remedying the child's distress. While not every child who undergoes psycho-social transition proceeds to medical transition, every medically transitioned child started by psycho-socially transitioning. Psycho-social transition is often a pre-requisite for cross-sex hormone therapy. Some of our members have been shocked to learn that their children were qualified for medical transition because, unbeknownst to the parent, the child had been living as the opposite sex at school for over a year.

18. **Third**, both psycho-social transition and medical transition cause risk of harm to children. Psycho-social transition can cement a transgender identity, setting a child on a course for chemical and surgical interventions. Apart from medical interventions, psycho-social transition can impact a child's relationship to family, friends, and his or her own history. If matters escalate to a medical transition, cross-sex hormones cause sterility, penile atrophy, and vaginal dryness and atrophy that can force a full hysterectomy.

19. Further, Our Duty Canada endorses the following positions relevant to this case:

a. Canadian law recognizes parents as the primary decision makers of their children for all significant decisions, including being charged with the responsibility for the education and moral upbringing of their children.

b. A parent's right to exercise decision making authority regarding their children involves being informed and involved in important decisions or any significant developments in their children's social behaviour at school, absent demonstrable risk of harm from the parents on a case-by-case basis.

c. School personnel lack the jurisdiction and expertise to change a child's name and pronouns, which is a significant intervention in a child's development that should not be done without the involvement of parents and, if necessary, clinicians.

d. The best interests of children, including their legal and constitutional rights, are protected by the informed involvement of their own parents.

20. The submissions of Our Duty Canada would be informed by the above knowledge and experiences which are relevant to issues raised in this case about whether Policy 713 is within the scope of the *Education Act*, whether it infringes the rights of the children subject to it, and, if so, whether that infringement is justified.

Different Submissions

21. The submissions of Our Duty Canada, in conjunction with the proposed joint intervenor Gender Dysphoria Alliance, would be different than those of the parties or other groups that have applied for intervenor status.

22. Unlike the Applicant or the group of proposed intervenors which includes Egale Canada, ODC and Gender Dysphoria Alliance support the parental notification requirement of Policy 713. Unlike the Respondent, ODC's submissions will be grounded in the experiences of the parents ODC represents. ODC's submissions will reflect the unique insight that our group has gained from the collective experience of its members, including the potential for harm to children if they undergo a psycho-social transition without parental guidance.

23. Our Duty Canada will consult with the parties and intervenors as necessary to avoid duplication.

24. I swear this Affidavit in support of the Joint Application to Intervene and for no improper purpose.

SWORN by Karin Litzcke
at the City of Vancouver
in the Province of British Columbia,
on the 28th day of November, 2023.

Margarida Angela Cardoso
A commissioner for taking oaths
in the Province of British Columbia
Expiry: March 31, 2025

Karin Litzcke

Stakeholder submission to the Universal Periodic Review (UPR) regarding the rights of the child in Canada

For the 44th Session of the Universal Periodic Review

Date: April 3, 2023

Submitted By:
Our Duty Canada, a Chapter of Our Duty International
Website: https://ourduty.group/canada/
Email contact: canada@ourduty.group

This is Exhibit "A" to the Affidavit of
KARIN LITZCKE
sworn (or affirmed) before me
this 28 day of NOVEMBER 2023.

A Commissioner/Notary Public for the
Province of British Columbia

Introduction

1. Our Duty Canada (ODC) submits the following Universal Periodic Review Stakeholder Report to the United Nations Human Rights Council. ODC is a non-partisan organization of parents and citizens with the common goal to protect children from high-risk, non-evidence-based medical interventions associated with gender affirming care. We inform and support parents, work toward increasing public knowledge and pressure our social, medical and political systems into conducting themselves from an evidence-based perspective.
2. The goal of this submission is to encourage the Canadian government to take concrete steps to improve the protection of children's rights, pursuant to its obligations as a signatory to the United Nations Convention on the Rights of the Child (UNCRC).

Definitions

3. Children: age 18 and younger per the UNCRC.
4. Transgender: relating to individuals experiencing incongruence between their subjective psychological experience and their sex.
5. Gender dysphoria (DSM-5-TR 302.85): clinically significant distress or impairment in individuals experiencing incongruence between their subjective psychological experience and their sex.
6. Social transition: includes changing one's name, pronouns, clothing, appearance, and using compression garments for breasts and male genitalia to express incongruence with one's sex.
7. Puberty blockers: gonadotropin-releasing hormone (GnRH) agonists, drugs such as Lupron and Trelstar that prevent the onset of puberty. In males, they cause the testicles to stop producing testosterone. In females, they cause the ovaries to stop producing estrogen and progesterone.

8. Cross-sex hormones: synthetic feminizing hormones used in males, and synthetic masculinizing hormones used in females.
9. Gender affirming surgery: includes double mastectomy and phalloplasty in females; breast implants, facial feminization, vaginoplasty in males; and other emerging procedures.
10. Gender affirming therapy: a therapeutic stance that focuses on unquestioningly affirming a child's self-selected gender identity regardless of his or her age.
11. Detransitioner: an individual who previously identified as transgender and received cross-sex hormones or gender affirming surgery, but discontinued these interventions and no longer identifies as transgender.

Background

12. Canada, like many countries in the Western world, has seen a significant increase in children identifying as transgender.[1] While ten years ago there were only a handful of gender clinics, today there are over 400 in North America, many established specifically for children.[2]
13. Canada has taken several measures to make affirming transgender healthcare widely available, but this has resulted in a failure to protect the rights of children under the UNCRC, specifically their right to protection "from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse"[3] and "the right of the child to the enjoyment of the highest attainable standard of health."[4]
14. The most concerning of these measures is the widespread North American trend for healthcare professionals to accept and

[1] Canadian Gender Report (2021) 10x growth in referrals to gender clinics in Canada and our "consent" based model.
[2] The Gender Mapping Project (2023) https://www.gendermapper.org/name-and-shame-doctors.
[3] UNCRC, Article 19 United Nations Convention on the Rights of the Child.
[4] UNCRC, Article 24.

exclusively use the “gender affirming care” model for transgender and gender dysphoric children. This model promotes gender affirming therapy, puberty blockers, cross-sex hormones and gender affirming surgeries as primary interventions.[5]

15. Gender affirming care is recommended by the World Professional Association for Transgender Health (WPATH), but its efficacy is under debate.[6] WPATH’s guidelines have been widely endorsed and disseminated to Canadian medical and mental health care bodies through, for example, the Canadian Medical Association Journal.[7] WPATH, however, has no rating with the ECRI[8] (Emergency Care Research Institute) TRUST (Transparency and Rigor Using Standards of Trustworthiness) Scorecard, a mechanism that rates the quality of guidelines, based on evidence strength and the measures taken to reduce bias in recommendations. WPATH standards are not based on established science.
16. Recent high-quality reviews of both WPATH’s and the Endocrine Society’s guidelines have concluded that: (1) there is weak evidence, no evidence, or mixed evidence to support the efficacy of puberty blockers, cross-sex hormones, and gender affirming surgeries in improving the mental health of children, and (2) the long-term health risks of these treatments in children have not yet been studied, while studies of their effects on adults have shown high risks of physical and psychological harm.[9]
17. Despite these alarming conclusions, gender affirming care continues to be forcefully advocated, excluding other safer, more developmentally appropriate methods of treatment that focus on

[5] Rainbow Health Ontario, Gender affirming options for gender independent children and adolescents.
[6] Jiska Ristori, Thomas D. Steensma, 28:1, 13-20 (2016) Gender dysphoria in childhood, International Review of Psychiatry.
[7] Bonifacio et al., CMAJ (2019) Management of gender dysphoria in adolescents in primary care.
[8] Ecri.org ECRI Guidelines Trust®.
[9] Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. V. Johansson, Niklas Langstrom, Mikael Landen (2011) Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden.

each individual child's needs,[10] even though it is recognized that "The clinical presentation of children who present with gender identity issues can be highly variable; the psychosexual development and future psychosexual outcome can be unclear, and consensus about the best clinical practice is currently under debate."[11]

18. Some healthcare professionals report feeling "under pressure to adopt the affirmation approach, and that is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters."[12] Susan Bradley, a Canadian child psychiatrist formerly with the Child and Adolescent Gender Identity Clinic at the Centre for Addiction and Mental Health (CAMH), former chief of psychiatry at Hospital for Sick Children, and former head of child and adolescent psychiatry at the University of Toronto has recently come forward to voice serious concerns. Bradley warns that the care of transgender and gender dysphoric children "has evolved into an ideological movement to normalize the practice of changing genders — and in the process is crossing ethical lines with a particularly vulnerable subset of young people struggling with issues of gender identity."[13]
19. In Canada, the pressure to provide gender affirming care intensified with the passing of Bill C-4 in 2021. This amendment to Canada's Criminal Code, due in large part to an activist-led petition,[14] expands the definition of "conversion therapy" to include "any practice, service or treatment designed to change a person's gender identity to cisgender, or gender expression to match the sex assigned at birth, or designed to repress or reduce gender

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[10] D'Angelo, R., Syrulnik, E., Ayad, S. *et al*, *Arch Sex Behav* 50, 7–16 (2021) One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria.
[11] Ristori J, Steensma TD (2016) Gender dysphoria in childhood: International Review of Psychiatry.
[12] Jennifer Block; British Medical Journal (2023) Gender dysphoria in young people is rising—and so is professional disagreement.
[13] Susan Bradley; National Post (2023) How trans activists are unethically influencing autistic children to change genders.
[14] Change.org, Public Petition (2021) Petition · End Conversion Therapy in Canada.

expression that does not match the sex assigned at birth."[15] Some argue Bill C-4 was expedited for political reasons and without an understanding of its potential impact on the treatment of transgender or gender dysphoric children.[16]

20. Specifically, because "conversion therapy" is ill-defined in Bill C-4, there is concern that it will be used to criminalize a range of potentially helpful treatment approaches by qualified professionals treating transgender or gender dysphoric children, despite the lack of consensus about best practices in these cases. Bill C-4 was made possible by a preceding amendment to the Canadian Human Rights Act, Bill C-16, which received Royal Assent in 2017. Bill C-16 added "gender identity and expression" to the list of grounds for discrimination and sparked national debate about gender, pronoun use and free speech.[17]

Risks from Off-label Drugs and Invasive Surgeries

21. It is imperative to highlight that administering puberty blockers and cross-sex hormones to transgender or gender dysphoric children constitutes **off-label use** of these drugs. The Canadian Paediatric Society (CPS) recognizes that off-label drug prescribing for children is "associated with significant risk, including adverse reactions and efficacy concerns."[18] The CPS also highlights that the percentage of off-label medications used in pediatrics in Canada is notably high, and that our country has fallen behind other nations in regard to safe and effective medication use in children.[19]

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[15] Government of Canada (2021) Bill C-4: An Act to amend the Criminal Code (conversion therapy).
[16] Ryan Tumilty, National Post (2021) Conservatives fast-tracked conversion therapy bill to avoid a fight they would surely lose.
[17] Canadian Legislative Summary of Bill C16 (2017) Legislative Summary of Bill C16.
[18] Charlotte Moore Hepburn, MD, Andrea Gilpin, PhD MBA, Julie Autmizguine, MD MSc, Avram Denburg, MD PhD, L Lee Dupuis, R.Ph. MScPhm PhD,et al, *Paediatrics & Child Health*, Volume 24, Issue 5, August 2019, p. 333–335. (2019) Improving paediatric medications: A prescription for Canadian children and youth.
[19] Ibid.

22. Though children may be diagnosed with gender dysphoria, this is not required to access gender affirming care: a self-selected gender identity is sufficient. WPATH and the Endocrine Society promote gender affirming care as safe, reversible and based on solid evidence; however these claims are now being called into question.
23. Several reviews have recently been conducted of the WPATH and Endocrine Society guidelines. One of these was conducted by the Canadian Agency for Drugs and Technologies in Health (CADTH), an independent, not-for-profit organization responsible for providing health care decision-makers with objective evidence to help make informed decisions about the optimal use of health technologies, including drugs. After reviewing the WPATH guidelines,[20] CADTH concluded that the "quality of this guideline was limited due to a lack of sufficient details provided for the methods used in searching for evidence and formulating the recommendations". It also found that the "guideline did not report the strength of recommendations or the quality of the evidence" and that there is "uncertainty associated with this low-quality guideline and its recommendations should be interpreted with caution."[21]
24. Another investigative report, whose findings were published in the British Medical Journal (BMJ)[22] in February 2023, also underscores serious problems with the above mentioned guidelines. It concludes, for example, that the Endocrine Society guidelines paired strong recommendation with weak evidence and "didn't look at the effect of the interventions on gender dysphoria itself, arguably 'the most important outcome.'" The report also highlights that "WPATH's recommendations lack a grading system to indicate the quality of the evidence" and that, while trustworthy

[20] Canada's Drug and Health Technologies (2022) About CADTH.
[21] Chen, Loshak H, Chen S, Loshak H., Canadian Agency for Drugs and Technologies in Health, Ottawa (ON) (2020) Primary Care Initiated Gender-Affirming Therapy for Gender Dysphoria: A Review of Evidence Based Guidelines.
[22] Ibid.

guidelines and transparency with commissioned systematic reviews is standard, “neither was made clear in the WPATH guidelines and [there are] several instances in which the strength of evidence presented to justify a recommendation was ‘at odds with what their own systematic reviewers found’.”[23]

25. The Editor-in-Chief of the BMJ, Dr. Kamran Abbasi, subsequently published an editorial on gender affirming care. He describes the BMJ´s “longstanding and leading position in acknowledging the limits of evidence and advocating against overdiagnosis and overtreatment—even when the state of the science disagrees with individual preferences.” He then cautions that, although medical societies and associations inform clinical practice, in the case of the WPATH guidelines, “closer inspection of that guidance finds that the strength of clinical recommendations is not in line with the strength of the evidence.”[24] Moreover, he notes that when an evidence base is weak or under debate, “[o]ther factors need to be weighed up, such as how invasive is the intervention you are recommending.”
26. The invasiveness of puberty blockers, cross-sex hormones and gender affirming surgeries cannot be overstated. The risk of harm to children is documented,[25] significant, and largely irreversible. Known risks include genital atrophy and histological changes to gonads;[26] diminished bone mineral density;[27] shrinkage of the hippocampus and gray matter structures of the brain;[28,29] significant increases in strokes, venous thromboembolic events, and heart

[23] Ibid.
[24] BMJ, 380, p553 (2023) Caring for young people with gender dysphoria.
[25] Zitner, Macdonald-Laurier Institute (2022) Gender dysphoria in children: Risking harm from well-intentioned parents and doctors.
[26] Cheng PJ, Pastuszak AW, Myers JB, Goodwin IA, Hotaling JM, Transl Androl Urol, (3): 209-218.(2019) Fertility concerns of the transgender patient.
[27] Delgado-Ruiz R, Swanson P, Romanos G, J Clin Med, 1;8(6):784 Systematic Review of the Long-Term Effects of Transgender Hormone Therapy on Bone Markers and Bone Mineral Density and Their Potential Effects in Implant Therapy.
[28] Seiger R, et al, 74:371-379, (2016) Subcortical gray matter changes in transgender subjects after long-term cross-sex hormone administration. Psychoneuroendocrinology.
[29] Ibid.

attacks;[30,31] sterilization and loss of sexual desire and function;[32] vaginal atrophy and pain; inability to orgasm; and uterine atrophy.[33] These latter effects are comparable to those of female genital mutilation practices, procedures that alter or injure female genitalia for non-medical reasons,[34] for which the United Nations General Assembly rightfully adopted a Resolution to ban Worldwide on December 20, 2012.[35]

27. Off-label use of drugs with these known risks, without strong evidence of their benefits, is a flagrant violation of a child's right to protection from injury and negligent treatment, and his or her right to enjoy the highest attainable standard of health. Transgender or gender dysphoric children in Canada are hastily being given prescriptions for puberty blockers, cross-sex hormones, and surgical interventions including bilateral mastectomies and the surgical removal or manipulation of their genitals without supporting evidence of safety or efficacy.[36]

28. The risks and unknown efficacy of gender affirming care have recently led other progressive Western countries to restrict or ban the use of puberty blockers, cross-sex hormones and gender affirming surgeries for transgender or gender dysphoric children. Sweden's National Board of Health and Welfare determined in 2022 that the risks of these treatments "currently outweigh the

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[30] Getahun D, Nash R, Flanders WD, Baird TC, Becerra-Culqui TA, Cromwell L, Hunkeler E, Lash TL, Millman A, Quinn VP, Robinson B, Roblin D, Silverberg MJ, Safer J, Slovis J, Tangpricha V, Goodman M, Ann Intern Med, 169(4):205-213, (2018) Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study.

[31] Nienke M. Nota, Chantal M. Wiepjes, Christel J.M. de Blok, Louis J.G. Gooren, Baudewijntje P.C. Kreukels and Martin den Heijer, (2019) Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy.

[32] Michael Biggs, Journal of Sex & Marital Therapy, (2022) The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence.

[33] J. Cohn, Journal of Sex & Marital Therapy (2022) Some Limitations of "Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View".

[34] United Nations International Day of The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence, Journal of Sex & Marital Therapy Zero Tolerance for Female Genital Mutilation.

[35] United Nations Women United Nations bans female genital mutilation.

[36] Jonathan Bradley, The Western Standard, (2022) Ontario hospital allows children to take puberty blockers before first assessment.

possible benefits" for children.[37] Likewise, medical authorities in Finland, France, the United Kingdom, Belgium, and several states in the USA are discouraging or banning gender affirming care for children and are instead encouraging psychotherapy with a focus on each individual child's specific needs in their professional guidelines.[38,39,40] A systematic review of the Gender Development Identity Service at the Tavistock Clinic in the United Kingdom (Cass Review)[41] has also recently questioned the evidence behind invasive interventions for transgender or gender dysphoric children, and is now advocating for appropriate psychological care instead.[42]

29. Predictably, the loose protocols of gender affirming care have led to a steady rise in detransitioners in Canada. Individuals who received gender affirming care that did not provide long term benefits are beginning to speak out.[43,44] Detransitioners face medical and mental health struggles without the social, medical or financial support that was readily available to them while they were receiving gender affirming care.[45] Although Canada's public media is reluctant to report on detransitioners, we submit that their numbers are high[46] and will continue to rise in step with the drastic increase in children receiving gender affirming care.[47] American physician and researcher Lisa Littman recently published a peer

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[37] Society for Evidence Based Gender Medicine, segm.org (2022) Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW).
[38] Finland,Council for Choices in Health Care (2020) Medical treatment methods for gender dysphoria in non-binary adults.
[39] French National Academy of Medicine (2022) Medicine and gender transidentity in children and adolescents.
[40] Lauwke Vandendriessche Pano, VRT News (2023) Fierce debate about puberty inhibitors and male/female hormones: "What you are doing is an experiment on children".
[41] British National Health Services, Cass Review: Independent Review of Gender Identity Services for Children and Young People (2023) Interim report – Cass Review.
[42] Cooke, The Guardian (2021) Tavistock trust whistleblower David Bell: 'I believed I was doing the right thing'.
[43] Adrian Humphreys, National Post (2023) Ontario detransitioner who had breasts and womb removed sues doctors.
[44] Lovett, Independent (2022) Tavistock gender clinic facing legal action over 'failure of care' claims | The Independent.
[45] Reddit.com, u/DetransIS The r/detrans demographic survey - Screened and broken down.
[46] Reddit.com r/detrans | Detransition Subreddit.
[47] Mia Ashton, The Post Millennial (2022) Rate of detransition among 'trans' youth higher than activists claim.

reviewed study which found: over 40% of detransitioners reported that online influence encouraged them to believe transitioning would help them; 60% eventually became more comfortable identifying as their natal sex; 49% had concerns about potential medical complications from transitioning; and 38% came to the view that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition.[48]

Comorbidities and Suicide Risk

30. Canada's current focus on gender affirming care excludes other safer, more developmentally appropriate interventions like psychotherapy and the assessment, diagnosis and treatment of common comorbid mental health conditions (comorbidities) in transgender or gender dysphoric children[49]. This further undermines the rights of the child to protection from negligent treatment and to the enjoyment of the highest attainable standard of health, given that studies show that, over time, many children overcome their feelings of incongruence with their sex.
31. Qualified and competent professionals are being discouraged from using their skills, training and best judgment, as well as abiding by their oath to "First Do No Harm," and are instead being directed toward fast-tracked gender affirming care. Some of these professionals object to this pressure and assert that "[t]o the extent that psychological treatments can help an individual obtain relief from gender dysphoria without undergoing body-altering interventions, ensuring access to these treatments is not only ethical and prudent but also essential."[50]
32. In Canada there is an overrepresentation of transgender and gender dysphoric children with comorbidities including Autism,

[48] Littman, L, *Arch Sex Behav* 50, 3353–3369 (2021) Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners.
[49] Devita Singh, Susan J. Bradley, Kenneth J. Zucker Frontier in Psychiatry, (2021) A Follow-Up Study of Boys With Gender Identity Disorder.
[50] Ibid.

ADHD, anxiety and depression, along with overrepresentations of children who are indigenous, in foster care or who are likely to be homosexual as adults.[51] The one-size-fits-all approach of gender affirming care fails to meet these children's unique needs. However, mental and medical health professionals risk their livelihoods and licenses if they attempt to provide psychotherapy to this cohort of children before proceeding with gender affirming care.

Lack of Evidence for Informed Consent and Exclusion of Parents from Decision-Making

33. Informed consent involves an adequate explanation of the nature of a proposed treatment and its anticipated outcome, as well as the risks involved and alternatives available.[52] According to Levine et al., "ethical concerns about inadequate informed consent for trans-identified youth have several potentially problematic sources, including erroneous assumptions held by professionals; poor quality of the evaluation process; and incomplete and inaccurate information that the patients and family members are given."[53] When long-term effects for children are unknown and the efficacy of the use of off-label drugs and experimental surgeries is in question, neither children nor their parents are able to provide informed consent.[54]
34. Informed consent is further undermined by the deliberate exclusion of parents from the decision-making process. Recent amendments to Canada's Human Rights Act to include "gender identity" as a grounds for discrimination are being used by schools

[51] Varun Warrier, David M. Greenberg, Elizabeth Weir, Clara Buckingham, Paula Smith, Meng-Chuan Lai, Carrie Allison, Simon Baron-Cohen (2020) Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals.
[52] The Canadian Medical Protective Association (CPMA) Consent: A guide for Canadian physicians.
[53] Stephen P. Lavine, E. Abbruzzese, Julia W. Mason (2022) Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults.
[54] Ibid.

to allow children's self-identification of gender[55] and implement policies that allow social transitioning of children without parents' knowledge or consent.[56] This violates the UNCRC, which underscores the importance of parents' rights and involvement in decision-making in the best interests of their child.[57] It is widely accepted that the "limited maturational cognitive capacities of minors are the key reason why parents serve as the ethical and legal surrogates for medical decision-making, tasked with signing an informed consent document."[58]

35. The false claim that transgender or gender dysphoric children will commit suicide[59] if they do not receive immediate gender affirming care negatively interferes with informed consent. This misrepresented suicide risk statistic for transgender or gender dysphoric children stems from the RaRE Research Project conducted in the United Kingdom in 2018.[60] The study's own lead author made a public statement[61] cautioning against misrepresentation of the study's findings. Moreover, the reviews of WPATH's recommendations also conclude that it is "impossible to draw conclusions about the effects of hormone therapy" on death by suicide.[62] Misrepresentation of suicide risk to transgender and gender dysphoric children is unethical– suicide is not caused by just one factor.[63]

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[55] Barbara Findlay, Q.C.,Glen Hansman, BCTF President; UBC Teacher Ed (Video) (2017) The Legal and Professional Landscape: Sexuality and Gender Identity in Schools.
[56] Tom Blackwell, National Post (2023); Canadian schools aid student gender transitions without family consent.
[57] UNCRC, Article 5.
[58] Grootens-Wiegers, P., Hein, I.M., van den Broek, J.M. et al, BMC Pediatr 17, 120 (2017) Medical decision-making in children and adolescents: developmental and neuroscientific aspects.
[59] Ibid.
[60] Nuno Nodin, Elizabeth Peel, Allan Tyler and Ian Rivers, PACE, (2017) LGBT Mental Health-Risk and Resiliency Explored.
[61] TransgenderTrend.com, Suicide Facts and Myths - Transgender Trend.
[62] *BMJ*, 380, p. 553 (2023) Caring for young people with gender dysphoria.
[63] The Center for Disease Control andPrevention (2022) Risk and Protective Factors | Suicide | CDC.

Recommendations

1. Remove “gender identity” and “gender expression” from Canada’s Criminal Code or, minimally, define “conversion therapy” to ensure that appropriate therapy is available to children, including the assessment and treatment of comorbidities and support for all aspects of children’s mental health and development.
2. Commission independent studies on the processes followed by gender affirming medical and mental health bodies in Canada, as the British and Swedish governments have done.
3. Commission independent studies and systematic reviews to understand the long-term impacts of gender affirming care on children.
4. Prohibit gender affirming drugs and surgeries for children in Canada until they are proven safe, and until it is determined that their benefits outweigh their potential long-term harm to transgender or gender dysphoric children.
5. Revisit the addition of “gender identity and expression” to the Canadian Human Rights Act, as it has been broadly interpreted and recklessly used to prevent children from receiving the care they need for comorbid mental health conditions.

Tab 4

Court File No.: FM-76-2023

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Applicant (Respondent on motion)

-and-

THE PROVINCE OF NEW BRUNSWICK, as represented by the MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

AFFIDAVIT OF DARREN LEUNG

COUR DU BANC DU ROI DU NOUVEAU-BRUNSWICK

DIVISION DE PREMIÈRE INSTANCE

CIRCONSCRIPTION JUDICIAIRE DE FREDERICTON

DANS L'AFFAIRE d'une requête en revision judiciare et de jugement déclaratoire en vertu de la règle 69 et la règle 38 des *Règles de procedure* du Nouveau-Brunswick

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Requérant (intimé â la requête)

-et-

LA PROVINCE DU NOUVEAU BRUNSWICK, représentée par le MINISTRE DE L'ÉDUCATION ET DU DÉVELOPPEMENT DE LA PETITE ENFANCE

Intimée (intimé â la requête)

-et-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Intervenants eventuelles (parties requérantes)

AFFIDAVIT DE DARREN LEUNG

I, Darren Leung, of the City of Toronto, in the Province of Ontario, **MAKE OATH AND SAY**:

1. I am a lawyer with Charter Advocates Canada and as such, have personal knowledge of the matters hereinafter deposed to, except where they are based on information and belief, in which case, I verily believe them to be true.

Kenneth J. Zucker, Ph.D., C.Psych.

2. I am informed by counsel for the proposed joint intervenors, Gender Dysphoria Alliance ("GDA") and Our Duty Canada ("ODC"), that they have retained Kenneth, J. Zucker, Ph.D., C.Psych., to assist the Court as an expert in this matter. A copy of Dr. Zucker's *Curriculum Vitae* is attached hereto to this my Affidavit as **Exhibit "A."**

3. Some of Dr. Zucker's significant professional experience include

- Psychologist-in-Chief, Centre for Addiction and Mental Health (2001-2014)
- Director of Training, APA-CPA Clinical Psychology Internship Programme, Clarke Institute of Psychiatry (1994-2000)
- Chair, DSM-5 Work Group on Sexual and Gender Identity Disorders, American Psychiatric Association (2007-2013)
- Committee Member, DSM-IV Subcommittee on Gender Identity Disorder of Childhood and Transsexualism (1989-1994)
- Participant in Work Group to Revise DSM-III, Gender Identity Disorder of Childhood and Transsexualism (New York State Psychiatric Institute, New York, New York, April 23, 1985)
- Consultant, Somatic Psychic Work Group, Task Force on Coding for Mental Health in Children, American Academy of Pediatrics (1992-1996)
- Member, Task Force on Gender Identity, Gender Variance, and Intersex Conditions, American Psychological Association (June 2005-2008)
- Past President, International Academy of Sex Research (2006)
- Editor, Archives of Sexual Behavior (2002-Present)
- Book Review Editor, Archives of Sexual Behavior (1988-2001)

4. As described on his website, Dr. Zucker maintains a practice as a clinical psychologist with a focus on Gender Dysphoria, including specifically:

1. Gender dysphoria in children, adolescents, and adults
2. Disorders of sex development (physical intersex conditions)
3. Sexualized and paraphilic behaviors in youth
4. Attachment issues in children, adolescents, and adults
5. Effects of sexual maltreatment
6. Relationship issues in adults, including those pertaining to consensual non-monogamy, relationship infidelity, etc.

See excerpts of https://www.kenzuckerphd.com/ attached hereto to this my Affidavit as **Exhibit "B."**

5. I am informed by counsel for the proposed joint intervenors, GDA and ODC, that Dr. Zucker has been asked to review Policy 713 and the Notice of Application of the Canadian Civil Liberties Association ("CCLA"), filed September 6, 2023.

6. Dr. Zucker has been asked to provide his expert opinion, including particularly on the "self identification" provisions contained in Policy 713 guiding school personnel in their use of a student's preferred name and pronoun(s).

7. Charter Advocates Canada is in receipt of the Will-Say of Dr. Kenneth Zucker, Ph.D., C.Psych., attached hereto to this my Affidavit as **Exhibit "C."** In it, Dr. Zucker provides a seven-point outline of his expert opinion related to the "self-identification" provisions of Policy 713. Dr. Zucker further indicates his willingness to assist the Court by providing his expert opinion on additional issues raised by the parties, including on issues raised in paragraphs 25 and 80 of the Notice of Application of the Canadian Civil Liberties Association. I am informed by counsel for the proposed joint intervenors, GDA

and ODC, that CCLA has not yet filed or specified the expert research referred to in paragraphs 25 and 80 of the Notice of Application.

New Brunswick Parent

8. I am informed by counsel for the proposed joint intervenors, GDA and ODC, that if granted party status, they intend to rely on the evidence of a mother in New Brunswick. To protect the privacy of her child and preserve her relationships with the child, she has indicated that she is only willing to provide her evidence if she is allowed to do anonymously. A redacted copy of her affidavit is attached to this Affidavit as **Exhibit "D"**.

Young Woman Socially Transitioned in School

9. I am informed by counsel for the proposed joint intervenors, GDA and ODC, that they would also seek to rely on a forthcoming affidavit of a young, neurodiverse woman sharing her experience undergoing social transition in school as a minor, without notice to her parents. To protect herself from the potential consequences which might result were her involvement with this matter to become known, she is requesting that her privacy be preserved by also being permitted to provide an anonymized affidavit. I am informed by counsel for the proposed joint intervenors, GDA and ODC, that this young woman has advised that she will be able to swear the attached draft affidavit in April. A redacted copy of her drafted affidavit is attached to this Affidavit as **Exhibit "E"**.

Father of Young Woman Socially Transitioned in School without his knowledge

10. I am informed by counsel for the proposed joint intervenors, GDA and ODC, that they would also seek to rely on a forthcoming affidavit of the father of the above neurodiverse woman, sharing his observations of the negative effect the school keeping

the transition of his daughter secret from him and his wife had on his daughter, their family and their relationships. To protect his family from the potential consequences which might result were their public identification and involvement with this matter to become known, he is requesting that his privacy be preserved by also being permitted to provide an anonymized affidavit. I am informed by counsel for the proposed joint intervenors, GDA and ODC, that this father will be able to swear the attached draft affidavit in April. A redacted copy of his drafted affidavit is attached to this Affidavit as **Exhibit "F"**.

11. I am informed by counsel for the proposed joint intervenors, GDA and ODC, that, if granted party status, they will bring a motion requesting that unredacted copies of the affidavits be sealed. Counsel informed me that they would provide the redacted copies attached hereto for the Court's public record. If the sealing order is granted, counsel would provide the unredacted copies of the affidavits to the parties and to the Court. Counsel has further informed me that they would request a publication ban with respect to the identities of the two affiants.

12. I swear this Affidavit in support of the Joint Application to Intervene, and for no improper purpose.

SWORN by Darren Leung, of the City of Toronto, in the Province of Ontario before me at the City of Mississauga, in the Province of Ontario this 20th day of March, 2024)

Hatim Kheir
Barrister & Solicitor
for the Province of Ontario

Darren Leung

This is **Exhibit "A"** referred to in the Affidavit of **Darren Leung** sworn before me this 20th day of March, 2024.

Barrister & Solicitor

March 2024

CURRICULUM VITAE

KENNETH J. ZUCKER

Personal Information

Birthdate:	December 29, 1950
Birthplace:	New York, New York
Citizenship:	United States
Canadian Status:	Landed Immigrant
E-mail:	ken.zucker@utoronto.ca or kzucker.phd@gmail.com
Phone (mobile):	416-986-4104
ORCID ID:	0000-0001-5313-6401
	http://orcid.org/0000-0001-5313-6401
LINKEDIN	https://www.linkedin.com/in/kenneth-zucker-809207111/
Website	https://www.kenzuckerphd.com/
Twitter	@ZUCKERKJ

Professor (Status Only), Department of Psychiatry, University of Toronto and Private Practice, Toronto, Ontario

Degrees Earned

B.A. Southern Illinois University, 1972, Psychology (with Honours)
M.A. Roosevelt University, 1975, Psychology (Clinical) (with Honours)

Thesis Title: The Effects of Cognitive Mechanisms on the Process of Sex-Role Development in Children

Ph.D. University of Toronto, 1982, Psychology (Developmental)

Thesis Title: The Development of Search for Mother During Brief Separation

Supervisor: Carl M. Corter, Ph.D.
Department of Psychology
University of Toronto
Erindale College
Mississauga, Ontario L5L 1C6

Registered Psychologist, College of Psychologists of Ontario (formerly Ontario Board of Examiners in Psychology) (Certificate Number 1712)

Academic and Hospital Appointments

Clinical Lead, Gender Identity Service, Child, Youth, and Family Program, Centre for Addiction and Mental Health, Toronto, Ontario (1981-2015)
Assistant Professor, Department of Psychology, University of Toronto (1986-1992)
Associate Professor, Department of Psychology (Associate Member, Graduate Faculty), University of Toronto (1992-1994)
Associate Professor, Department of Psychology (Member, Graduate Faculty), University of Toronto (1994-2001)
Assistant Professor, Department of Psychiatry, University of Toronto (1987-1992)
Associate Professor, Department of Psychiatry, University of Toronto (1992-2001)
Adjunct Faculty, Department of Psychology, Faculty of Graduate Studies (Graduate Programme in Psychology), York University (1985-2016)
Associate Member, Department of Education, University of Toronto (1987-1988)
Graduate Faculty, Department of Human Development and Applied Psychology, The Ontario Institute for Studies in Education of the University of Toronto (1998-2016, 2017-2020)
Scientific Staff, Division of Child and Youth Mental Health (formerly Division of Child Psychiatry), Hospital for Sick Children (1988-2016)
Clinical Professor, Fuller Graduate School of Psychology (1993-1994)
Associate Graduate Faculty, University of Guelph (2002-2005)
Professor, Department of Psychology (Member, Graduate Faculty), University of Toronto (2001-2009)
Professor, Department of Psychiatry, University of Toronto (2001-2015)
Professor (Status Only), Department of Psychiatry, University of Toronto (since 2016)

Teaching Experience

Department of Psychology, University of Toronto
Human Development and Applied Psychology, The Ontario Institute for Studies in Education of the University of Toronto
Faculty of Social Work, University of Toronto

Undergraduate Level

September-December 1978	(Introduction to Developmental Psychology)
January-April 1981	(Psychopathology of Childhood)
January-April 1982	(Psychopathology of Childhood)
July-August 1982	(Psychopathology of Childhood)
January-April 1983	(Social Development)
July-August 1983	(Psychopathology of Childhood)
January-April 1984	(Social Development)
September-December 1986	(Psychopathology of Childhood)
June-August 1987	(Psychopathology of Childhood)
January-April 1988	(Social Development)
January-April 1989	(Social Development)
December 1999	(Advanced Research Seminar in Abnormal Psychology) (1 2 hr session)

Graduate Level

January 1993	Topics in Abnormal Psychology, 1 2 hr session)
March 1994	(Research Seminar in Applied Developmental Psychology, 3 2 hr sessions)
February 1995	(Topics in Abnormal Psychology, 1 2 hr session)
January-April 1997	(Psychopathology of Infancy and Childhood)
March 1998	(Strategies and Methods of Psychology, 1 2 hr session)
January-April 1999	(Psychopathology for School and Child-Clinical Practice)
March 1999	(Strategies and Methods of Psychological Research, 1 1 hr session)
April 1999	(Developmental Psychopathology, 2 6 hr sessions), Toronto Advanced Professional Education in the Human Services, Faculty of Social Work, University of Toronto
February 2000	(Strategies and Methods of Psychological Research, 1 1 hr session)
January-April 2003	Psychosexual Differentiation and Its Disorders)
February 2010	(Lecture on DSM-5), HDP1218, OISE/UT
February 2017	Seminar on Gender Dysphoria, Behavioral Disorders in Children (PS8704), Department of Psychology, Ryerson University

Publications

Book

Zucker, K. J., and Bradley, S. J. Gender identity disorder and psychosexual problems in children and adolescents. New York: Guilford Press, 1995. [Translated and reprinted in Japanese, Japan UNI Agency, 2010; in Russian, Mockba, 2020]

Edited Books

Atkinson, L., and Zucker, K. J. (Eds.). Attachment and psychopathology. New York: Guilford Press, 1997.

Drescher, J., and Zucker, K. J. (Eds.). Ex-gay research: Analyzing the Spitzer study and its relation to science, religion, politics, and culture. New York: Harrington Park Press, 2006.

Technical Report

APA Task Force on Gender Identity and Gender Variance. Report of the Task Force on Gender Identity and Gender Variance. Washington, DC: American Psychological Association, 2008. (Members: Schneider, M., Bockting, W. O., Ehrbar, R. D., Lawrence, A. A., Rachlin, K., and Zucker, K. J.)

Articles

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Skorska, M. N., Lobaugh, N. J., Lombardo, M. V., van Bruggen, N., Chavez, S., Thurston, L. T., Aitken, M., Zucker, K. J., Chakravarty, M. M., Lai, M.-C., and VanderLaan, D. P. (2022). Inter-network brain functional connectivity in adolescents assigned female at birth who experience gender dysphoria. Frontiers in Endocrinology, 2022, 13. doi:10.3389/fendo.2022.903058

Singh, D., Bradley, S. J., and Zucker, K. J. A follow-up study of boys with gender identity disorder. Frontiers in Psychiatry, 2021, 12. doi:10.3389/fpsyt.2021.632784

Skorska, M. N., Chavez, S., Devenyi, G. A., Patel, R., Thurston, L. T., Lai, M.-.C., Zucker, K. J., Chakravarty, M. M., Lobaugh, N. J., and VanderLaan, D. P. A multi-modal MRI analysis of cortical structure in relation to gender dysphoria, sexual orientation, and age in adolescents. Journal of Clinical Medicine, 2021, 10(2). https://doi.org/10.3390/jcm10020345

Wang, Y., Feng, Y., Su, D., Wilson, A., Pan, B., Liu, Y., Wang, N., Guo, B., Han, M., Zucker, K. J., and Chen, R. Validation of the Chinese version of the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults. Journal of Sexual Medicine, 2021, 18, 1632-1640.

Blanchard, R., Krupp, J., VanderLaan, D. P., Vasey, P. L., and Zucker, K. J. A method yielding comparable estimates of the fraternal birth order and female fecundity effects in male homosexuality. Proceedings of the Royal Society B: Biological Sciences, 2020, 287. http://dx/doi.org/10.1098/rspb/2019.2907

Khorashad, B. S., Zucker, K. J., Talaei, A., Rajabzadeh, F., Hamed, Z., Akbarian, P., and Blanchard, R. Birth order and sibling sex ratio in androphilic males and gynephilic females diagnosed with gender dysphoria from Iran. Journal of Sexual Medicine, 2020, 17, 1995-1202.

Wang, Y., Yu, H., Yang, Y., Drescher, J., Li, R., Yin, W., Yu, R., Wang, S., Deng, W., Jia, Q., Zucker, K. J., and Chen, R. Mental health status of cisgender and gender-diverse secondary school students in China. JAMA Network Open, 2020, 3(10), e2022796. doi:10.100/jamanetworkopen.2020.22796

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Zucker, K. J. Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. Archives of Sexual Behavior, 2019, 48, 1983-1992.

Bogaert, A. F., Skorska, M. N., Wang, C., Gabrie, J., MacNeil, A. J., Hoffarth, M. R., VanderLaan, D. P., Zucker, K. J., and Blanchard, R. Male homosexuality and maternal immune responsivity to the Y-linked protein NLGN4Y. Proceedings of the National Academy of Sciences USA, 2018, 115, 302-306.

de Graaf, N. M., Carmichael, P., Steensma, T. D., and Zucker, K. J. Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Gender Identity Development Service in London (2000-2017). Journal of Sexual Medicine, 2018, 15, 1381-1383.

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VanderLaan, D. P., Santarossa, A., Nabbijohn, N., Wood, H., Owen-Anderson, A., and Zucker, K. J. Separation anxiety among birth-assigned male children in a specialty gender identity service. European Child & Adolescent Psychiatry, 2018, 27, 89-98.

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Zucker, K. J., Cohen-Kettenis, P. T., Drescher, J., Meyer-Bahlburg, H. F. L., Pfäfflin, F., and Womack, W. M. Memo Outlining Evidence for Change for Gender Identity Disorder in the DSM-5. Archives of Sexual Behavior, 2013, 42, 901-914.

Heylens, G., De Cuypere, G., Zucker, K. J., Schelfaut, C., Elaut, E., Vanden Bossche, H., De Baere, E., and T'Sjoen, G. Gender identity disorder in twins: A review of the literature. Journal of Sexual Medicine, 2012, 9, 751-757.

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Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. Standards of Care for the Health of Transsexual, Transgender, and Gender-

Nonconforming People, Version 7. International Journal of Transgenderism, 2011, 13, 165-232.

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Zucker, K. J., and Wood, H. Assessment of gender variance in children. Child and Adolescent Psychiatric Clinics of North America, 2011, 20, 665-680.

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Meyer-Bahlburg, H. F. L., Dolezal, C., Johnson, L. L., Kessler, S. J., Schober, J. M., and Zucker, K. J. Development and validation of the Pregnancy and Infant Orientation Questionnaire. Journal of Sex Research, 2010, 47, 598-610.

Owen-Anderson, A. F. H., Bradley, S. J., and Zucker, K. J. Expressed emotion in mothers of boys with gender identity disorder. Journal of Sex & Marital Therapy, 2010, 36, 327-345.

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Kolla, N., and Zucker, K. J. Desire for nonmutilative disability in a nonhomosexual, male-to-female transsexual. Archives of Sexual Behavior, 2009, 38, 1057-1063.

Wallien, M. S. C., Quilty, L. C., Steensma, T. D., Singh, D., Lambert, S. L., Leroux, A., Owen-Anderson, A., Kibblewhite, S. J., Bradley, S. J., Cohen-Kettenis, P. T., and Zucker, K. J. Cross-national replication of the Gender Identity Interview for Children. Journal of Personality Assessment, 2009, 91, 545-552.

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Steensma, T. D., Cohen-Kettenis, P. T., VanderLaan, D. P., and Zucker, K. J. Self-harm and suicidality in Dutch children referred for gender dysphoria. European Professional Association for Transgender Health, Belgrade, Serbia, April 2017.

Zucker, K. J. (Moderator). ICD-11 Panel Discussion. Society for Sex Therapy and Research, Montreal, April 2017.

Zucker, K. J. Suicidality in children and adolescents with gender dysphoria. Society for Sex Therapy and Research, Montreal, April 2017.

Zucker, K. J., and Steensma, T. D. Gender trouble: Item 110 on the Child Behavior Checklist and Youth Self-Report. European Professional Association for Transgender Health, Belgrade, Serbia, April 2017; International Academy of Sex Research, Charleston, South Carolina, July 2017.

Zucker, K. J. Gender variations during childhood. In Development of gender variations: Features and factors (Chair: H. F. L. Meyer-Bahlburg), U.S. Professional Association for Transgender Health, Los Angeles, February 2017.

Zucker, K. J. Persistence and desistence in children and adolescents with gender variance: A comparative-developmental perspective. In Transgender Identities Emerging During Adolescents' Struggles with Mental Health Problems (Chair: M. Sevlever). American Academy of Child and Adolescent Psychiatry, New York, October 2016.

Steensma, T. D., VanderLaan, D. P., Kreukels, B. P. C., and Zucker, K. J. Self-harm and suicidality in a Dutch sample of children referred for gender dysphoria. Gender Development Research Conference, San Francisco, October 2016.

Zucker, K. J. The clinical practitioner's perspective. In Gender laws: The case of trans* children and adolescents (Chair: H. F. L. Meyer-Bahlburg). World Professional Association for Transgender Health, Amsterdam, the Netherlands, June 2016.

Zucker, K. J. Gender incongruence in childhood and *The International Classification of Diseases-11th revision*: A developmental perspective. In Gender Identity Variations of Childhood and Psychiatry: *The International Classification of Diseases 11th Revision* Controversy (Chair: H. F. L. Meyer-Bahlburg). American Academy of Child and Adolescent Psychiatry, San Antonio, October 2015.

VanderLaan, D. P., Lobaugh, N. J., Chakravarty, M. M., Patel, R., Chavez, S., Stojanovski, S., Tagaki, A., Hughes, S. K., Wasserman, L., Bain, J., Cantor, J. M., and Zucker, K. J. The neurohormonal hypothesis of gender dysphoria: Preliminary evidence of cortical surface area differences in adolescent natal females. International Academy of Sex Research, Toronto, August 2015.

Zucker, K. J., Leef, J. H., Wood, H., Hughes, S. K., Wasserman, L., and VanderLaan, D. P. LinkedIn? On the relation between gender dysphoria and traits of autism spectrum disorder in children. International Academy of Sex Research, Toronto, August 2015.

Bogaert, A. F., Skorska, M., Wang, C., Gabrie, J., Zucker, K., VanderLaan, D. P., and Blanchard, R. A test of the maternal immune hypothesis of men's sexual orientation. Puzzle of Sexual Orientation Conference, Lethbridge, Alberta, July 2015.

VanderLaan, D. P., Leef, J. H., Wood, H., Hughes, S. K., and Zucker, K. J. Recent progress in establishing and explaining the link between gender dysphoria and autism spectrum disorder in children. Puzzle of Sexual Orientation Conference, Lethbridge, Alberta, July 2015.

Zucker, K. J. Gender incongruence in childhood: A developmental perspective. In P. Carmichael (Chair), Ongoing debates. European Professional Association for Transgender Health, Ghent, Belgium, March 2015.

Zucker, K. J. A developmental, biopsychosocial treatment model for children with gender dysphoria. In J. Drescher and W. Byne (Chairs), Symposium on Controversies in the Treatment of Transgender Children and Adolescents. American Psychiatric Association, New York, May 2014.

Zucker, K. J. Sexual and gender identity disorders. In D. A. Regier and D. J. Kupfer (Chairs), DSM-5: What You Need to Know. American Psychiatric Association, New York, May 2014.

Zucker, K. J. Gender identity differentiation in girls with or without a disorder of sex development. In E. Vilain and A. P. Arnold (Chairs), Differences in Gender Development: What Have We Learned from Patients with DSD? Organization for the Scientific Study of Sex Differences, Minneapolis, April 2014.

Zucker, K. J. Prevalence and correlates of suicidality in clinic-referred adolescents with gender dysphoria: A cross-national, cross-clinic comparative analysis. World Professional Association for Transgender Health, Bangkok, Thailand, February 2014.

Zucker, K. J. Gender dysphoria and DSM-5. World Professional Association for Transgender Health, Bangkok, Thailand, February 2014.

VanderLaan, D. P., Singh, D., and Zucker, K. J. Childhood separation anxiety in gender dysphoric boys and sexual orientation at follow-up: Implications for the minority stress hypothesis. International Academy of Sex Research, Chicago, August 2013.

Zucker, K. J. Developmental trajectories of children with gender identity disorder. In S. B. Levine (Chair), Symposium on Trends, Uncertainties, and Controversies in the Treatment of the Transgendered. American Psychiatric Association, San Francisco, May 2013.

Zucker, K. J. Has the DSM-5 (partially) depathologized pedophilic disorder? In K. J. Zucker (Chair), Report of the DSM-5 Sexual and Gender Identity Disorders Work Group. American Psychiatric Association, San Francisco, May 2013.

Zucker, K. J. Towards DSM-5: What's changing for children and adolescents? International Association for Child and Adolescent Psychiatry and Allied Professions. Paris, France, July 2012.

Zucker, K. J. Developmental trajectories of children with Gender Identity Disorder. International Association for Child and Adolescent Psychiatry and Allied Professions. Paris, France, July 2012.

Zucker, K. J. Key recommendations from the DSM-5 Sexual and Gender Identity Disorders Workgroup. In D. A. Regier and D. J. Kupfer (Chairs), The Future of Psychiatric

Diagnosis: Updates on the Proposed Diagnostic Criteria for DSM-5 (Part III). American Psychiatric Association, Philadelphia, May 2012.

Zucker, K. J. DSM-5: Specific issues. World Professional Association for Transgender Health, Atlanta, September 2011.

Zucker, K. J. Long-term outcome of boys with gender identity disorder. World Professional Association for Transgender Health, Atlanta, September 2011.

Zucker, K. J. A twin study of 25 children with gender identity disorder. World Professional Association for Transgender Health, Atlanta, September 2011.

Zucker, K. J. Symposium on Gender Identity Disorder in Children and Adolescents: Theoretical and Empirical Advances (Chair). Joint meeting of the American Academy of Child and Adolescent Psychiatry and the Canadian Academy of Child and Adolescent Psychiatry, Toronto, October 2011.

Zucker, K. J. and Neilson, B. Cultural factors in the clinical management of patients with disorders of sex development. In V. A. Rosario (Chair), Symposium on Intersex Mental Health. Joint meeting of the American Academy of Child and Adolescent Psychiatry and the Canadian Academy of Child and Adolescent Psychiatry, Toronto, October 2011.

Zucker, K. J. Reflections on the "disorder vs. variance" debate in gender incongruent children and adolescents. In H. F. L. Meyer-Bahlburg (Chair), Symposium on Gender-related identities as mental disorders? Society for the Scientific Study of Sexuality, Las Vegas, NV, November 2010.

Zucker, K. J. An empirical analysis of the diagnostic criteria for gender identity disorder. In K. J. Zucker (Chair), Symposium on Gender identity disorder and the DSM-5: An update. American Academy of Child and Adolescent Psychiatry, New York, October 2010.

Zucker, K. J. Key recommendations from the DSM-5 Sexual and Gender Identity Disorders Workgroup. In D. A. Regier (Chair), Symposium on DSM-5 Update Series Part I: Reports from the Work Groups. American Psychiatric Association, New Orleans, LA, May 2010.

Zucker, K. J. History of gender identity disorder and developmental trajectories in children. In T. Mazur (Chair), Symposium on Gender Dysphoria in youth: Diagnosis, management, and follow-up data from a developmental perspective. Lawson Wilkins Pediatric Endocrine Society, Vancouver, BC, May 2010.

Singh, D., Bradley, S. J., and Zucker, K. J. A follow-up study of boys with gender identity disorder. Gender Development Research Conference, San Francisco, April 2010.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., and Singh, D. A parent-report Gender Identity/Gender Role Questionnaire for Adolescents. Gender Development Research Conference, San Francisco, April 2010.

Zucker, K. J. Introduction. Symposium on DSM-V: The sexual dysfunctions. Society for Sex Therapy and Research, Boston, April 2010.

Zucker, K. J. Beyond gender identity: Quality of life in disorders of sex development. 2nd World Conference, Hormonal and Genetic Basis of Sexual Differentiation Disorders and Hot Topics in Endocrinology, Miami Beach, Florida, January 2010.

Zucker, K. J. Towards DSM-V: An overview. In K. J. Zucker (Chair), What's New (Or Ought to be New) in DSM-V? New Perspectives on Female Sexual Problems (Symposium). International Academy of Sex Research, San Juan, Puerto Rico, August 2009.

Leroux, A., and Zucker, K. J. Do children with gender identity disorder have an in-group or an out-group gender-based bias? World Professional Association for Transgender Health, Oslo, Norway, June 2009.

Zucker, K. J. Introduction. In K. J. Zucker (Chair), Provisional Report by the DSM-V Sexual and Gender Identity Disorders Workgroup. Society for Sex Therapy and Research, Arlington, VA, April 2009.

Zucker, K. J. The DSM diagnostic criteria for gender identity disorder in children. In K. J. Zucker (Chair), Provisional Report by the DSM-V Sexual and Gender Identity Disorders Workgroup. Society for Sex Therapy and Research, Arlington, VA, April 2009.

Zucker, K. J. Associated psychopathology in children and adolescents with gender identity disorder. In H. F. L. Meyer-Bahlburg (Chair), From Mental Disorder to Iatrogenic Hypogonadism: Dilemmas in Conceptualizing Gender Identity Disorder (GID) as a Psychiatric Condition (Symposium). American Academy of Child and Adolescent Psychiatry, Chicago, October 2008.

Wherrett, D., Neilsen, B., Bradley, S. J., Zucker, K. J. and the Multidisciplinary Urogenital (MUG) Clinic Team. Behavior problems in children with disorders of sex development. Paper presented at the World Professional Association for Transgender Health, Chicago, September 2007.

Zucker, K. J., Owen-Anderson, A., and Bradley, S. J. The Recalled Childhood Gender Identity/Gender Role Questionnaire: A comparative study of adolescents with gender identity disorder and transvestic fetishism. Paper presented at the World Professional Association for Transgender Health, Chicago, September 2007.

Dawood, K., Sanders, A. R., and Zucker, K. J. Familial aspects of gender identity disorder in boys. Poster presented at the International Academy of Sex Research, Vancouver, BC, August 2007.

Zucker, K. J. The development of sexual orientation in women: Lessons learned from diverse populations. In S. Berenbaum (Chair), Biopsychology of sexual orientation. Society for Behavioral Neuroendocrinology, Pacific Grove, CA, June 2007.

Gedrose, B., Zucker, K. J., Fairbrother, C., and Bertollo, J. “Is it better to be a boy or a girl”? Qualitative responses of children with gender identity disorder. Poster presented at the International Academy of Sex Research, Amsterdam, The Netherlands, July 2006.

Zucker, K. J. Do girls with gender identity disorder have a natural history? Presidential address, International Academy of Sex Research, Amsterdam, The Netherlands, July 2006.

Zucker, K. J. Is there a best practice for the treatment of children with gender identity disorder? Paper presented at the meeting of the Canadian Academy of Child and Adolescent Psychiatry, Toronto, November 2006.

Zucker, K. J. Predictors of psychopathology in boys with gender identity disorder. In S. J. Bradley (Chair), Gender Identity Disorder in Children and Adolescents. (Institute). American Academy of Child and Adolescent Psychiatry and Canadian Academy of Child Psychiatry, Toronto, October 2005.

Zucker, K. J. Reforming the DSM criteria for gender identity disorder. In S. J. Bradley (Chair), Gender Identity Disorder in Children and Adolescents. (Institute). American Academy of Child and Adolescent Psychiatry and Canadian Academy of Child Psychiatry, Toronto, October 2005.

Zucker, K. J. Psychological perspectives. Paper presented at the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, April 2005.

Zucker, K. J., Lambert, S., Bradley, S. J., and Owen-Anderson, A. Risk factors for general behavior problems in boys with gender identity disorder. Paper presented at the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, April 2005.

Zucker, K. J. Debating DSM. Paper presented at the Harry Benjamin International Gender Dysphoria Association, Gent, Belgium, September 2003.

Zucker, K. J. Persistence and desistance of gender identity disorder in children [Discussant]. Harry Benjamin International Gender Dysphoria Association, Gent, Belgium, September 2003.

Connolly, P. H., Blanchard, R., and Zucker, K. J. Birth order in transgendered males from Polynesia. Poster presented at the International Academy of Sex Research, Bloomington, Indiana, July 2003.

Zucker, K. J. Gender-related behavior in girls with or without somatic intersexuality. International Academy of Sex Research, Bloomington, Indiana, July 2003; International Conference on Behavioral Development: Biological Basis of Sexual Orientation and Sex-Typical Behavior, Minot, North Dakota, August 2005.

Zucker, K. J., Do parents of newborns with physical intersex conditions show symptoms analogous to post-traumatic stress disorder? Society for Sex Therapy and Research, March 2003, Miami Beach, Florida.

Zucker, K. J. Discussant. In N. Donson (Chair), Contributions from child psychoanalysis: Treatment of gender identity disorders. American Academy of Child and Adolescent Psychiatry, New York, New York, October 2000.

Zucker, K. J. Is there a biological diathesis for gender identity disorder in boys? Paper presented at the Harry Benjamin International Gender Dysphoria Association, London, England, August 1999.

Zucker, K. J. Gender identity issues in children and adolescents. Paper presented at the Harry Benjamin International Gender Dysphoria Association, London, England, August 1999.

Birkenfeld-Adams, A., Zucker, K. J., and Bradley, S. J. Boys with gender identity disorder: Signs of separation anxiety and distress. Poster presented at the Second International Conference on Attachment & Psychopathology, Toronto, Ontario, October 1998.

Birkenfeld-Adams, A., Zucker, K. J., and Bradley, S. J. Quality of attachment in young boys with gender identity disorder. Poster presented at the Second International Conference on Attachment & Psychopathology, Toronto, Ontario, October 1998.

Fridell, S. R., Zucker, K. J., Schneider, B. S., and Bradley, S. J. Playmate choices and social skills of boys with gender identity disorder. International Academy of Sex Research, Sirmione, Italy, June 1998.

Zucker, K. J. Gender identity disorder in children: Therapeutic and ethical considerations. American Academy of Child and Adolescent Psychiatry/Canadian Academy of Child Psychiatry, Toronto, October 1997.

Bradley, S. J., and Zucker, K. J. Gender-dysphoric adolescents: How are they different from gender-dysphoric children? American Academy of Child and Adolescent Psychiatry/ Canadian Academy of Child Psychiatry, Toronto, October 1997.

Zucker, K. J. Development of gender identity and sexual orientation in children and adults. In B. A. Gladue (Chair), Current directions in sex research. American Psychological Association, Toronto, August 1996.

Zucker, K. J. Pathological gender mourning in mothers of boys with gender identity disorder:

Clinical evidence and some psychocultural hypotheses. Society for Sex Therapy and Research, Miami Beach, Florida, March 1996.

Smith, M., Kuksis, M., Zucker, K. J., and Beitchman, J. H. Cognitive profile and psychopathology in children admitted to psychiatric day treatment: A comparison to outpatient and normal controls. International Society for Research in Child and Adolescent Psychopathology, Santa Monica, California, January 1996.

Zucker, K. J. Childhood sex-typed behavior and sexual orientation. In K. J. Zucker (Chair), Developmental aspects of sexual orientation. Society for Research in Child Development, Indianapolis, Indiana, March 1995.

Zucker, K. J. Discussant. In C. J. Patterson (Chair), Sexual orientation, children and families: Current issues in research. Society for Research in Child Development, Indianapolis, Indiana, March 1995.

Zucker, K. J. Treating childhood gender disorders. In S. Althof (Moderator), Treating sexual problems in the 2000s: Where are we now? Where are we going? Society for Sex Therapy and Research, New York, March 1995.

Zucker, K. J. Child characteristics and familial correlates of gender identity disorder. In S. J. Bradley (Chair), Gender identity disorder: Recent research and approaches to treatment. (Institute). American Academy of Child and Adolescent Psychiatry, New York, October 1994.

Zucker, K. J., Bradley, S. J., Lowry Sullivan, C. B., Mitchell, J. N., and Birkenfeld-Adams, A. Psychopathology in boys with gender identity disorder: Patterns and correlates. Society for Research in Child and Adolescent Psychopathology, London, England, June 1994; International Academy of Sex Research, Edinburgh, Scotland, June 1994; American Academy of Child and Adolescent Psychiatry, New York, October 1994.

Zucker, K. J. Towards DSM-IV. Thirteenth International Symposium on Gender Dysphoria, New York, New York, October 1993.

Zucker, K. J., Kuksis, M., and Beitchman, J. H. Assessment of children in psychiatric day-treatment: A comparison to outpatient and normal controls. Third Conference on Challenge and Change in Childhood Psychopathology. Children's Day Treatment: Interventions and Trends, Toronto, May 1993.

Zucker, K. J. Should the gender identity disorder of childhood be retained in DSM-V? Society for Sex Therapy and Research, Montreal, Quebec, March 1992.

Grimshaw, G., Zucker, K. J., Bradley, S. J., Lowry, C. B., and Mitchell, J. N. Verbal and spatial ability in boys with gender identity disorder. International Academy of Sex Research, Barrie, Ontario, August 1991.

Maing, D. M., da Costa, G. A., and Zucker, K. J. Patterns of psychopathology in sexually abused girls: A comparison to clinic and nonclinic control girls. International Academy of Sex Research, Barrie, Ontario, August 1991; Society for Research in Child and Adolescent Psychopathology, Sarasota, Florida, February 1992.

Tkachuk, J., and Zucker, K. J. The relation among sexual orientation, spatial ability, handedness, and recalled childhood gender identity in women and men. International Academy of Sex Research, Barrie, Ontario, August 1991.

Zucker, K. J. Contributions of developmental psychology and psychopathology to the understanding of children with gender identity disorder. Symposium on Psychosexual Development (Chair: K. J. Zucker), World Congress for Sexology, Amsterdam, The Netherlands, June 1991.

Zucker, K. J. (Chair). Principles of and experiences in the treatment of children with gender identity disorder. Symposium presented at the Canadian Academy of Child Psychiatry, Toronto, September 1990.

Zucker, K. J. Can "erotic preference" be measured in children? II. Effects of increasing the salience of the putative erotic stimuli. International Academy of Sex Research, Sigtuna, Sweden, August 1990.

Zucker, K. J. Assessment and diagnosis of children with gender identity disorder. In S. J. Bradley (Chair), Psychosexual disorders in children and adolescents (Institute). American Academy of Child Psychiatry, New York, October 1989.

Zucker, K. J., and Bradley, S. J. Follow-up studies on children and adolescents with gender dysphoria. Eleventh International Symposium on Gender Dysphoria, Cleveland, September 1989.

Zucker, K. J. Can "erotic preference" be measured in children? Symposium on Sexual Behavior and Eroticism in Childhood (Organizer and Chair, K. J. Zucker). International Academy of Sex Research, Princeton, June 1989.

Zucker, K. J. Can "erotic preference" be measured in children? Nags Head Conference on Sex and Gender, Kill Devil Hills, North Carolina, May 1989.

Zucker, K. J. Girls with the gender identity disorder of childhood. Society for Sex Therapy and Research, Tucson, March 1989.

Zucker, K. J., and Bradley, S. J. Gender identity and sexual orientation in cross-gender-identified children: A follow-up in adolescence. Society for Research in Child and Adolescent Psychopathology, Miami Beach, February 1989.

Zucker, K. J. Clinical management of children with gender identity disorder. American Psychiatric Association, Montreal, May 1988.

Zucker, K. J., and Bradley, S. J. Patterns of temperament in cross-gender-identified children. Child Psychiatry Day, Hospital for Sick Children, Toronto, February 1988.

Zucker, K. J., Bradley, S. J., Lowry, C. B., and Sackin, H. D. (Symposium) Gender identity disorders in children and adolescents: Research and treatment issues. Canadian Academy of Child Psychiatry, London, Ontario, September 1987.

Zucker, K. J., and Bradley, S. J. Parent-report of psychopathology in cross-gender-identified boys. International Academy of Sex Research, Tutzing, West Germany, June 1987.

Zucker, K. J. Therapeutic strategies with gender identity confused children. The 9th Annual Guelph Conference on Sexuality, Guelph, Ontario, June 1987.

Zucker, K. J. The nature of eroticism in the child: Implications for child sexual abuse policy and research. Canadian Child Sexual Abuse Research Conference, Toronto, May 1987.

Zucker, K. J. Eroticism and gender identity in children. Youthdale Psychiatric Crisis Service Conference on Sexual Abuse, Toronto, February 1987.

Zucker, K. J., Bradley, S. J., and Gladding, J. A. A follow-up study of transsexual, transvestitic, homosexual, and "undifferentiated" adolescents. International Academy of Sex Research, Amsterdam, September 1986.

Zucker, K. J. The relation between homosexuality and transsexualism in adolescence: A phenomenological perspective. American Academy of Child Psychiatry, Toronto, October 1984.

Bradley, S. J., and Zucker, K. J. Gender-dysphoric adolescents: Presenting and developmental characteristics. American Academy of Child Psychiatry, Toronto, October 1984.

Zucker, K. J., Doering, R. W., Bradley, S. J., Lozinski, J. A., and Alon, N. Sex-typed fantasy play in cross-gender-identified children. Child Psychiatry Day, Toronto, March 1984; International Academy of Sex Research, Cambridge, England, September 1984.
Zucker, K. J. Friendships in cross-gender-identified children. American Orthopsychiatric Association, Toronto, April 1984.
Zucker, K. J., and Corter, C. M. Infants' use of sound in search for social objects. International Society for the Study of Behavioural Development, Toronto, August 1981.
Zucker, K. J., and Corter, C. M. Infants' use of sound in search for mother during brief separation. Society for Research in Child Development, Boston, April 1981.
Zucker, K. J., and Corter, C. M. Effects of differential experience on the infant's search for mother during brief separation. University of Waterloo Conference on Child Development, Waterloo, Ontario, May 1980.
Zucker, K. J., and Corter, C. M. Selective visual search as an index of "person permanence." Eastern Psychological Association, Philadelphia, April 1979.
Zucker, K. J., and Bradley, S. J. Core gender identity and psychological androgyny: Some theoretical considerations. Canadian Psychiatric Association, Saskatoon, Saskatchewan, September 1977.
Zucker, K. J., and Milord, J. T. Attribution of responsibility for physical and psychological disease. Canadian Psychological Association, Vancouver, BC, June 1977.

Student Supervision

Ted Guloien, University of Guelph, Research Practicum, June-August 1982.
Debra N. Wilson, Institute of Child Study, Research and Clinical Practicum, September 1982-April 1984.
Jodie Waisberg, University of Windsor, Clinical Practicum, May-August, 1983.
Lorraine Skinner, University of Toronto, B.A. Thesis, 1984.
Jodi A. Lozinski, Institute of Child Study, Clinical Practicum, May 1984-May 1985; M.A. thesis, Ontario Institute for Studies in Education, University of Toronto, 1988.
Adele Goldberg, University of Toronto, B.A. Thesis, 1985.
Anita Stern, University of Toronto, B.A. Thesis, 1985.
Helen Torkos, University of Toronto, B.A. Thesis, 1985.
Mark Whitehead, University of Toronto, B.A. Thesis, 1985.
David Schwartzbain, York University, Clinical Practicum, April-August 1985.
Janice Kurita, University of Toronto, B.A. Thesis, 1986.
Deborah Leonoff, York University, Clinical Practicum, September 1985-August 1986.
Dianne Maing, University of Windsor, Clinical Practicum, September 1985-May 1986.
Myra Radzins (Kuksis), York University, Clinical Practicum, September 1986-August 1987.
Kathy Hall, University of Toronto, B.A. Thesis, 1987.
Deborah Cowman, York University, Clinical Practicum, September 1987-August 1988.
Alison Niccols, York University, Applied Practicum, September 1987-December 1987.
Erika Cassavia, University of Toronto, B.A. Thesis, 1988.
Michelle Peterson-Badali, Ontario Institute for Studies in Education, Clinical Practicum, May-August 1988.
Jean Couitis, Ontario Institute for Studies in Education, Clinical Practicum, September 1988-April 1989.

Cheryl Arnold, York University, Clinical Practicum, September 1989-April 1990.
Janet N. Mitchell, Doctoral Dissertation Committee Member and Site Supervisor, York University, September 1988-November 1991.
Karen Leitner, Ontario Institute for Studies in Education, Clinical Practicum, September 1989-July 1990.
Jan Tkachuk, University of Toronto, B.A. Thesis, 1990.
Andrea Menezes, Drexell University, APA-CPA Intern, September 1991-August 1992.
Sherry Maharaj, York University, Clinical Practicum, September 1991-April 1992.
Shannon Stewart, York University, Clinical Practicum, February-May 1992.
Kathy Short, University of British Columbia, APA-CPA Intern, September 1992-August 1993.
Claudia Koshinsky Clipsham, York University, Clinical Practicum, September 1992-April 1993; September 1993-April 1994.
Christina Garofano, University of Toronto, B.A. Thesis, 1993.
Elizabeth Gilchrist, York University, Clinical Practicum, May-August, 1993.
Sicily Tan, Ontario Institute for Studies in Education, Clinical Practicum, September 1993-December 1993.
Kathy Lawrence, Fuller Graduate School of Psychology, APA-CPA Intern, September 1993-August 1994.
Wendy Lewis, Clinical Practicum, University of Saskatchewan, May-August 1994.
Patricia Peters, Concordia University, APA-CPA Intern, September 1994-August 1995.
Patricia A. Title, Ontario Institute for Studies in Education, Clinical Practicum, September 1994-April 1995; September 1997-April 1998.
Sari R. Fridell, Ontario Institute for Studies in Education, Clinical Practicum, September 1994-August 1996.
Shauna Lightbody, University of Waterloo, Clinical Practicum, May-August 1995.
Joanne Tilden, Concordia University, APA-CPA Intern, September 1995-August 1996.
Marie Antoinette Galea, Adler School of Professional Psychology, Clinical Practicum, September 1995-August 1996.
Stephanie A. McDermid, University of Toronto, B.A. Thesis, 1996.
Christine Boisvert, University of Ottawa, APA-CPA Extern, September-November, 1996.
Carol Root, Ontario Institute for Studies in Education, Clinical Practicum, September 1996-April 1997.
Nancy Cox, York University, Clinical Practicum, September 1996-April 1997.
Mary Motz, York University, Clinical Practicum, September 1996-April 1997.
Deborah A. Roth, University of Toronto, Clinical Practicum, May-August 1997.
Joy Crabtree, Illinois School of Professional Psychology, APA-CPA Intern, September 1997-August 1998.
Revital Ben-Knaz, York University, Clinical Practicum, September 1997-April 1998; September 1998-April 1999.
Julie-Ann Baxter, Ontario Institute for Studies in Education, Clinical Practicum, September 1997-April 1998.
Diane Warling, Ontario Institute for Studies in Education, Clinical Practicum, September 1997-April 1998.
Rona S. Atlas, York University, Clinical Practicum, September 1998-August 1999.
Ali Taradash, York University, Clinical Practicum, September 1998-April 1999; September 1999-April 2000.

Genevieve Sauvageau, York University, Clinical Practicum, September 1998-April 1999.
Karen Ghelani, Ontario Institute for Studies in Education, Clinical Practicum, September 1998-April 1999.
Loren E. McMaster, York University, APA-CPA Intern, September 1998-August 1999.
Ana Cavacas, University of Toronto, B.A. Thesis, 1999.
Nicole Beaulieu, University of Toronto, B.A. Thesis, 1999.
Joanna Pozzulo, Centre for Addiction and Mental Health, Clarke Division, Supervised Practice for Registration with the College of Psychologists of Ontario, 1999.
Elana Miller, Ontario Institute for Studies in Education, Clinical Practicum, January 1999-April 1999.
Karin E. Gleason, University of Western Ontario, APA-CPA Intern, September 1999-August 2000.
Jennifer Crosbie, Ontario Institute for Studies in Education, Clinical Practicum, September 1999-April 2000.
Allison Owen, Ontario Institute for Studies in Education, Clinical Practicum, September 1999-April 2000.
Danielle Ruskin, Ontario Institute for Studies in Education, Clinical Practicum, September 1999-April 2000.
Pamela Wilansky, York University, Clinical Practicum, September 1999-April 2000; APA-CPA Intern, September 2000-August 2001.
Drew Dane, Ontario Institute for Studies in Education, Clinical Practicum, April 2000-June 2000.
Michelle Eidlitz, Ontario Institute for Studies in Education, Clinical Practicum, September 2000-April 2001.
Adrine McKenzie, Ontario Institute for Studies in Education, Clinical Practicum, September 2000-August 2001.
Terry Diamond, York University, Clinical Practicum, September 2000-April 2001.
Caroline Ho, Ontario Institute for Studies in Education, Clinical Practicum, September 2001-April 2002.
Laurel L. Johnson, University of Guelph, Clinical Practicum, January 2002-June 2002.
Siegi Schuler, York University, Clinical Practicum, January 2002-May 2002.
Dahlia N. Ben-Dat, Concordia University, Clinical Practicum, May 2002-August 2002.
Christine Sloss, DePaul University, APA-CPA Intern, September 2002-August 2003.
Nanci Lipstein, Adler School of Professional Psychology, Clinical Practicum, September 2002-April 2003.
Amy Yuile, York University, Clinical Practicum, September 2002-April 2003.
Sanaz Mehranvar, York University, Clinical Practicum, September 2002-April 2003.
Jacqueline Cohen, University of New Brunswick, Clinical Practicum, May 2003-August 2003.
Urszula Jasiobedska, Concordia University, Clinical Practicum, May 2003-August 2003.
Nicole Li, University of Windsor, APA-CPA Intern, September 2003-August 2004.
Melissa Korson, Adler School of Professional Psychology, Clinical Practicum, September 2003-April 2004.
Andrea Turner, University of Windsor, Clinical Practicum, September 2003-April 2004.
Andrea Spooner, University of Guelph, Clinical Practicum, September 2003-April 2004.
Kelley Drummond, Ontario Institute for Studies in Education/UT, M.A. thesis, Graduate Advisor, September 2003-December 2005.

Jennine Rawana, Lakehead University, Clinical Practicum, January 2004-June 2004.
Sandy W. Chiu, University of Toronto, Undergraduate Independent Study, September 2003-April 2004.
Joseph J. Deogracias, B.A. Thesis, University of Toronto, April 2004.
Jennifer Felsher, McGill University, APA-CPA Intern, September 2004-August 2005.
Debbie Leung, State University of New York at Stony Brook, Clinical Practicum, September 2004-August 2005.
Sarah Kibblewhite, University of Windsor, Clinical Practicum, September 2004-June 2005; APA-CPA Intern, September 2005-August 2006.
Susan Lambert, York University, Clinical Practicum, September 2004-June 2005.
Tracy Vieira, Ontario Institute for Studies in Education/UT, Clinical Practicum, September 2004-June 2005.
Amrit Dhariwal, York University, Clinical Practicum, September 2005-June 2006.
Anne Pleydon, York University, Clinical Practicum, September 2005-June 2006.
Laura-Lynn Stewart, Ontario Institute for Studies in Education/UT, Clinical Practicum, September 2005-June 2006.
Devita Singh, Ontario Institute for Studies in Education/UT, M.A. thesis, Graduate Advisor, September 2005-August 2007.
Benjamin Gedrose, University of Hamburg, Research Practicum, January-April 2006.
Amanda DeGoeas, Yorkville University, Clinical Practicum, April 2006-December 2006.
Shannon Edison, APA-CPA Intern, University of Guelph, September 2006-August 2007.
Lana C. Zinck, Clinical Practicum, McGill University, September 2006-August 2007.
Kelley McShane, Clinical Practicum, Concordia University, September 2006-August 2007.
Tania Serrentino, Clinical Practicum, Yorkville University, September 2006-June 2007.
Annie Leroux, Ontario Institute for Studies in Education/UT, M.A. thesis, Graduate Advisor, September 2006-August 2008.
Janet Mah, Clinical Practicum, University of British Columbia, May 2007-August 2007.
Deanne Simms, Clinical Practicum, University of New Brunswick, May 2007-August 2007.
Dessy Marinova, Clinical Practicum, University of Guelph, September 2007-August 2008.
Hayley Wood, APA-CPA Intern, Ontario Institute for Studies in Education/UT, September 2007-August 2008.
Mary Tomlinson, Clinical Practicum, IASP (Zurich), September 2007-June 2008.
Anne Wagner, Clinical Practicum, Ryerson University, May 2008-August 2008.
Elizabeth Orr, Clinical Practicum, University of Waterloo, May 2008-August 2008.
Nora Klemenic, Clinical Practicum, University of Guelph, May 2008-August 2008.
Gregory Knoll, York University, Clinical Practicum, September 2008-June 2009.
Erin Ruttle, York University, Clinical Practicum, September 2008-June 2009.
Marc Schiffman, Clinical Practicum, University of Guelph, September 2008-June 2009.
Jonathan Leef, Ontario Institute for Studies in Education/UT, Clinical Practicum, September 2008-June 2009.
Barbara Mancini, Ontario Institute for Studies in Education/UT, Clinical Practicum, September 2008-June 2009; APA-CPA Intern, September 2011-August 2012.
Marlene Sachs, Ontario Institute for Studies in Education/UT, Clinical Social Work Practicum, September 2008-June 2009.

Gillian Liberman, Wilfred Laurier University, Clinical Social Work Practicum, September 2008-December 2008.
Carol-Anne Hendry, APA-CPA Intern, University of Guelph, September 2008-August 2009.
Sophie Hymen, APA-CPA Intern, University of Ottawa, January 2009-August 2009.
Leonie Knebel, Philipps-Universität Marburg, Clinical Practicum, May-August 2009.
Giovanni Foti, APA-CPA Intern, University of Guelph, September 2009-August 2010.
Jen Scully, APA-CPA Intern, Ontario Institute for Studies in Education/UT, September 2009-August 2010.
Immaculate Antony, Ontario Institute for Studies in Education/UT, Clinical Practicum, September 2009-June 2010.
Holly McGinn, Ontario Institute for Studies in Education/UT, Clinical Practicum, September 2009-June 2010.
Dina Lafoyiannis, York University, Clinical Practicum, September 2009-June 2010.
Kelly Nash, Ontario Institute for Studies in Education/UT, Clinical Practicum, September 2009-June 2010.
Blanca Heredia, Ontario Institute for Studies in Education/UT, Clinical Internship, September 2009-August 2010.
Lori Postema, VU University Medical Center, Research Elective, September 2010-December 2010.
Megan Ames, York University, Clinical Practicum, September 2010-June 2011; APA-CPA Intern, September 2013-August 2014.
Rachel Horton, York University, Clinical Practicum, September 2010-June 2011.
Stacey Schell, University of Guelph, Clinical Practicum, September 2010-June 2011.
Carly Guberman, APA-CPA Intern, Ontario Institute for Studies in Education/UT, September 2010-August 2011.
Tamara Kornacki, Clinical Practicum, Ontario Institute for Studies in Education/UT, May 2011-August 2011; September 2011-June 2012.
Claire Salisbury, Clinical Practicum, University of Western Ontario, May 2011-August 2011.
Amanda Fuentes, York University, Clinical Practicum, September 2011-June 2012.
Dilys Haner, York University, Clinical Practicum, September 2011-June 2012.
Korina Zorzella, York University Clinical Practicum, September 2011-June 2012.
Olivia Ng, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2011-June 2012.
Rachel Gropper, Clinical Internship, Ontario Institute for Studies in Education/UT, September 2011-August 2012.
Angela Varma, Clinical Internship, Ontario Institute for Studies in Education/UT, September 2011-August 2012.
Sophia Fantus, Clinical Practicum, Department of Social Work, Ontario Institute for Studies in Education/UT, September 2011-August 2012.
Melanie Bechard, Medical Student (Susan Bradley Scholarship), University of Toronto, June-August 2012.
Julia Vinik, APA-CPA Intern, Ontario Institute for Studies in Education/UT, September 2012-August 2013.

Madison Aitken, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2012-June 2013; APA-CPA Intern, September-December 2015.
Narges Hosseini-Sedehi, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2012-June 2013.
Vicky Lishak, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2012-June 2013.
Lauren Batho, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2012-June 2013.
Maggie Clarke, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2012-June 2013.
Olivia Leung, Clinical Practicum, McGill University, September 2012-June 2013.
Anna Takagi, Clinical Practicum, McGill University, September 2012-June 2013.
Doug VanderLaan, CIHR Post-doctoral Fellow, September 2012-September 2015.
Elyse Reim, Clinical Practicum, University of Guelph, September 2013-June 2014.
Julia Wreford, Clinical Practicum, University of Guelph, September 2013-June 2014.
Lindsay Fitzsimmons, Clinical Practicum, York University, September 2013-June 2014.
Dillon Browne, Clinical Practicum, Ontario Institute for Studies in Education/UT, May 2014-February 2015.
Theresa Grimbos, Clinical Practicum, Ontario Institute for Studies in Education/UT, May 2014-June 2015.
Zohrah Haqanee, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2014-December 2015.
Linda Iwenofu, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2014-December 2015.
Kathleen Lee, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2014-June 2015.
Heather Prime, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2014-June 2015.
Nina Vitopoulous, APA-CPA Intern, Ontario Institute for Studies in Education/UT, September 2014-August 2015.
Brent Mulrooney, Clinical Practicum, Ontario Institute for Studies in Education/UT, September 2015-December 2015.

Thesis Supervision

Supervisor

Drummond, K. D. A follow-up study of girls with gender identity disorder. Master's thesis, Ontario Institute for Studies in Education of the University of Toronto, 2006.
Owen-Anderson, A. "I know what he is feeling because it is like I am inside of him." Examining sensory sensitivities, empathy, and expressed emotion in boys with gender identity disorder and their mothers: A comparison to clinical control boys and community control boys and girls. Doctoral dissertation, Ontario Institute for Studies in Education of the University of Toronto, 2006.

Leroux, A. Do children with gender identity disorder have an in-group or an out-group gender-based bias? Master's thesis, Ontario Institute for the Study in Education of the University of Toronto, 2008.

Singh, D. Psychometric assessment of gender identity/gender dysphoria and recalled sex-typed behaviour in childhood: A comparison of adolescents and adults with gender identity disorder and clinical controls. Master's thesis, Ontario Institute for the Study in Education of the University of Toronto, 2008.

Singh, D. A follow-up study of boys with gender identity disorder. Doctoral dissertation, Ontario Institute for the Study in Education of the University of Toronto, 2008.

Committee Member

Mitchell, J. N. Maternal influences on gender identity disorder in boys: Searching for specificity. Doctoral dissertation, York University, Downsview, Ontario, 1991.

Radzins Kuksis, M. Risk and protective factors for child psychopathology. Doctoral dissertation, York University, 1992.

Fridell, S. R. Sex-typed play behavior and peer relationships in boys with gender identity disorder. Doctoral dissertation, Ontario Institute for Studies in Education of the University of Toronto, 2001.

Wilansky, P. Does Mohnan matter in cases of child sexual abuse? Doctoral dissertation, York University, 2002.

Johnson, L. L. Predicting young women's body dissatisfaction and disordered eating during the transition to university. Doctoral dissertation, University of Guelph, Guelph, Ontario, 2009.

Lambert, S. L. Assessment of body image in boys with gender identity disorder: A comparison to clinical control boys and community control boys. Doctoral dissertation, York University, 2009.

de Vries, A. Gender dysphoria in adolescents: Mental health and treatment evaluation. Doctoral dissertation, VU University, Amsterdam, the Netherlands, 2010.

Shiffman, M. Peer relations in adolescents with gender identity disorder. Doctoral dissertation, University of Guelph, Guelph, Ontario, 2013.

Leef, J. H. Characteristics of autism spectrum disorder in children with gender dysphoria. Doctoral dissertation, Ontario Institute for Studies in Education of the University of Toronto, 2018.

Site Supervisor

Ipp, H. R. Object relations of feminine boys: A Rorschach assessment. Doctoral dissertation, York University, 1986.

Kolers, N. Some ego functions in gender-disturbed boys. Doctoral dissertation, York University, 1986.

Lozinski, J. A. Sex-typed responses in the Rorschach protocols of cross-gender-identified children. Master's thesis, University of Toronto, 1988.

Maing, D. M. Patterns of psychopathology in sexually abused girls. Doctoral dissertation, University of Windsor, 1991.
Gotlib, L. Gender truths: Disordered identity reproductions in a gender identity clinic. Doctoral dissertation, University of Toronto, 2004.

External Examiner

Jeremy Baumbach, Department of Psychology, University of Saskatchewan, Saskatoon, Saskatchewan, 1987.
Kathleen Mary McDougall, Department of English, University of Toronto, 1995.
Vickie L. Pasterski, Department of Psychology, City University, London, England, 2002.
Briony Fane, Department of Psychology, City University, London, England, 2002.
Caroline P. L. Ripa, University of Copenhagen, Copenhagen, Denmark, 2002.
Madeleine Wallien, VU University, Amsterdam, the Netherlands, 2008.
Wang Ivy Wong, Department of Psychology, University of Cambridge, Cambridge, England, 2013.
Gu Li, Department of Psychology, University of Cambridge, Cambridge, England, 2017.
Karen Man Wa Kwan, Department of Psychology, The University of Hong Kong, Hong Kong, 2020.
Marta Beneda, Department of Psychology, University of Cambridge, Cambridge, England, 2022.

Honours Bestowed

President's Scholar, Southern Illinois University, 1969-1972.
University of Toronto Doctoral Fellowship, 1975-1980.
Zucker, K. J. Children and adolescents with gender dysphoria. In K. S. K. Hall and Y. M. Binik (Eds.), Principles and practice of sex therapy (Sixth ed.). New York: Guilford Press, 2020, pp. 395-422. [2021 recipient of the American Association of Sex Educators, Counselors and Therapists Book Award for Sexuality Professionals]

Professional Associations

American Psychological Association (Life Status Member, 2016)
Human Behavior and Evolution Society (2011-)
International Academy of Sex Research (Member)
International Society for Research in Child and Adolescent Psychopathology (Charter Member)
Ontario Psychological Association (2016-)
Society for Behavioral Neuroendocrinology (2001-2015)
Society for Research in Child Development (1982-1999)
Society for Sex Therapy and Research (1988-2014, 2019-)
Society for the Scientific Study of Sexuality
World Professional Association for Transgender Health (formerly Harry Benjamin International Gender Dysphoria Association)

Miscellaneous

Psychologist-in-Chief, Centre for Addiction and Mental Health (2001-2014)
Senior Psychologist, Clarke Institute of Psychiatry (1991-2000)
Psychologist-in-Charge, Child and Family Studies Centre, Clarke Institute of Psychiatry (1991-1998) [position ended with the elimination of disciplines, June 1998]
Director of Training, APA-CPA Clinical Psychology Internship Programme, Clarke Institute of Psychiatry (1994-2000)
Editor, Archives of Sexual Behavior (2002-)
Book Review Editor, Archives of Sexual Behavior (1988-2001)
Secretary-Treasurer, International Academy of Sex Research (1989-1991)
Secretary-Treasurer, International Academy of Sex Research (1991-1993)
Secretary-Treasurer, International Academy of Sex Research (1993-1995)
Secretary-Treasurer, International Academy of Sex Research (1995-1997)
Secretary-Treasurer, International Academy of Sex Research (1997-1999)
Secretary-Treasurer, International Academy of Sex Research (1999-2001)
President, International Academy of Sex Research (2005-2006)
Consulting Editor, Journal of Psychology and Human Sexuality (now International Journal of Sexual Health (1990-)
Consulting Editor, Journal of Sex & Marital Therapy (1995-)
Editorial Board, Annals of Sex Research (1988-1993)
Editorial Board, Sexual Abuse: A Journal of Research and Treatment (1996-1999)
Editorial and Advisory Board, Annual Review of Sex Research (1994-2004)
Editorial Board, Scandinavian Journal of Sexology (1998-2001)
Editorial Board, International Journal of Transgenderism (now International Journal of Transgender Health) (1997-)
Editorial Board, Hormones and Behavior (2001-2007)
Editorial Board, Journal of Gay & Lesbian Psychotherapy (now Journal of Gay & Lesbian Mental Health) (2004-)
Editorial Board, SEXES (2023-)
Associate Editor, Parenting Studies (1984-1986)

Ad Hoc Journal Reviewer:

Acta Obstetricia et Gynecologica Scandinavica, Adolescent Health, Medicine and Therapeutics, American Journal of Psychiatry, American Psychologist, Archives of Sexual Behavior, Asian Journal of Andrology, Autism Research, Biological Psychiatry, BMC Psychiatry, BMC Public Health, BMC Women's Health, BMJ Medicine, BMJ Paediatrics Open, British Journal of Health Psychology, British Medical Journal, Canadian Journal of Behavioural Science, Canadian Journal of Psychiatry, Canadian Medical Association Journal, Child and Adolescent Psychiatry and Mental Health, Child Development, Child Development Research, Children and Youth Services Review, Clinical Child Psychology and Psychiatry, Clinical Practice Endocrinology & Metabolism, Cognitive Development, Cognitive Therapy and Research, Current Opinion in Behavioral Sciences, Developmental Psychology, eNeuro, European Child & Adolescent

Psychiatry, European Journal of Pediatrics, European Journal of Social Psychology, European Psychologist, Frontiers in Neuroendocrinology, Frontiers in Psychiatry, Frontiers in Psychology, General Hospital Psychiatry, GLQ: A Journal of Gay and Lesbian Studies, Hormones and Behavior, International Journal of Endocrinology, International Journal of Impotence Research, International Journal of Psychiatry, International Journal of Sexual Health (formerly Journal of Psychology & Human Sexuality), International Journal of Transgenderism, Israel Journal of Psychiatry, JAMA Networks Open, Journal of Abnormal Child Psychology, Journal of Abnormal Psychology, Journal of Adolescent Health, Journal of Autism and Developmental Disorders, Journal of Child Psychology and Psychiatry, Journal of Clinical Endocrinology & Metabolism, Journal of Clinical Psychology, Journal of Counseling Psychology, Journal of Consulting and Clinical Psychology, Journal of Developmental and Behavioral Pediatrics, Journal of Experimental Child Psychology, Journal of Forensic Psychiatry & Psychology, Journal of Gay and Lesbian Mental Health (formerly Journal of Gay & Lesbian Psychotherapy), Journal of Pediatrics, Journal of Pediatric Endocrinology and Metabolism, Journal of Pediatric Nursing, Journal of Pediatric Psychology, Journal of Personality Assessment, Journal of Psychosomatic Research, Journal of Sex & Marital Therapy, Journal of Sex Research, Journal of Sexual Medicine, Journal of the American Academy of Child and Adolescent Psychiatry, Journal of Journal of the American Medical Association, Lancet, Lancet Psychiatry, Nature, Nature Reviews Urology, Neuroimage, Neuropsychiatric Disease and Treatment, Neuroscience and Biobehavioral Reviews, New England Journal of Medicine, Nordic Journal of Psychiatry, Pediatrics, Pediatric Research, Personality and Individual Differences, Perspectives on Psychological Science, Philosophical Transactions B, Philosophy, Psychiatry, & Psychology, PLoS ONE, Postgraduate Medicine, Proceedings of the National Academy of Sciences, USA, Psychiatry and Clinical Neurosciences, Psychiatry Research, Psychobiology, Psychological Bulletin, Psychological Medicine, Psychological Reports, Psychological Science, Psychological Review, Psychoneuroendocrinology, Scandinavian Journal of Child and Adolescent Psychiatry and Psychology, Scandinavian Journal of Public Health, Self and Identity, Sex Roles, Sexes, Sexological Review, Sexual Medicine Reviews, Social Behavior and Personality, Social Development, Theoretical Biology, Transcultural Psychiatry, Trends in Cognitive Sciences, Trends in Endocrinology

Peer Review: Ontario Mental Health Foundation (Toronto), Health and Welfare Canada (Ottawa), National Institute of Mental Health (Washington, DC), Wellcome Foundation (London, England), BBS (Israel-United States); National Institutes of Health (Washington, DC), The Research Council of Norway

Participant in Work Group to Revise DSM-III, Gender Identity Disorder of Childhood and Transsexualism (New York State Psychiatric Institute, New York, New York, April 23, 1985)

Committee Member, DSM-IV Subcommittee on Gender Identity Disorder of Childhood and Transsexualism (1989-1994)

Consultant, Somatic Psychic Work Group, Task Force on Coding for Mental Health in Children, American Academy of Pediatrics (1992-1996)

Advisory Committee Member, Human Sexuality Counseling Programme, Toronto Board of Education (1988-1991)
Member, North American Task Force on Intersexuality (October 1999-)
Member, Task Force on Gender Identity, Gender Variance, and Intersex Conditions, American Psychological Association (June 2005-2008)
Chair, DSM-5 Work Group on Sexual and Gender Identity Disorders, American Psychiatric Association (August 2007-2012)

Invited Addresses (Outside Toronto)

Western New York Association for Professionals Working in Human Sexuality, Buffalo, New York, October 1983.
New York Hospital-Cornell Medical Center, Department of Child and Adolescent Psychiatry, Westchester, New York, September 1984.
Roosevelt Hospital, Department of Child and Adolescent Psychiatry, New York, New York, September 1984.
Case Western Reserve University, Department of Psychiatry, Cleveland, Ohio, May 1985.
Developmental Psychoendocrinology Group, New York State Psychiatric Institute, New York, New York, April 1987.
Department of Psychology, University of Saskatchewan, Saskatoon, Saskatchewan, October, 1987.
Grand Rounds, Child Psychiatry, Presbyterian Hospital, New York State Psychiatric Institute, New York, New York, October 1987.
Department of Psychology, University of Windsor, Windsor, Ontario, December 1987.
Master Lecture, Society for Sex Therapy and Research, New York, New York, March 1988.
Developmental Psychoendocrinology Group, New York State Psychiatric Institute, New York, New York, February 1990.
Grand Rounds, Department of Psychiatry, State University of New York Health Science Center at Brooklyn, February 1990.
Psychosexual development in male pseudohermaphroditism. Summer School Institute of the European Society of Pediatric Endocrinology, Vienna, Austria, August 1990.
Colloquium, Department of Psychology, North Dakota State University, Fargo, North Dakota, October 1990.
Lecture, Universita Di Genova, Istituto Di Psicologia, Della Facolta Medica, Genova, Italy, June 1991.
Grand Rounds, Child and Adolescent Psychiatry, Schneider Children's Hospital, New Hyde Park, New York, October 1991.
Developmental Psychoendocrinology Group, New York State Psychiatric Institute, New York, New York, October 1991.
Lecture, Conference on Gender Identity and Development in Childhood and Adolescence, St. George's Hospital, London, England, March 1992.
Developmental Psychoendocrinology Group, New York State Psychiatric Institute, New York, New York, October 1992.

Grand Rounds, Child Psychiatry, New York State Psychiatric Institute, New York, New York, October 1992.
Lecture, Conference on Psychomedical Aspects of Gender Problems, Amsterdam, The Netherlands, April 1992.
Lecture, Kinder- en Jeugdpsychiatrie, Divisie Psychiatrie, Academisch Ziekenhuis Utrecht, Utrecht, The Netherlands, April 1992.
Seminar, Kinder- en Jeugdpsychiatrie, Divisie Psychiatrie, Academisch Ziekenhuis Utrecht, Utrecht, The Netherlands, April 1992.
Colloquium, Department of Psychology, Northwestern University, Evanston, Illinois, May 1993.
Inservice, Department of Child and Adolescent Psychiatry, Riley Hospital, Indianapolis University School of Medicine, Indianapolis, Indiana, May 1993.
Developmental Psychoendocrinology Group, New York State Psychiatric Institute, New York, New York, October 1994.
International Congress on Gender, Cross Dressing and Sex Issues, Van Nuys, California, February 1995.
International Behavioral Development Symposium: Biological Basis of Sexual Orientation and Sex-Typical Behavior, Minot, North Dakota, May 1995.
Rounds, Sexual Behaviors Consultation Unit and Division of Child Psychiatry, Johns Hopkins University School of Medicine, Baltimore, Maryland, June 1995.
Congenital Adrenal Hyperplasia Due to 21-Hydroxylase Deficiency: A Symposium, Baltimore, Maryland, June 1995.
Childhood Psychopathology Institute, University of Southern Maine, Portland, Maine, June 1995.
Treatment of Children and Adolescents with Gender Identity Disorders, International Expert Symposium, Satellite Symposium to the XIV Harry Benjamin International Gender Dysphoria Symposium, Department of Psychotherapy, Ulm University, Ulm, Germany, September 1995.
Developmental Trajectories Towards Homosexuality, Transsexuality and Transvestism: Are There Any Predictors in Childhood. Workshop at the conference A Stranger in My Own Body: Atypical Gender Identity Development and Mental Health, Portman Clinic (Tavistock Centre), London, England, November 1996.
Atypical Gender Identification and Associated Psychopathology in the Child and the Family. Invited lecture at the conference A Stranger in My Own Body: Atypical Gender Identity Development and Mental Health, Portman Clinic (Tavistock Centre), London, England, November 1996.
Psychosexual Assessment of Women with CAH, Symposium on Adolescent Endocrinology, Cambridge, England, December 1996.
Gender Identity Disorder in Children: Science, Politics, and Ethics, American Psychological Association, Chicago, Illinois, August 1997.
Psychoanalysis and Gender Identity: Gender Identity Disorder in Childhood, American College of Psychoanalysts, Toronto, May 1998.
Nature, Nurture, and Gender Identity, American College of Psychiatrists, San Francisco, February 1999.

Screening and Diagnosis of Children with Gender Identity Disorder, Symposium Genderidentiteitsstoornissen, Academisch Ziekenhuis Utrecht, Utrecht, The Netherlands, October 1999.

Gender Identity Disorder in Children: Searching for the Biological and Psychosocial Influences, John P. Zubek Memorial Lecture, Department of Psychology, University of Manitoba, Winnipeg, Manitoba, March 2000.

Gender Assignment and Gender Identity, American Society of Andrology, Boston, April 2000.

Children with Gender Identity Disorder: Some Therapeutic Methods. Conference on Atypical Gender Identity Development: Therapeutic Models, Philosophical and Ethical Issues, London, England, November 2000.

Children with Gender Identity Disorder: Diagnosis, Assessment, and Etiology, Illinois Council of Child and Adolescent Psychiatry (Update on Child and Adolescent Psychiatry), Chicago, April 2001.

Treatment of Children with Gender Identity Disorder, Illinois Council of Child and Adolescent Psychiatry (Update on Child and Adolescent Psychiatry), Chicago, April 2001.

Discussant, The Kinsey Institute Sexual Development Conference, Bloomington, Indiana, May 2001.

Intersexuality and Gender Identity Differentiation, North American Society for Pediatric and Adolescent Gynecology, Toronto, May 2001.

Working with Youth with Gender Identity Disorder (Workshop), North American Society for Pediatric and Adolescent Gynecology, Toronto, May 2001.

Gender Identity Disorder in Children, Grand Rounds, Child and Adolescent Psychiatry, New York State Psychiatric Institute, Columbia University College of Physicians and Surgeons, November 2001.

Gender Identity Differentiation in Children: Lessons from Clinical Populations, Colloquium, Department of Psychology, Emory University, Atlanta, April 2002.

Gender Identity and Its Disorder: Focus on Children and Developmental Issues, Department of Psychology, City University, London, England, May 2002.

Conclusions and Implications from Recent Studies on Gender Identity Disorders, Meeting on Intersexuality: Medical, Social and Psychological Aspects, Universitäat Hamburg, Hamburg, Germany, June 2002.

Gender Identity Disorder in Children: Concepts, Controversies, and Conundrums, Society for the Scientific Study of Sexuality, Montreal, Quebec, November 2002.

Gender Identity Disorder in Children, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark, November 2002.

Gender Identity Disorder in Children, Association des médecins psychiatres du Québec, Gatineau, Quebec, June 2003.

Girls with Gender Identity Disorder and Physical Intersex Conditions: Similarities and Differences. Sexuality and Gender Seminar, Department of Psychiatry, New York State Psychiatric Institute, Columbia University, New York, New York, December 2003.

Intersexuality and Psychosexual Differentiation, Grand Rounds, Department of Obstetrics and Gynecology, MacDonald Women's Hospital, Case Western Reserve University, Cleveland, October 2004.

Gender Identity Disorder in Children: A Snapshot of Recent Research, Institute of Psychiatry, London, England, May 2006.

Intersexuality and Psychosexual Differentiation, Society for Fetal Urology, Atlanta, May 2006.

Gender Identity Disorder in Children: Looking Towards DSM-V, Warren Wright Adolescent Center Guest Lecture Series, Department of Child and Adolescent Psychiatry, Children's Memorial Hospital, Chicago, November 2007.

Definition and Spectrum of Gender Identity Disorders. Royal Society of Medicine (Gender Identity Disorder in Adolescence), London, England, October 2008.

Hormonal and Psychosocial Therapeutics for Adolescents with Gender Identity Disorder. Imperial College (Sex Hormone Treatment of the Teen Transsexual), London, England, September 2008.

Gender Identity Disorder in Children and Adolescents: Looking Towards DSM-V. Colloquium, Department of Psychology, Boston University, February 2009.

Gender Identity Disorder in Children: Biological and Psychosocial Factors, Dipartimento di Neuroscienze e Scienze del Comportamento, Unità di Psicologia Clinica e Psicoanalisi Applicata, Università degli Studi di Napoli, Naples, Italy, May 2009.

Psychosexual Differentiation and Disorders of Sex Development, III World ISHID Congress on Hypospadias and Disorders of Sex Development, Toronto, Ontario, November 2009.

Psychosexual Differentiation in Children: Lessons Learned from Clinical Populations, Center for Gender-Based Biology, University of California Los Angeles, November 2009.

Gender Identity Disorder in Children and Adolescents: Anticipating DSM-5. Colloquium, Department of Psychology, Laval University, Quebec City, March 2010.

Zucker, K. J. Gender Dysphoria in Children and Adolescents: Towards DSM-5. Grand Rounds, Department of Psychiatry, St. Lukes/Roosevelt Hospital, New York, September 2010.

Zucker, K. J. Gender Identity Disorder in Children and Adolescents: Towards DSM-5 (2013). Invited lecture, British Psychological Society, Manchester, England, December 2010.

Zucker, K. J. Gender Identity Disorder in Children and Adolescents. Grand Rounds, Department of Pediatrics, Alberta Children's Hospital, Calgary, May 2011.

Zucker, K. J. Gender Identity and Sexual Orientation: Lessons Learned from Life-Course Research. Michigan State University, East Lansing, November 2012.

Zucker, K. J. DSM-5 and the Sexual and Gender Identity Disorders: The Verdict. Society for Sex Therapy and Research, Baltimore, April 2013.

Zucker, K. J. Gender Non-Conforming Children Should Be Supported in Accepting Their Assigned Gender. Pediatric Endocrine Society Ethics Debate: Approach to the Prepubertal Gender Non-Conforming Child: Should Intervention Attempt to Support the Assigned or Affirmed Gender? Pediatric Academic Societies, Washington, DC, May 2013.

Zucker, K. J. Sexual and Gender Identity Disorders. DSM-5: What You Need to Know (Master Course). American Psychiatric Association, San Francisco, May 2013.

Zucker, K. J. DSM-5: Implications for the Field of Sexuality. American Association of Sexuality Educators, Counselors and Therapists, Miami, June 2013.

Zucker, K. J. The science and politics of DSM-5. Classifying Sex: Debating DSM-5, Centre for Research in the Arts, Social Sciences and Humanities (CRASSH), University of Cambridge, Cambridge, England, July 2013.

Zucker, K. J. Gender Dysphoria, DSM-5 and Beyond. World Association for Sexual Health, Porto Alegre, Brazil, September 2013.

Zucker, K. J. DSM-5 and the Sexual and Gender Identity Disorders. Academy of Psychosomatic Medicine, Tucson, November 2013.

Zucker, K. J. Sexual and Gender Identity Disorders, Grand Rounds in Psychiatry, UT Southwestern Medical Center, Dallas, Texas, April 2014.

Zucker, K. J. Disforia de gênero em criancas e adolescents. Sul-Rio-Grandense de Psiquiatria Din mica, Canela, Brazil, September 2014.

Zucker, K. J. Variacões de gênero em criancas e adolescents. Sul-Rio-Grandense de Psiquiatria Din mica, Canela, Brazil, September 2014.

Zucker, K. J. Évolution des demandes, des concepts et des soins au cours des dernières, décennies, sur sexe et genre, identitée sexuée, dysphorie de genre. Société Française de Psychiatrie de l'Enfant et de l'Adolescent & Disciplines Associées, Paris, France, January 2015.

Zucker, K. J. Gender dysphoria in children and adolescents. National Congress of Child and Adolescent Mental Health, Istanbul, Turkey, April 2015.

Zucker, K. J. Gender-nonconforming children: Different therapeutic perspectives. American Psychological Association, Toronto, August 2015.

Zucker, K. J. Pediatric Endocrine Society Transgender Special Interest Group Meeting, Baltimore, April 2016.

Zucker, K. J. Developmental considerations in the treatment of children and adolescents with gender dysphoria. Grand Rounds, Department of Pediatrics, C. S. Mott Children's Hospital, University of Michigan, Ann Arbor, May 2016

Zucker, K. J. Gender dysphoria in children and adolescents: Access to care. Health Service Research Seminar, University of Michigan, Ann Arbor, May 2016.

Zucker, K. J. Gender dysphoria in children and adolescents. Grand Rounds, Child and Adolescent Psychiatry, University of Michigan, Ann Arbor, May 2016.

Zucker, K. J. Best-practice therapeutics for children and adolescents with gender dysphoria: Science, politics, and more. Psychiatry Grand Rounds, School of Medicine, Case Western Reserve University, Cleveland, September 2016.

Zucker, K. J. Behavioral and emotional problems in children and adolescents with gender dysphoria: Implications for peer relationships. Gender Nonconformity: A Community Response to a Vulnerable Population, The Center for Psychosexual Health, Canisius College, Buffalo, November 2016.

Zucker K. J. Sex ratio of transgender adolescents: An international update. Gender Identity Development Services (GIDS) for Children and Adolescents, Tavistock and Portman NHS Trust, London, England; Center of Expertise on Gender Dysphoria, VU University Medical Center, Amsterdam, The Netherlands, October 2017.

Zucker, K. J. Ethical considerations and challenges regarding gender-affirming hormone therapy in children and adolescents with gender dysphoria/incongruence: An evidence-based discussion. Pediatric Endocrine Society, Toronto, Ontario, May 2018.

Zucker, K. J. Gender dysphoria (Seminar). Department of Psychiatry, University of Ottawa, Ottawa, Ontario, February 2019.

Zucker, K. J. Gender identity and kids. Still Talking Series, Vancouver, BC, May 2019.

Zucker, K. J. Gender dysphoria in children and adolescents. Pusaudžu Resursu Centrs, Riga, Latvia, November 2019

Zucker, K. J. Children and adolescents with gender dysphoria: Some contemporary research and clinical issues. Culture, Mind & Brain Program, Division of Social & Transcultural Psychiatry, McGill University, Montreal, Quebec, January 2020.

Zucker, K. J. [Publishing and Peer Review]. Fellows Meeting (Chair: T. M. Sandfort), Division of Gender, Sexuality and Health, New York State Psychiatric Institute, October 2020.

Zucker, K. J. [Publishing and Peer Review]. Staff Meeting (Chair: A. I. R. van der Miesen), Center of Expertise on Gender Dysphoria, Amsterdam University Centers, Location VUmc. October 2020.

Zucker K. J. Contemporary clinical and research issues in children and adolescents with gender dysphoria. Presentation to Debalzo, Elgudin, Levine, Risen, LLC, January 2022.

Zucker, K. J. 46 Years of Treating GD in Kids. Pioneer Series. Gender: A Wider Lens Podcast (S. Ayed and S. O'Malley), January 2022.

Zucker, K. J. Developmental trajectories of children with gender dysphoria. Virtual presentation at the meeting of the Observatory of Ideological Discourses on Children and Adolescents:

Zucker, K. J. Impact on Medical Practices, Influence of Social Networks, Paris, France, February 2022.

Zucker, K. J. Gender dysphoria in children and adolescents: Some contemporary research and clinical issues. Grand Rounds, Department of Psychiatry, WMC Health, Valhalla, New York, March 2022.

Zucker, K. J. Gender identity development and gender dysphoria in children and adolescents: What we know and don't know. Invited Address, ISAR, Istanbul, Turkey, May 2022.

Zucker, K. J. Participant in Pediatric Gender Interventions: Correcting Course in Medicine and Education, Manhattan Institute for Policy Research, New York, New York, October 2022.

Zucker, K. J. Gender dysphoria in children and adolescents: Basics and research. Bhutan Symposium Gender Dysphoria, Khesar Gyalpo University of Medical Sciences of Bhutan and THE LINK. Thimphu, Bhutan, January 2023 (Virtual).

Zucker, K. J. Gender dysphoria in children and adolescents. Whitestone Academy, Columbia, Tennessee, May 2023 (Virtual).

Zucker, K. J. Children with gender dysphoria: Developmental trajectories. Genspect Conference, Killarney, Ireland, May 2023.

Zucker, K. J. Contemporary perspectives on therapeutics for children and adolescents with gender dysphoria. Adolescent Forensic Unit and Gender Identity Service. Tampere, Finland, May 2023.

Zucker, K. J. Children with gender dysphoria: Developmental trajectories. Psychotherapeutic Processes with Young People Experiencing Gender Dysphoria, Tampere University, Tampere, Finland, June 2023.

Zucker, K. J. Society for Evidence Based Gender Medicine, New York, New York, October 2023.

Zucker, K. J. The science and politics of gender dysphoria: Close encounters with "cancel culture." Free Speech in Medicine, Cape Breton, Nova Scotia, October 2023.

Invited Addresses (in Ontario, since 1988)

Zucker, K. J. Contemporary research and clinical issues in children and adolescents diagnosed with gender dysphoria. 24th Annual Practice Clinical Day, Humber River Hospital, Toronto, December 2021.

Zucker, K. J. Therapeutic care of gender dysphoria in pre-pubertal children. Conference on Understanding Gender Identity Development in Children and Youth, Department of Psychiatry, Division of Child and Adolescent Psychiatry Annual Conference, Schulich Medicine & Dentistry, London Health Sciences Centre, London, Ontario, May 2018.

Zucker, K. J. Sex ratio of transgender adolescents: A meta-analysis. Sexuality Interest Network, Department of Psychology, University of Toronto, March 2018.

Zucker, K. J. Gender identity and sexual orientation: What you need to know in 2017 and maybe even more. Jerome Diamond Centre, Toronto, September 2017.

Zucker, K. J. Gender dysphoria in children and adolescents. The Journal Club for Paediatric, Family Physicians, and Allied Health Professionals with a Special Interest in Child and Adolescent Mental Health, North York, October 2016.

Zucker, K. J. Gender dysphoria in children and adolescents: The long and winding road (1976-2014). Invited Plenary, Canadian Sex Research Forum, Kingston, October 2014.

Zucker, K. J. Gender dysphoria in children and adolescents. The Journal Club for Paediatric, Family Physicians, and Allied Health Professionals with a Special Interest in Child and Adolescent Mental Health, North York, October 2014.

Zucker, K. J. Gender dysphoria in children and adolescents: Why gender-free washrooms are not enough. Psychology Department, Peel District School Board, Mississauga, May 2014.

Zucker, K. J. DSM-5. Ontario Shores Centre for Mental Health Sciences, Whitby, March 2014.

Zucker, K. J. Gender dysphoria in children and adolescents. Invited address, School of Psychology, University of Ottawa, Ottawa, March 2014.

Zucker, K. J. DSM-5. Mental Health Rounds, North York General Hospital, February 2014.

Zucker, K. J. Another Look at DSM-5: An Insider's Account. Colloquium, Department of Psychology, Ryerson University, November 2013.

Zucker, K. J. DSM-5. Grand Rounds, Centre for Addiction and Mental Health, October 2013.

Zucker, K. J. DSM-5. York Support Network Services, Newmarket, September 2013.

Zucker, K. J. DSM-5. Education Rounds, Centre for Addiction and Mental Health, June 2013.

Zucker, K. J. Gender identity disorders. 5th Annual Clinical Day, Humber River Regional Hospital, June 2012.

Zucker, K. J. A long-term follow-up study of boys in the gender identity disorder spectrum. Grand Rounds, Division of Child Psychiatry, Hospital for Sick Children, November 2011.

Zucker, K. J. The New DSM-V and Parental Alienation. Association of Family and Conciliation Courts Ontario Second Annual Conference: The Future of Family Law, October 2010.

Zucker, K. J. Gender Identity Disorder in Children and Adolescents, Grand Rounds, Department of Pediatrics, Toronto East General Hospital, June 2010.

Zucker, K. J. Gender Identity Disorder in Children and Adolescents, Developmental Pediatrics Program, Hospital for Sick Children and Bloorview Kids Rehab, Toronto, May 2010.

Zucker, K. J. To Block or Not to Block? Use of Puberty-Blocking Sex Hormone Therapy in Adolescents with Gender Identity Disorder, Psychiatry Rounds, Hospital for Sick Children, Toronto, February 2010.

Zucker, K. J. Intersexuality and Psychosexual Differentiation: Lessons to be Learned from the Caster Semenya Case, Neuropsychiatry Rounds, Toronto Western Hospital, October 2009.

Zucker, K. J. Gender Identity Disorder in Children, Resource Network, Cabbagetown Early Learning Centre, Toronto, November 2007.

Zucker, K. J. Gender Identity Disorder and the Dawn of DSM-V (circa 2012), Colloquium, Department of Human Development and Applied Psychology, OISE/UT, November 2007.

Zucker, K. J. Gender Identity Disorder in Children and Adolescents: (Some) Lessons Learned, Grand Rounds, Division of Child Psychiatry, Hospital for Sick Children, March 2007.

Zucker, K. J. Intersexuality and Psychosexual Differentiation, 13th Annual Symposium: New Developments in Prenatal Diagnosis and Medical Genetics, Department of Obstetrics and Gynaecology, Maternal-Fetal Medicine Division, Mount Sinai Hospital, Toronto, May 2005.

Zucker, K. J. Current Issues in Gender Identity Disorder, Current Perspectives on Child and Adolescent Disorders, Fourteenth Annual Update in Child and Adolescent Psychiatry, Hospital for Sick Children, Toronto, November 2003 [Lecture and two workshops].

Zucker, K. J. Intersexuality and Psychosexual Differentiation, Clinical and Theoretical Research on Sexual Orientation and Gender Identity: A Lecture Series to Commemorate the 35th Anniversary of the CAMH Gender Identity Clinics, Centre for Addiction and Mental Health, Toronto, October 2003.

Zucker, K. J. Intersexuality and Psychosexual Differentiation, Colloquium, Department of Psychology, University of Guelph, Guelph, Ontario, November 2002.

Zucker, K. J. Pediatric Grand Rounds, Hospital for Sick Children, September 2002.

Zucker, K. J. Demographic Characteristics, Social Competence, and Behavior Problems in Children with Gender Identity Disorder: A Cross-National, Cross-Clinic Comparative Analysis. Culture, Community, & Health Studies Inter Faculty Research Seminar, Centre for Addiction and Mental Health, April 2002.

Zucker, K. J. Meditations on Psychosexual Differentiation. Professors' Lecture Series, Department of Psychiatry, University of Toronto, March 2002.

Zucker, K. J. Gender Identity. 14th Annual Humatrope Symposium and Canadian Pediatric Endocrine Group Meeting, Niagara-on-the-Lake, February 2002.

Zucker, K. J. Psychosexual Differentiation. Staff Development in Social Work, Center for Addiction and Mental Health, Toronto, November 2001.

Zucker, K. J. Gender Identity Disorder. Child/Youth Addiction and Mental Health Issues, Center for Addiction and Mental Health, Toronto, November 1999.

Zucker, K. J. Gender Identity Disorder in Children. Current Perspectives on Child and Adolescent Disorders, Tenth Annual Update in Child and Adolescent Psychiatry, Division of Child Psychiatry, University of Toronto, Hospital for Sick Children, November 1999.

Zucker, K. J. Gender Identity Disorder in Children (Workshop). Current Perspectives on Child and Adolescent Disorders, Tenth Annual Update in Child and Adolescent Psychiatry, Division of Child Psychiatry, University of Toronto, Hospital for Sick Children, November 1999.

Zucker, K. J. Is There A Biological Diathesis for Gender Identity Disorder in Boys? Psychiatry Rounds, Division of Child Psychiatry, Hospital for Sick Children, September 1999.

Zucker, K. J. Genetics and Psychosexual Differentiation, Workshop, Quality of Life and Genetics: Reflections on Ethical Implications of Genetic Research, The Third Annual Conference on Ethical Issues for the Next Millennium, Continuing Education Division, St. Michael's College, University of Toronto, May 1999.

Zucker, K. J. Gender Identity Disorder in Children, Child Health Unit, Toronto Western Hospital, Toronto, April 1999.

Zucker, K. J. Physical Intersex Conditions, Psychiatry Rounds, Hospital for Sick Children, Toronto, April 1999.

Zucker, K. J. Gender Identity Disorder in Children, Colloquium, Department of Human Development & Applied Psychology, OISE/UT, October 1998.

Zucker, K. J. Gender Identity Disorder in Children, Colloquium, Brock University, April 1998.

Zucker, K. J. "Experiments of Nature and Nurture": Psychosexual Differentiation in People with Physical Intersex Conditions, Grand Rounds, Clarke Institute of Psychiatry, November 1997.

Zucker, K. J. Sexual Ghosts, Grand Rounds, Clarke Institute of Psychiatry, May 1997.

Zucker, K. J. Discussant, Gender Identity Disorder: Early Relationships and Attachment, Canadian Psychoanalytic Society, Toronto, June 1997.

Zucker, K. J. Gender Identity Conflict in Children and Adolescents, Association of Professional Student Services Personnel, The Dufferin-Peel Roman Catholic Separate School Board, Mississauga, April 1997.

Zucker, K. J. Girls with Gender Identity Disorder, Grand Rounds, Division of Child Psychiatry, Hospital for Sick Children, October 1996.

Zucker, K. J. Psychosexual Assessment in Women with Congenital Adrenal Hyperplasia, Pediatric Endocrinology, Hospital for Sick Children, Toronto, April 1996.

Zucker, K. J. Gender Identity Disorder in Children: Research and Treatment Issues, Department of Child Psychiatry, Credit Valley Hospital, November 1995.

Zucker, K. J. Gender Identity Disorder in Children, Colloquium, Applied Developmental School and Child-Clinical Psychology, Ontario Institute for Studies in Education, October 1995.

Zucker, K. J. Grand Rounds, Recent Research on the Origins of Sexual Orientation, Department of Psychiatry, North York General Hospital, May 1995.

Zucker, K. J. Gender Identity Issues in Children and Adolescents, Annual Update in Pediatrics, Hospital for Sick Children, April 1995.

Zucker, K. J. Attachment and Gender Identity Disorders, Ontario Child and Adolescent Psychotherapists, St. Catharines, December 1994.

Zucker, K. J. Rounds, Department of Social Work, North York General Hospital, October 1994.

Zucker, K. J. Canadian Sex Research Forum, Elora, Ontario, September 1994.

Zucker, K. J. A Day in Child Psychiatry, Child Psychiatry Division, University of Toronto, April 1994.

Zucker, K. J. Ontario Association for Counselling and Attendance Services, Central Region Workshop, Pickering, Ontario, February 1994.
Zucker, K. J. Ontario Foster Treatment Association, Toronto, November 1993.
Zucker, K. J. Colloquium, Children who wish to change sex, Department of Psychology and Department of Family Studies, University of Guelph, March 1993.
Zucker, K. J. Pediatrics Rounds, Hospital for Sick Children, Toronto, March 1993.
Zucker, K. J. Child Psychiatry for the 90's: An Update for Students and Practitioners, University of Toronto, Division of Child Psychiatry, November 1992.
Zucker, K. J. C. M. Hincks Treatment Centre, June 1992.
Zucker, K. J. Discussant, Toronto Child Psychotherapy Program, Spring Scientific Case Presentation, April 1992.
Zucker, K. J. Ontario Psychiatric Association, Toronto, February 1992.
Zucker, K. J. Residents in Psychiatry Seminar, Department of Psychiatry, St. Michael's Hospital, January 1992.
Zucker, K. J. Child Study Research Colloquia, Institute of Child Study, University of Toronto, November 1991.
Zucker, K. J. Brain and Behavior Research Programme and Department of Psychiatry, McMaster University, Hamilton, Ontario, April 1991.
Zucker, K. J. Grand Rounds, Children's Hospital, London, Ontario, February 1991.
Zucker, K. J. Grand Rounds, Orillia Soldier's Memorial Hospital, June 1990.
Zucker, K. J. Psychiatry Rounds, Hospital for Sick Children, January 1989.
Zucker, K. J. Psychology Rounds, Hospital for Sick Children, January 1988.
Zucker, K. J. Paediatric Grand Rounds, Hospital for Sick Children, July 1988.
Zucker, K. J. Psychology Rounds, Hospital for Sick Children, December 1988.

Grants

Assessment of Gender-Disturbed Children: A Comparison to Sibling and Psychiatric Controls. S. J. Bradley, K. J. Zucker, R. W. Doering, $110,000, Sonor Foundation (1978-1981)

A Follow-up Study of Transsexual, Transvestitic, Homosexual, and Undifferentiated Adolescents. K. J. Zucker and S. J. Bradley, $3000, Research Fund, Clarke Institute of Psychiatry, 1984-85

Sex Roles and the Child Psychiatric Referral Process. K. J. Zucker, $2000, Research Fund, Clarke Institute of Psychiatry, 1983-84

Gender Identity Disorder of Childhood: A Prospective Follow-up in Adolescence. K. J. Zucker and S. J. Bradley, $5000, Laidlaw Foundation, 1986; $6100, Laidlaw Foundation, 1987-88

A review of the short- and long-term effects of child sexual abuse. J. H. Beitchman, K. J. Zucker, and G. A. da Costa. Health and Welfare Canada, $14000, 1988

Children in psychiatric day treatment: A comparison to normal and outpatient controls. K. J. Zucker and J. H. Beitchman. Health and Welfare Canada, $80109, 1989-1991

Reproductive and psychosexual outcome in women with congenital adrenal hyperplasia. J. Blake, K. Zucker, S. Fleming, and S. Bradley. The Physicians' Serviced Incorporated Foundation, $34000, 1990-1991 (18 months)

Maternal influences on gender identity disorder in boys: Searching for specificity. K. J. Zucker, J. N. Mitchell, C. B. Lowry, S. J. Bradley. Clarke Institute of Psychiatry Research Fund, $3400, 1990-1991; Dean's Funds, University of Toronto, $7800, 1991-1992
DSM-IV Work Group on Gender Identity Disorders and Transsexualism, K. J. Zucker et al. MacArthur Foundation, $500 (US), 1990

Quality of Attachment in Young Boys with Gender Identity Disorder, K. J. Zucker, A. Birkenfeld-Adams, S. J. Bradley, C. B. Lowry Sullivan, Clarke Institute of Psychiatry Research Fund, $5000, 1992-1993

Biodemographic studies of homosexual and heterosexual pedophilia. R. M. Blanchard, H. E. Barbaree, K. J. Zucker, R. Dickey, A. F. Bogaert, Social Sciences and Humanities Research Council of Canada, $45000, 1995-1998

Peer Relationships of Boys with Gender Identity Disorder, K. J. Zucker, Clarke Institute of Psychiatry Research Fund, $5446, 1995

Handedness in Boys with Gender Identity Disorder, K. J. Zucker, Centre for Addiction and Mental Health Psychiatry Research Fund, $2092, 1999

Psychosocial Adjustment and Gender Identity in Genetic Males Born with Ambiguous Genitalia, D. Wherrett, K. J. Zucker, S. J. Bradley, B. Neilson, Seed Grant Competition, Hospital for Sick Children Research Institute, $31280, 2001-2002

The Gender Identity Questionnaire for Adults and the Infant Orientation Scale: Psychometric Properties, K. J. Zucker, H. F. L. Meyer-Bahlburg, S. J. Kessler, J. Schober, North American Task Force on Intersexuality, $2900, 2004.

Effects of Sex Hormone Treatment on Brain Development: A Magnetic Resonance Imaging Study of Adolescents with Gender Dysphoria, K. J. Zucker, M. M. Chakravarty, J. Bain, J. Cantor, S. Chavez, N., Lobaugh, D. VanderLaan. Canadian Institutes of Health Research, $952955 (recommended), 5 years (starting July 2015)

<u>Grant Consultant</u>

Hormonal Influences on Neural/Behavioral Development (M. Hines, PI). NINCDS (HD 24542), $750,000 (U.S), 2005-2010.

This is **Exhibit "B"** referred to in the Affidavit of **Darren Leung** sworn before me this 20th day of March, 2024.

Barrister & Solicitor

KENNETH J. ZUCKER (/)

KENNETH J. ZUCKER, PH.D., C.PSYCH.

Clinical Psychologist Focus on Gender Dysphoria

I hold a Ph.D. in Psychology, am a Certified Psychologist with the College of Psychologists of Ontario (Reg. No. 1712), and am a Professor (Status Only) in the Department of Psychiatry, University of Toronto. More detailed information can be found on my c.v. here (/research).

My general theoretical perspective regarding children and adolescents is a biopsychosocial developmental model. In a broader way, my clinical work is informed by attachment theory.

I accept self-referrals or referrals from other professionals (e.g., teachers, pediatricians, family doctors, other mental health clinicians). I accept referrals from anywhere in Canada, the United States, or anywhere else. My practice is located in downtown Toronto.

LEARN MORE ABOUT SERVICES (/SERVICES)

☎ CONTACT

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(416) 986-4104

Dr. Kenneth J. Zucker, Ph.D. is a certified psychologist licensed by the College of Psychologists of Ontario with a focus on issues related to

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Clinical Psychology Services

identity. His practice is located in Toronto, ON, Canada

KENNETH J. ZUCKER, PH.D., C.PSYCH.

Clinical Services

I conduct Assessment and/or Treatment in the following areas:

1. Gender dysphoria in children, adolescents, and adults
2. Disorders of sex development (physical intersex conditions)

☎ CONTACT

3. Sexualized and paraphilic behaviors in youth
4. Attachment issues in children, adolescents, and adults
5. Effects of sexual maltreatment
6. Relationship issues in adults, including those pertaining to consensual non-monogamy, relationship infidelity, etc.

Fees: Payment for clinical services might be covered if you have private insurance. I discuss my fee schedule with potential clients on an individual basis.

Feel free to contact me by telephone or email if you have questions or would like to book an appointment.

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Dr. Kenneth J. Zucker, Ph.D. is a certified psychologist licensed by the College of

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Clinical Psychology Services

Psychologists of Ontario with a focus on issues related to gender dysphoria and gender identity. His practice is located in Toronto, ON, Canada

KENNETH J. ZUCKER (/)

PROFESSIONAL ACTIVITIES

Contributions

- Psychologist-in-Chief, Centre for Addiction and Mental Health (2001-2014)
- Director of Training, APA-CPA Clinical Psychology Internship Programme, Clarke Institute of Psychiatry (1994-2000)

☎ CONTACT

- Chair, DSM-5 Work Group on Sexual and Gender Identity Disorders, American Psychiatric Association (2007-2013)
- Committee Member, DSM-IV Subcommittee on Gender Identity Disorder of Childhood and Transsexualism (1989-1994)
- Participant in Work Group to Revise DSM-III, Gender Identity Disorder of Childhood and Transsexualism (New York State Psychiatric Institute, New York, New York, April 23, 1985)
- Consultant, Somatic Psychic Work Group, Task Force on Coding for Mental Health in Children, American Academy of Pediatrics (1992-1996)
- Member, Task Force on Gender Identity, Gender Variance, and Intersex Conditions, American Psychological Association (June 2005-2008)
- Past President, International Academy of Sex Research (2006)
- Editor, Archives of Sexual Behavior (2002-Present)
- Book Review Editor, Archives of Sexual Behavior (1988-2001)

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Dr. Kenneth J. Zucker, Ph.D. is a certified psychologist licensed by the College of Psychologists of Ontario with a focus on issues related to gender dysphoria and gender identity. His practice is located in Toronto, ON, Canada

This is **Exhibit "C"** referred to in the Affidavit of **Darren Leung** sworn before me this 20th day of March, 2024.

Barrister & Solicitor

Will-Say of Kenneth J. Zucker, Ph.D., C.Psych. (Reg. No. 1712)

Comment on "self-identification" provisions of Policy 713

1. Children who exhibit Gender Dysphoria and desire to change their name and pronouns to alleviate that condition require a professional diagnostic assessment.

2. Changing the gender of a student through a change of name and pronouns, often called "social transitioning," is a psychotherapeutic intervention available for a mental health diagnosis of Gender Dysphoria as referenced in the DSM-5 (American Psychiatric Association, 2013).

3. Teachers and other school personnel are not equipped with the necessary qualifications to diagnose and offer treatment options for mental health conditions. When a child is seeking social transitioning to address their Gender Dysphoria, that minor should be referred to a professional with the necessary qualifications and experience in making that treatment decision.

4. Social transitioning significantly impacts outcomes in children with Gender Dysphoria.

5. Social transitioning is not the appropriate option for all children experiencing Gender Dysphoria.

6. Parental involvement is necessary and beneficial for children experiencing Gender Dysphoria at every stage of treatment, absent a specific risk of harm from such parents.

7. Split gender identities for children between school and elsewhere can harm children, create tension within families and damage the relationship between families and schools.

Comment on additional issues raised by the parties

1. Should it be necessary to assist the Court, Dr. Zucker is willing and able to review and provide his expert opinion on issues raised in this matter within the scope of his expertise, including, but not limited to:

    a. Whether failing to immediately socially transition a minor with Gender Dysphoria leads to negative educational and health outcomes, including increased risk of depression, anxiety, eating disorders, self-harm, and suicide (see paragraph 25 of the Notice of Application); and

    b. At what age a child may experience Gender Dysphoria and the extent to which a school-aged gender identity is variable or fixed (see paragraph 80 of the Notice of Application).

This is **Exhibit "D"** referred to in the Affidavit of **Darren Leung** sworn before me this 20th day of March, 2024.

Barrister & Solicitor

Court File No.: FM-76-2023

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

BETWEEN:

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Applicant (Respondent on motion)

-and-

THE PROVINCE OF NEW BRUNSWICK, as represented by the MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

AFFIDAVIT OF [redacted]

COUR DU BANC DU ROI DU NOUVEAU-BRUNSWICK

DIVISION DE PREMIÈRE INSTANCE

CIRCONSCRIPTION JUDICIAIRE DE FREDERICTON

DANS L'AFFAIRE d'une requête en revision judiciare et de jugement déclaratoire en vertu de la règle 69 et la règle 38 des *Règles de procedure* du Nouveau-Brunswick

BETWEEN:

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Requérant (intimé â la requête)

-et-

LA PROVINCE DU NOUVEAU BRUNSWICK, représentée par le MINISTRE DE L'ÉDUCATION ET DU DÉVELOPPEMENT DE LA PETITE ENFANCE

Intimée (intimé â la requête)

-et-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Intervenants eventuelles (parties requérantes)

AFFIDAVIT DE [redacted]

(Hereinafter, "A.B.")

I, A.B., of the Province of New Brunswick, MAKE OATH AND SAY:

1. I am a mother of a 16-year-old adolescent enrolled in the New Brunswick public school system and as such have personal knowledge of the facts herein deposed, except where based on information and belief, in which case I verily believe the same to be true.

2. My 16-year-old (hereinafter, "C"), is a natal female who now identifies as a transgender boy and uses the male pronouns he/him.

3. In the spring of 2020, C gave me a letter she (the pronoun she used at this time) had written informing me that she was struggling with her gender identity. In the letter, she informed me that her gender identity was "non-binary."

4. This came as a shock to me because, prior to this point, C had shown no signs of confusion or ambivalence about her sex or gender identity. She loved to wear dresses and preferred clothing with glitter and sequins. She also loved to dress up in my clothing and high-heeled shoes.

5. My immediate reaction was to reassure C of my unconditional love and support. I did research to learn about ways to support children who struggle with gender identity. C wanted a short haircut and more masculine clothing. I took C to a hairdresser for the haircut and to the mall to buy new clothes. I love my children more than life and always want them to feel loved and supported. I also believe that girls and boys should be free to wear whatever clothing and hairstyles they want.

6. I was surprised by the language contained in the letter. I had never heard C use the vocabulary and phrasing that was in this letter. At this time, C was only 12 years old. For example, the letter said, "I always knew I was different" and "I need to live as my authentic self."

7. In retrospect, I suspect that much of the letter's language was drawn from online sources which had influenced my child. Before the COVID pandemic, I was restrictive with my children's computer and internet use. However, once schools were closed and gathering restrictions were imposed, I permitted them much more time on the internet as a way to mitigate loneliness.

8. In a further effort to support C, I found a psychologist with expertise related to transgender youth. C began to see this psychologist in the fall of 2020.

9. The psychologist told me that C was experiencing gender dysphoria and that I should "follow C's lead" and use any preferred pronouns and names chosen by C or else I would harm C and my relationship with my own child.

10. I had no previous experience with gender identity at that time and so complied with the psychologist's advice. The psychologist explained to me that changing a child's pronouns and name is a process called "social transition." The psychologist also reassured me that it was completely harmless and totally reversible, but that it would make C feel supported and give C space and time to safely explore issues relating to gender identity. At that time, I was convinced by the psychologist's argument.

11. I continued to support C as advised by the psychologist over the next year. During that time, C adopted several different names and continued to identify as non-binary. I adapted and used the changing names to "follow my child's lead," as I had been instructed to do by the psychologist. However, in a desire to be informed about what C was experiencing, I also began doing my own research. The first thing that caught my attention was that I read that gender dysphoria creates distress in those who struggle with it. This made me question C's situation because C was not in distress. I could plainly see that C was thriving before and during this time period.

12. To continue learning more, I started to follow Facebook groups of parents of transgender children. I found groups with different perspectives and approaches to the issue. Some fully supported an affirmative approach to a child's gender identity, and others expressed concern about gender transitions in children. I did this in order to see the opinions of both sides and come to a more fully informed understanding of the issue. I did not participate in either group, but I read copiously. I learned that, despite being told by C's psychologist that there is consensus on how to best respond to children struggling with gender identity, there is actually a fierce debate between healthcare professionals who support an "affirming" approach to children's transgender identity and those who support a very cautious approach. I learned that the issue is very politicized, which made it difficult to find good, evidence-based information. Ultimately, one of these parent groups led me to Our Duty Canada, a proposed intervenor in this matter. I became a member because of its focus on evidence-based information on issues related to gender identity in children.

13. In the spring of 2021, C told me about "coming out" at school as a boy. C told me he was now certain that he was a transgender boy. He wanted to use the pronouns he/him and a new name (hereinafter, "D"). What I understood from this revelation was that C had shared this information ("came out") with friends or classmates and asked them to use the new name "D" and male pronouns. Since there had been several name changes over the previous year, I did not think this was anything different.

14. Shortly thereafter, the mother of one of C's classmates told me that it was not only C's friends who were using this most recent preferred name and pronouns, but also the teachers and staff.

15. When this mother told me that teachers and staff were using my child's most recent preferred name and pronouns, I felt a bit skeptical. I wasn't sure this was possible since no one

from the school had contacted me to tell me about this change or ask if it was ok with me. I thought there might be some misunderstanding or exaggeration of what was going on at the school. The mother encouraged me to contact the school.

16. I was unsure how to proceed – whether to contact the school or talk to my child, or both. Before I had reached a decision, I received a phone call from the school's vice-principal (the "**VP**"). The call was unexpected and confusing. The VP said that administrative staff noticed that when I picked up C from school, I used C's legal name rather than C's preferred name. The VP asked why. I opened up to the VP and shared some of the struggles of the previous year. I said that I had been advised to use C's preferred names and pronouns, but that this use had been limited to our immediate family.

17. The VP explained during this phone call that the entire school, including teaching and administrative staff, were using C's most recent (male) preferred name and pronouns, at C's request. I asked why no one had ever contacted me about this. The VP responded that they were "following the policy."

18. I became upset and explained to the VP that C had changed names several times over the previous year, and that I believed my child was exploring. I expressed concern that by "officially" changing C's name and pronouns, the school would close the door on this exploration process and that C might feel "boxed in." I explained that I wanted to take this process slowly and, for that reason, we only used the preferred names and pronouns at home while we waited to see where things would lead and if C would eventually "stick" with a name for an extended period of time, which had not yet happened. I also expressed dismay that C's teacher, with whom I had had a very good working relationship, would fail to contact me to tell me what was going on. This teacher

knows me and knows how much I love and support my children and how involved I am in their lives and education.

19. As I became more upset during the call, the VP hung up very abruptly, saying "I have to go, we can talk again another time." The VP never contacted me again. I do not know why the VP contacted me that day, given the policy requirements he referenced when we spoke.

20. After the phone call, I googled "New Brunswick schools" and "transgender students." I immediately found Policy 713 which, at the time, prohibited school staff from informing parents about a child's preferred name without the child's consent (the "**Policy**", attached as Exhibit "A" to this affidavit). What was disturbing to me about the Policy is that it prohibited school staff from discussing a student's gender identity with parents without the student's permission. It seemed as though the Policy was premised on the assumptions that I was not a safe and loving parent, and that school staff knew better than I did, as a parent, about what was best for my children. I also felt, after reading the policy, that it was futile to continue to discuss the issue with school staff. I understood that they were authorized to keep information from me by virtue of the Policy. I no longer trusted the school staff.

21. The school's adoption of C's male identity, name and pronouns, without my prior knowledge, consent, or involvement marked a change in my relationship with my child. I had become an outlier among the adults in C's life. Other adults with important roles in C's life, namely teachers and school officials, were unquestioningly encouraging C's gender transition and determining the pace at which it would progress.

22. As a result, I have had to become quite careful in how I discuss this issue with my child. In the context of discussing the parents of C's trans-identified friends, C has told me that parents who do not use the child's chosen name are transphobic and that parents need to be "cut out" if

they are transphobic. C cannot see any other reason that parents might be hesitant or cautious about changing their child's name and pronouns.

23. Accordingly, I am very guarded about expressing my views on this topic and request to be permitted to remain anonymous in providing this affidavit. I fear that if C were to learn of my involvement in this matter, it would seriously, and possibly irreparably, damage my relationship with C.

24. I am also very fearful of these personal details of C's life being made public and want C's privacy to be protected. Details of C's psychological and medical history are bound up in my account of my experience. I desire to preserve C's privacy with respect to these matters. I would be unwilling to participate in this matter if I am not granted leave to remain anonymous.

25. C's transition process has continued with no other adults in her life expressing any desire for caution or hesitancy. My concern about C becoming "boxed into" a transgender identity continues to play out as I see that C is being celebrated by school staff and asked to take on leadership roles in gender-identity-related activities at the school, and that C is also being publicly celebrated on the school and district Facebook pages. I worry that, at such a young age, if C's identity further evolves, it will be difficult for C to openly change.

26. Notwithstanding my increasing concerns, I continued to follow the psychologist's recommendations in 2021-2022. For example, I bought binders for C and made doctor's appointments to find ways to suppress C's periods, which the psychologist told me C found "distressing." The psychologist told me in an email from September 2021 that this is what my child needed from me to feel supported and loved, and to decrease gender dysphoria. I could not bear the thought of letting my child down somehow, of failing my child.

27. In the spring of 2022, the psychologist contacted me with an update on recent sessions with C. The psychologist said that C wanted to begin taking cross-sex hormones (testosterone). In this email, the psychologist wrote that it was still too early.

28. In the fall of 2022, the psychologist wrote to me again and requested a meeting to discuss C's "continued desire to pursue gender affirming hormone treatment." We met shortly thereafter (the "**Fall 2022 Meeting**"). At this meeting, the psychologist recommended beginning hormone treatment. When I asked what criteria was being used for this recommendation, the psychologist told me the recommendation was based on C's "persistent gender dysphoria" and the fact that he had socially transitioned and had been living as a boy for over a year. The psychologist also informed me that, although the previous WPATH guidelines had recommended waiting until age 16 to begin hormone therapy, the new WPATH guidelines had eliminated minimum age requirements. The psychologist told me that waiting to begin taking hormones had been very distressing for C and recommended that C begin taking testosterone even though C was only 14 years old.

29. Hearing that social transition was a requirement for medical treatment was distressing to me. The psychologist had never shared this information with me when encouraging me to use C's preferred names and pronouns. In fact, the psychologist had explicitly told me that social transition was a harmless and risk-free measure.

30. The Fall 2022 Meeting marked a turning point for me. I began to experience intense panic because the psychologist was unable to provide evidence of the long-term safety of cross-sex hormones in adolescents in response to my requests for this evidence.

31. I could see at this point that the social transition led to other riskier, irreversible medical interventions.

32. On the basis of a letter from the psychologist, our family doctor made a referral to a pediatrician to begin gender-affirming hormone therapy, namely testosterone.

33. C had two appointments with the pediatrician in 2023. I tried to discuss my concerns with the pediatrician. I brought publications from reputable researchers and journals, such as testimony of Dr. Miriam Grossman (attached as Exhibit "B" to this affidavit), a journal article by Dr. Stephen Levine (attached as Exhibit "C" to this affidavit), and a report published in the British Medical Journal in February 2023 (attached as Exhibit "D" to this affidavit) that concluded that the evidence underlying the WPATH recommendations was weak or non-existent. The pediatrician had not read the articles but promised to do so before our second appointment. At the second appointment, the pediatrician was unable to provide a response to these research findings but relied on the fact that the "affirmative" approach embodied in the WPATH guidelines was the one approved by the Canadian Paediatric Society. After that second appointment, the pediatrician wrote the prescription for C to begin taking testosterone.

34. C began taking testosterone in the summer/fall of 2023. I signed the authorization form because C's 16th birthday was imminent, at which time C would have been able to consent to the treatment without me. The pediatrician emphasized, in the presence of C, that delaying treatment would increase my child's risk of mental illness and possibly suicide. At this time C did not suffer from mental illness or have suicide ideation. However, once the pediatrician said this to C, I feared that not signing the consent form would drive C away while only minimally delaying the inevitable.

35. The next step of gender transition that C requested was a bilateral mastectomy. When the psychologist called to inform me of C's desire, the psychologist recommended that the surgery take place as soon as possible. I asked what the criteria are for recommending a bilateral

mastectomy in someone under the age of 18. The psychologist told me that the criteria are "persistent gender dysphoria" and the youth's "intellectual capacity to provide informed consent." I asked if there are any circumstances in which the psychologist would not recommend, or would recommend delaying, a bilateral mastectomy for a minor. The psychologist responded that only if the youth had not yet socially transitioned at school and at home, or if the youth had intellectual disabilities.

36. Again, the psychologist revealed that C's social transition, which took place at school without my knowledge, was a preliminary step to hormonal and surgical interventions. When the social transition was initiated, I had absolutely no idea that hormones were given to youth, or that surgical alterations to a healthy young person's body were even practiced.

37. Only a letter from the psychologist is required for C to be approved for the operation. The psychologist relied on the social transition C underwent at school as a basis for determining that the double mastectomy was appropriate.

38. I swear this affidavit *bona fide* for no improper purpose.

SWORN by [redacted]
before me at Island View
in the Province of New Brunswick
on the 18th day of March, 2024.

[redacted]

David McMath
Barrister & Solicitor
A commissioner for taking oaths
In the province of New Brunswick

This is **Exhibit "A"** referred to in the Affidavit of [redacted] sworn before me this 18th day of March, 2024.

Barrister & Solicitor

New Nouveau Brunswick

Department of Education and Early Childhood Development

Subject: **Sexual Orientation and Gender Identity**
Effective: **August 17, 2020**
Revised:

1.0 PURPOSE

This policy sets minimum requirements for school districts and public schools to create a safe, welcoming, inclusive, and affirming school environment for all students, families, and allies who identify or are perceived as LGBTQI2S+.

2.0 APPLICATION

This policy applies to the school environment, which includes:

a) all students who are registered in public schools in New Brunswick;
b) all school personnel, contract/casual employees, visiting professionals, student teachers, parents, visitors, and volunteers;
c) school transportation: on school buses or other school system-organized transportation;
d) school sponsored and endorsed events and activities;
e) all school documents, classroom instruction, forms, report card, classroom materials, and evaluations/tests; and
f) all communications related to school (e.g. meetings, phone calls, written correspondence, emails, social media messaging, and other instances that could have an impact on the school environment).

3.0 DEFINITIONS

Ally refers to an individual who acknowledges that LGBTQI2S+ people face discrimination and advocates for social justice.

Cisgender refers to an individual whose gender identity corresponds with their sex assigned at birth.

Gender Expression refers to the way an individual express themselves and how they present and communicate their gender to society. An individual can express themselves by using a name, pronoun, or physical appearance that is different from the social normativity. An individual's gender expression is independent from their sex assigned at birth or sexual orientation.

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MINISTER

Gender Identity refers to an individual's internal sense of their gender, which may or may not align with their sex assigned at birth and is not visible to others.

Homophobia/transphobia refers to negative attitudes, feelings, discrimination, and behaviours towards individuals who identify or are perceived to be a member of the LGBTQI2S+ community.

Legal name refers to the name that appears on a birth certificate.

LGBTQI2S+ is a commonly used acronym that represents different identities within society. The acronym refers to an individual who identifies as: lesbian, gay, bisexual, transgender, queer, intersex and two-spirited. The acronym ends with a plus symbol to reflect that in society there are many more identities that could be represented.

Members of the school environment refer to all students who are registered in the public school system in New Brunswick, all school personnel, contract and casual employees, visiting professionals, student teachers, parents, visitors, and volunteers.

Non-binary gender refers to an individual whose gender identity is neither exclusively male nor female or is in between or beyond both genders.

Parents refer to parents or guardians, as defined in the *Education Act*.

Preferred first name refers to a name that has been identified by a transgender or non-binary student to be used in place of their legal first name.

Preferred pronoun refers to a pronoun that has been identified by a transgender or non-binary student that aligns with their gender identity.

Sexual orientation refers to an individual's psychological, emotional and/or sexual attraction towards another person.

Students refer to pupils, as defined in the *Education Act*.

School Personnel as defined in the *Education Act*. For the purpose of this policy, school personnel also includes volunteers.

Transgender refers to an individual who does not identify either fully or in part with the gender associated with their sex assigned at birth.

4.0 LEGAL CONSIDERATIONS AND AUTHORITY

Education Act, section 6

The Minister…

b.2) may establish provincial policies and guidelines related to public education within the scope of this Act […]

Education Act,

Subsection 13(1)(e) and 13(3), Roles of parents

Subsection 27(1), Duties of Teachers

Subsection 48(2)(b), Duties of Superintendent

Paragraphs 28(2)(c),28(2)(e) and 28(2)(h), Duties of Principals

Paragraphs 33(1.1), Duties of Parent School Support Committees

Paragraphs 36.9(5)(a) and (b), Duties of the District Education Council

5.0 GOALS / PRINCIPLES

The Department of Education and Early Childhood Development (EECD) believes:

5.1 All members of the school environment have the right to self identify and express themselves without fear of consequences and with an expectation of dignity, privacy, and confidentiality;

5.2 All members of the school environment have the right to learn and work together in an atmosphere that is respectful and free from harassment and discrimination;

5.3 It is important that all students have a sense of belonging and connection to their school environment. Students should feel that they are supported by school personnel;

5.4 School personnel will create a culture whereby LGBTQI2S+ students see themselves and their lives positively reflected in the school environment;

5.5 It is important to collaborate with community stakeholders to support the needs of all LGBTQI2S+ members of the school environment; and

5.6 Support groups such as Gender and Sexuality Alliances (GSA) are important and provide a safe space for students. Gender and Sexuality Alliance and school personnel will work together to create a safe and inclusive school environment for LGBTQI2S+ students.

6.0 REQUIREMENTS / STANDARDS

6.1 Supportive School Environment

6.1.1 The school principal will ensure that all members of the school environment are aware of the requirements set out in this policy.

6.1.2 School personnel will ensure that the school environment respects student's right to self-identify, and appropriate measures are in place to protect personal information and privacy.

6.1.3 EECD and school districts will provide professional learning opportunities to school personnel to understand and support the needs of LGBTQI2S+ students.

6.1.4 Homophobic/transphobic language, behaviour, or discrimination towards a member of the school environment will not be tolerated and will be immediately reported to the principal or designate. All allegations will be taken seriously and dealt with in a timely and effective manner as per Policy 703 – Positive Learning and Working Environment.

6.1.5 All students will be able to participate in curricular, co-curricular, and extracurricular activities that are safe, welcoming, and consistent with their gender identity.

6.1.6 EECD, school districts, and school personnel will ensure that classroom materials and activities contain positive and accurate information related to sexual orientation and gender identities.

6.1.7 EECD, school districts, and schools will strive to use inclusive and gender-neutral language when communicating with members of the school environment. This includes: classroom instruction, classroom materials, school and school district newsletters, forms, social media, emails, phone calls, and meetings.

6.2 Supportive Alliances

6.2.1 All schools will have a designated member of the school environment to act as an advocate for students who identify as LGBTQI2S+ and their families.

6.2.2 The school principals and school personnel will support the establishment of a Gender Sexuality Alliance and will support any events and activities organized by the group.

6.2.3 Gender Sexuality Alliance membership does not require parental consent and privacy and confidentiality will be respected.

6.3 Self-identification

6.3.1 School personnel will consult with a transgender or non-binary student to determine their preferred first name and pronoun(s). The preferred first name and pronoun(s) will be used consistently in ways that the student has requested.

6.3.2 Transgender or non-binary students under the age of 16 will require parental consent in order for their preferred first name to be officially used for record-keeping purposes and daily management (EECD, school district, and school software applications, report cards, class lists, etc.).

Before contacting a parent, the principal must have the informed consent from the student to discuss their preferred name with the parent. If it is not possible to obtain parental consent for the use of the preferred first name, a plan will be put in place to support the student in managing the use of the preferred name in the learning environment..

6.4. Universal Spaces

6.4.1 All students will have access to washroom facilities that align with their gender identity. The washroom facilities will be available to all students in a non-stigmatizing manner.

6.4.2 All schools will have at least one, universal washroom facility that is accessible at all times.

7.0 GUIDELINES / RECOMMENDATIONS

7.1 Where possible, schools are encouraged to provide more than one, universal washroom facility that is accessible at all time.

7.2 Superintendents will make reasonable efforts to support students who request to transfer schools due to reasons relating to their sexual orientation, gender identity, and gender expression.

7.3 Where possible, student should have access to accommodations that align with their gender identity when travelling off school property. This includes field trips, co-curricular and curricular activities, travelling for competition, or events at another school, etc.

8.0 District Education Council Policy-Making

A District Education Council may develop policies and procedures that are consistent with, or more comprehensive than, this provincial policy. Their policy must be posted on the school district website, and shared with all members of the school environment at the beginning of every school year.

9.0 References

Canadian Charter of Rights and Freedom

Human Rights Act

Education Act

Policy 703 – Positive Learning and Working Environment

New Brunswick LGBTQ Inclusive Education Resource

10.0 Contacts for More Information

Department of Education and Early Childhood Development, Policy and Planning Division, 506 453-3090

Department of Education and Early Childhood Development, Education and Support Services Branch (Anglophone Sector), 506 453-2816

ORIGINAL SIGNED BY

MINISTER

This is **Exhibit "B"** referred to in the Affidavit

of [redacted] sworn before me this

18th day of March, 2024.

Barrister & Solicitor

Miriam Grossman MD

Child, Adolescent and Adult Psychiatry

SUMMARY OF TESTIMONY

June 14, 2023 to the House Energy and Commerce

Subcommittee on Health

1. Suicide of youth with gender dysphoria is extremely rare.

2. Gender dysphoria is a psychiatric condition. There is no established evidence of a biological cause. Most cases resolve on their own, by young adulthood.

3. There is no evidence that puberty blockers, cross-sex hormones, and gender surgeries are lifesaving or medically necessary.

4. The U.S. is increasingly an outlier in the treatment of youth with gender dysphoria

5. Health authorities in the UK, Finland, Sweden and Norway now recommend exploratory psychotherapy as the first line of treatment and have severely restricted hormonal interventions, reserving them for exceptional cases.

6. Those countries have done systemic reviews and concluded that long term benefit from medical interventions has not been established, while the risk of harm is significant.

7. In US hospitals, young teens' natural puberties are prevented. Girls as young as twelve are having mastectomies. Minors are also having genital surgeries. We have no long-term evidence of benefit of these drastic interventions in the current population.

Miriam Grossman MD

Child, Adolescent and Adult Psychiatry

Chair McMorris-Rodgers and members of the House Energy and Commerce Subcommittee on Health:

Thank you very much for the opportunity to testify this morning.

My name is Miriam Grossman and my psychiatric practice is focused on youth who have distress about being male or female, and their parents.

I'm here today to provide you with facts you haven't heard. You haven't heard them because when it comes to youth gender dysphoria (also called "transgenderism"), the public and most importantly parents, are, I am sad to say, consistently fed misinformation. It's for that reason I wrote a book - *Lost in Trans Nation: A Child's Psychiatrist's Guide Out of the Madness,* so that people and especially parents be truly informed.

I'll start with the claim that Gender Affirming Care (GAC) - puberty blockers, cross-sex hormones, and surgeries - are "lifesaving", and that restricting minors' access to them will result in a wave of suicides.

Let me be clear - we are all on the same page here. Every suicide is a tragedy. But this claim is both false and dangerous.

First, it conflates *suicidality* with actual suicide. Suicidality refers to thoughts about suicide and to self-injurious behaviors. The former might be thinking for a moment, "I wish I was never born". The latter would include making superficial scratches on one's arm with a paper clip. I am not minimizing the distress involved, but these thoughts and behaviors are extremely common, especially among teenagers, and certainly among teens with mental health issues. When people are questioned about past suicidality, they almost always say they did *not* wish to die.

When you hear about the alarmingly high risk to the well-being of transgender youth, what's meant is suicidality, not actual suicide. This is a critical distinction of which few are aware.

Actual suicide is thankfully extremely rare, even among transgender-identified teens. In the US there are no data on suicide rates in this population. In the U.K., a peer-reviewed study found the rate of suicide amongst 15,000 youth referred to a clinic for gender dysphoria during a 10 year period was 0.03% - there were 4 deaths - an extremely low rate.

Please note, two of the suicides were amongst patients being treated, and the other two were amongst those on the waiting list – not being treated. If GAC is indeed as we are told "lifesaving", we would expect suicides only among patients on the waiting list.

A longitudinal study in Sweden – one of the only long-term studies on this population - found that even after full sex reassignment, transsexual people were over 19 times more likely to die by suicide than population-matched controls.

The claim that kids who identify as transgender are at higher risk for suicidality than non-transgender identified kids is technically true, but it confuses correlation and causation. There is much more evidence that kids with severe mental health problems, which are independently linked to suicidality, are gravitating toward a transgender identity, perhaps believing that gender is the source of and the solution to their problems. By placing these immature and troubled patients in the driver's seat and allowing them to direct their medical care, medical professionals fail to provide the care they need, and instead compound their problems by adding to their emotional issues a lifetime of sterility and medical complications.

Not only is the suicide narrative false, but its use in public debates is outright dangerous. The CDC has long warned that there is never a single cause to suicide and that it's irresponsible to ignore the complex, underlying triggers for this behavior.

Finland's widely acknowledged expert on youth with gender dysphoria is Riittakerttu Kaltiala. When asked about the claim that trans youth have an increased risk of suicide and therefore urgently need treatment and support, she responded, "It's purposeful disinformation, the spreading of which is irresponsible."

The U.S. is increasingly an outlier in how we treat youth with gender dysphoria. Sweden, Finland, and the U.K. all had so-called "gender-affirming care" in their pediatric clinics for about a decade, and all have since backed away from that model in favor of a more conservative approach. Health authorities in all three countries now recommend exploratory psychotherapy as the first line of treatment and reserve hormonal interventions only for exceptional cases.

To qualify for puberty blockers, an adolescent's gender issues will need to have started in early childhood. In addition, any co-occurring mental health problems the patient has will have to be reasonably well-controlled. The Europeans have stipulated these two conditions because they've recognized that a majority of minors presenting at their clinics were teenagers with no childhood history of gender issues and with many psychological problems, including autism, ADHD, and history of sexual abuse.

If American clinics were to adopt these eligibility criteria, it would automatically exclude most of the teenagers getting sex change drugs today.

Sweden, Finland, and the U.K. also require that any medical interventions be done strictly within research settings. This is because puberty blockers and cross-sex hormones have not been adequately studied. As Finland's Council for Choices in Healthcare has said, this is "an experimental practice."

Earlier this year, Norway's healthcare watchdog UKOM said that the affirmative model is not safe and contains too many risks and unknowns. It did this after receiving complaints from former patients and families who said they were rushed into medical transition. Norway is expected to join the list of countries that have severe restrictions on hormonal interventions.

In France, the National Academy of Medicine has urged "great caution" in the use of puberty blockers and cross-sex hormones to treat gender-related distress in minors. Two months ago, the director of Belgium's Center for Evidence Based Medicine said that he would throw the World Professional Association for Transgender Health's guidelines "into the bin." And just a few weeks ago, a major insurance company in Australia decided it would no longer be offering medical malpractice insurance to doctors in private practice who prescribe hormonal interventions for gender issues.

In short, other countries are turning away from the treatment model known as "gender-affirming care," recognizing that its risks are serious and that its benefits are unproven.

Here in the United States, doctors and hospitals are fully committed to the affirmative model. At the heart of that model is the belief that being transgender is innate, and that a child knows their permanent transgender identity from as early as age 2. Practitioners of the affirmative model regularly tell us that because "trans kids know who they are," it's unethical to use exploratory therapy to discern whether a child's rejection of her body in favor of some alternative "gender identity" is being caused by some underlying mental health issue or as a response to family issues, trauma, the social pressures of adolescence, or other factors.

In 2018 the American Academy of Pediatrics explicitly called exploratory therapy, the treatment recommended by European countries, "conversion therapy" and declared it unethical. Dr. Megan Mooney, who is president of the Texas Psychological Association, recently told lawmakers in Texas that she uncritically "affirms"—that is, agrees with—the transgender self-identification of any child who enters her practice, regardless of circumstance. When asked if she has ever refused to write a letter of support recommending hormonal treatments for any of her patients, Dr. Mooney couldn't or wouldn't recall a single instance.

In February, a brave whistleblower, Jamie Reed, signed a sworn affidavit documenting egregious and harmful practices at the pediatric clinic of the Washington University Transgender Center in St. Louis, Missouri. Parents were promised full psychological evaluation and support but received little or none. Instead, their children were instantly "affirmed" and put on the medical track. The psychological support their kids received was in the form of therapists agreeing with their self-diagnosis of being transgender.

Doctors and clinics that practice affirmative medicine claim that care is individualized and multidisciplinary. This is highly misleading. In practice, all of the clinicians and staff who work at these centers are committed to the affirmative approach: the child knows best who they are and what they need.

How do I know? They say so. At the Oregon Health and Science University Transgender Health Program, for example, a social worker recently explained that every single physician, mental

health professional, social worker, and staff member is affirming. This means that no one examines a particular patient's self-diagnosis. Jamie Reed described the same thing at her clinic. It didn't matter how mentally ill the patient was, if he or she claimed a transgender identity, it was at once accepted. This would not be acceptable in any other field of medicine.

When affirmative clinicians say that care is "individualized," they don't mean that the circumstances of every patient that led him or her to adopt a trans identity and seek drugs and surgeries is carefully scrutinized. What they mean, instead, is that clinicians appreciate that each patient's "embodiment goals" are different. One patient might want testosterone but no double mastectomy. Another might want a double mastectomy but no genital surgery. A third might want "non-binary" surgery, a new category of procedures that essentially removes all genitals, and a vagina-preserving phalloplasty, which leaves the patient with a vagina and a surgically crafted penile shaft.

Supporters of "gender-affirming care" regularly deny that surgeries are happening. In Texas, lawyer and physicians Cody Miller Pyke told state senators that "children under the age of eighteen in this country do not have gender reassignment surgery. There isn't a single case." Louis Apel, president of the Texas chapter of the American Academy of Pediatrics, and Jessica Zwiener, a Houston-based endocrinologist, testified in the same hearing that "surgeries are not part of the standard of care for minors." Dr. Zwiener also said that "no one is touching these kids' genitals. There is not surgery done on minors."

The facts tell another another story. First of all, the World Professional Association for Transgender Health, whose Standards of Care are cited by American doctors and hospitals as authoritative, does include surgeries—including genital surgeries—within its standard of care for minors. Indeed, shortly after publishing its latest standards of care last year, WPATH quickly eliminated all age minimums for physical interventions.

The Reuters investigation from last year found evidence of at least 56 genital surgeries on children ages 13-17 between 2019 and 2021. This number doesn't include children whose parents paid for the procedure out of pocket. A 2017 peer-reviewed article titled "Age is Just a

Number" found WPATH-affiliated surgeons reporting "a definite increase in the number of minors seeking vaginoplasty."

Meanwhile, the number of bilateral mastectomies for teenage girls has surged. Double-mastectomies—known euphemistically as "top surgery"—increased 13-fold between 2013 and 2020, and by 500% percent between 2016 and 2019 alone. The youngest document patient to receive a "gender-affirming" double mastectomy was 12 years old.

The Biden administration's Department of Health and Human Services has said double mastectomies as well as genital surgeries are "typically used in adulthood or case-by-case in adolescents."

The affirmative model of care is driven by a potent combination of radical gender ideology and profit motives. In 2018, the director of the Vanderbilt University Medical Center transgender program told an audience at her grand rounds that sex change procedures are a source of profit for hospitals. Genital surgeries in particular, she said, are "huge moneymakers."

This is not medicine. It's pharmaceutical and surgical consumerism. And it preys on society's most vulnerable population: children, and loving parents who are in crisis and trust the professionals to whom they turn for guidance.

Why have European countries backed away from "gender-affirming care"? What do health authorities in these countries know that our medical associations don't? Why is there a growing international consensus against "gender-affirming care"?

Sweden, Finland, and the U.K. have all done systematic reviews of evidence for the use of puberty blockers and cross-sex hormones in this context. All three countries came to the same conclusion. In the words of Sweden's SBU, the risks of early physical interventions "currently outweigh the possible benefits."

In evidence-based medicine, systematic reviews of evidence constitute the highest level of evidence evaluation for a particular intervention. The expert opinion of doctors constitutes the

lowest level, meaning the least reliable source of information, due to its vulnerability to confirmation bias.

In contrast to their European counterparts, American medical associations have either not done or have not based their recommendations on systematic reviews of evidence. The American Academy of Pediatrics' policy statement, for example, was written by a single doctor fresh out of residency and cherry-picks studies and blatant omissions and mischaracterizations of the available research. It is precisely this kind of biased review of the literature that systematic reviews are designed to prevent.

An investigative report published in the prestigious British Medical Journal earlier this year interviewed the world's leading experts in evidence-based medicine, including Professor Gordon Guyatt. The report found that although U.S. guidelines for treating youth gender dysphoria are "consensus-based," they are not "evidence-based."

Even this consensus, however, is a mirage. The AAP, for instance, has spent the past five years doing everything in their power to silence pediatricians who argue that guidelines should be based on systematic reviews and not the whim of one inexperienced doctor.

In sum, around the world medical authorities are slowly but surely aligning their practices with the principles of evidence-based medicine. They are taking seriously their commitment to the principle of "first, do no harm." Here in the U.S., I regret to say, professional medical associations are allowing a small group of ideologically driven activists to dictate the standard of care.

Last year, England's National Health Service decided to close its main pediatric gender clinic. In her report to the NHS, Dr. Hilary Cass, who evaluated the clinic, said that clinicians and staff "feel under pressure to adopt an unquestioning affirmative approach [that is] at odds with the standard process of clinical assessment and diagnosis…" This affirmative approach, Dr. Cass said, "originated in the USA."

I want to conclude by debunking two common myths about "gender-affirming care." The first is that puberty blockers are safe and fully reversible, and merely provide children with "time to think" about their identities and whether to continue on to cross sex hormones.

This is simply untrue.

The claim about reversibility is based on the drug's original use in treating precocious puberty – which unlike dysphoria is *a medical condition*. Kids with dysphoria have no physical abnormalities. Furthermore, studies over the past decade have consistently shown that 93 to 98 percent of children who take puberty blockers for gender dysphoria end up going further down the medical pathway, on cross sex hormones. You have to be either naïve or deeply immersed in gender ideology to believe that the reason for this extremely high rate of persistence is the clinicians' ability to avoid false positives. A far more plausible explanation is that puberty blockers themselves lock in feelings of dysphoria and interfere with the natural process of dysphoria resolution, *which is puberty itself*. We know, for instance, that between two-thirds and four-fifths of kids with gender dysphoria will desist from it by adulthood—meaning, they will come to terms with their bodies and their sex. Most, in fact, will turn out to be gay.

Even the Dutch clinicians who pioneered this work have recognized the possibility that puberty blockers cause the very thing they purport to cure. In a paper published in February, the Dutch team acknowledged the possibility that "starting [puberty blockers] in itself makes adolescents more likely to continue medical transition."

Last year, New Zealand's health ministry deleted the words "safe and fully reversible" from its website when discussing puberty blockers. In her book on what happened at the Tavistock clinic, for which she interviewed dozens of clinicians who worked there, BBC Hannah Barnes documents the disillusionment that so many of these clinicians experienced when they saw the near certainty with which kids whose puberty was blocked would continue with medical transition. As one clinician who worked there put it: "It totally exploded the idea that when we were offering puberty blockers, we were actually offering time to think."

American doctors who practice "gender-affirming care" insist that puberty blockers are safe. They can't possibly know that as there have never been randomized controlled trials to assess

what the risks are and whether they are worth any purported benefits. Proponents of puberty blockers for gender dysphoric teens claim that such trials would be unethical because puberty blockers are known to improve mental health. But that is precisely what they cannot know without randomized controlled trials.

The assertion that puberty blockers improve mental health does not stand up to critical scrutiny. It is based on a small number of highly flawed studies with serious methodological problems. For example, a 2022 study at Seattle Children's Hospital found no evidence of improvement among those who received puberty blockers. It did find mental health deterioration among those who did not receive puberty blockers, but even this wasn't a reliable finding because 80% of the non-intervention group dropped out by the end of the study. It's possible, and I'd argue likely, that many or most of these kids dropped out because they got better without puberty blockers. The researchers have thus far refused to publish their data, so it's impossible to know.

The European health institutions that did systematic reviews of evidence looked at these studies and rated the quality of their evidence as "low" or "very low."

The final myth I want to address is the claim that regret and detransition – returning to the identity consistent with one's body - are extremely rare. There is absolutely no evidence to support this assertion. The studies that are cited in support of this claim were done primarily on those who "transitioned" as adults, and the few minors who are included were transitioned under the Dutch, not the affirmative, protocol. We are dealing with an entirely different population now. Again, today's gender dysphoric youth would have been excluded from the original Dutch study, as they would not have met their strict criteria, including a stable mental health status.

More recent studies have found rates of hormone discontinuation of up to 30 percent. A 2021 study found that three-quarters of detransitioners never report their decision to their providers, often because they feel shame. Others feel that their providers don't want to hear about regret or mistakes in diagnosis. Whistleblower Jamie Reed's sworn affidavit confirms that doctors at the St. Louis clinic were uninterested in following up on patient outcomes.

The truth is that we don't know how common regret and detransition are, and likely won't know for at least a decade. That's because the affirmative model of treatment, which actively opposes

any "gatekeeping," has only been in use for about a decade, and most cases of medicalization have happened in the past few years alone.

We know that rates of trans identification and medicalization among youth are soaring. Between 1.4 and 9.2 percent of Generation Z now identifies as transgender. According to data from Reuters, 121,882 new diagnoses of gender dysphoria for children ages 6-17 were added between 2017 and 2021. That includes a 20% year-over-year increase between 2017 and 2020, and a 70% percent increase between 2020 and 2021—the year that COVID lockdowns resulted in more teenage isolation and social medica addiction. The Doernbecher Children's Hospital in Portland, Oregon, saw a 4,500 percent increase in pediatric referrals between 2013 and 2021.

In sum, the American medical establishment is clearly unwilling or unable to regulate itself in the interest of patient health. It is the duty of Congress to protect children and families, including from those who have taken an oath to "first, do no harm."

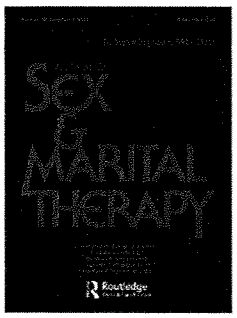
Thank you all for your service to the citizens of your districts and our nation. I look forward to your questions.

This is **Exhibit "C"** referred to in the Affidavit

of [redacted] sworn before me this

18th day of March, 2024.

Barrister & Solicitor



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REVIEW

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Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults

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ABSTRACT

In less than a decade, the western world has witnessed an unprecedented rise in the numbers of children and adolescents seeking gender transition. Despite the precedent of years of gender-affirmative care, the social, medical and surgical interventions are still based on very low-quality evidence. The many risks of these interventions, including medicalizing a temporary adolescent identity, have come into a clearer focus through an awareness of detransitioners. The risks of gender-affirmative care are ethically managed through a properly conducted informed consent process. Its elements—deliberate sharing of the hoped-for benefits, known risks and long-term outcomes, and alternative treatments—must be delivered in a manner that promotes comprehension. The process is limited by: erroneous professional assumptions; poor quality of the initial evaluations; and inaccurate and incomplete information shared with patients and their parents. We discuss data on suicide and present the limitations of the Dutch studies that have been the basis for interventions. Beliefs about gender-affirmative care need to be separated from the established facts. A proper informed consent process can both prepare parents and patients for the difficult choices that they must make and can ease professionals' ethical tensions. Even when properly accomplished, however, some clinical circumstances exist that remain quite uncertain.

KEYWORDS

Informed consent; ethics; gender dysphoria; gender identity; detransition

Introduction

Reconsideration of the meanings, purposes, indications, and processes of informed consent for transgender-identified youth is urgently needed. Parents of gender atypical children are considering social transition as early as preschool or grade school. Parents of preteens and teens are considering supporting their children's wishes to present in a new gender, take puberty blockers and cross-sex hormones, and plan for surgical alterations. College-aged youth are declaring new identities for the first time and obtaining hormones and surgery without their parents' knowledge.

When uncertain parents of children and teens consult their primary care providers, they are usually referred to specialty gender services. Parents and referring clinicians assume that specialists with "gender expertise" will undertake a thorough evaluation. However, the evaluations preceding the recommendation for gender transition are often surprisingly brief (Anderson & Edwards-Leeper, 2021) and typically lead to a recommendation for hormones and surgery, known as *gender-affirmative* treatment.

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This article has been corrected with minor changes. These changes do not impact the academic content of the article.

Despite the widely recognized deficiencies in the evidence supporting gender-affirmative interventions (National Institute for Health & Care Excellence, 2020a; 2020b), the process of obtaining informed consent from patients and their families has no established standard. There is no consensus about the requisite elements of evaluations, nor is there unanimity about how informed consent processes should be conducted (Byne et al., 2012). These two matters are inconsistent from practitioner to practitioner, clinic to clinic, and country to country.

Social transition, hormonal interventions, and surgery have profound implications for the course of the lives of young patients and their families. It is incumbent upon professionals that these consequences be thoroughly, patiently clarified over time prior to undertaking any element of transition. The informed consent process does not preclude transition; it merely educates the family about the state of the science underpinning the decision to transition. Social transition, hormones, and surgeries are unproven in a strict scientific sense, and as such, to be ethical, require a thorough and fully informed consent process.

Ethical Concerns About Inadequate Informed Consent

The concept of informed consent in medicine has roots in both ethical theory and law. The ethical foundation is centered in the principles of beneficence, justice, and respect for autonomy, while the legal issues have to do with questions of malpractice (Katz et al., 2016).

Patients consenting to treatment must meet age-based and decisional capacity requirements (Katz et al., 2016). Minors less than the age of consent participate in decision-making by providing *assent*—an agreement with the intervention. The limited maturational cognitive capacities of minors are the key reason why parents serve as the ethical and legal surrogates for medical decision-making, tasked with signing an informed consent document (Grootens-Wiegers, Hein, van den Broek, & de Vries, 2017).

The informed consent process consists of three main elements: a disclosure of information about the nature of the condition and the proposed treatment and its alternatives; an assessment of patient and caregiver understanding of the information and capacity for medical decision-making; and obtaining the signatures that signify informed consent has been obtained (Katz et al., 2016). The current expectation that clinicians and institutions are required to thoroughly inform their patients about the benefits, risks, and uncertainties of a particular treatment, as well as about alternatives, has a long legal history in the United States (Lynch, Joffe, & Feldman, 2018).

Ethical concerns about inadequate informed consent for trans-identified youth have several potentially problematic sources, including *erroneous assumptions* held by professionals; *poor quality of the evaluation process*; and *incomplete and inaccurate information* that the patients and family members are given.

These concerns are amplified by the *dramatic growth* in demand for youth gender transition witnessed in the last several years that has led to a perfunctory informed consent process. A rushed process does not allow for a proper discussion of not only the benefits, but the profound risks and uncertainties associated with gender transition, especially when gender transition is undertaken before mature adulthood.

a. *Dramatic growth in demand for services threatens true informed consent*

Gender identity variations were thought to be extremely rare a generation ago. While the incidence in youth had not been officially estimated, in adults it was 2-14 per 100,000 (American Psychiatric Association, 2013, p. 454). However, around 2006, the incidence among youth began to rise, with a dramatic increase observed in 2015 (Aitken et al., 2015, de Graaf, Giovanardi, Zitz, & Carmichael, 2018). Currently, 2-9% of U.S. high school students identify as transgender, while in colleges, 3% of males and 5% of females identify as gender-diverse (American College Health Association, 2021; Johns et al., 2019; Kidd et al., 2021).

Whereas previously most of the affected individuals identified as the opposite sex, there is now a growing trend toward identifying as *nonbinary*: neither male nor female or both male and female (Chew et al., 2020). A recent study reported that the majority of transgender-identifying youth (63%) now have a non-binary identity (Green, DeChants, Price, & Davis, 2021). Although the incidence of natal males asserting a trans identity in adolescence has significantly increased, the dramatic increase is driven primarily by the natal females requesting services (Zucker, 2017). Many suffer from significant comorbid mental health disorders, have neurocognitive difficulties such as ADHD or autism or have a history of trauma (Becerra-Culqui et al., 2018; Kozlowska, McClure, et al., 2021).

The increase in rates of transgender identification is reflected in the numbers of youth seeking help from medical professionals. For example, according to data reported by the Tavistock gender clinic in the UK, in 2009, there were 51 requests for services (de Graaf et al., 2018); in 2019-2020, 2728 referrals were recorded—a 53-fold increase in just over a decade (Tavistock & Portman NHS Foundation Trust, 2020). The growing number of urban transgender health centers that have arisen in recent years (HRC, n.d.) reflects the increased demand for gender-related medical care among young people in North America Australia, and Europe.

This unprecedented increase has created pressure on institutions and practitioners to rapidly evaluate these youth and make recommendations about treatment. To respond to growing demand, an innovative *informed consent model of care* has been developed. Under this model, mental health evaluations are not required, and hormones can be provided after just one visit following the collection of a patient's or guardian's consent signature (Schulz, 2018). The provision of transition services under this model of care is available not just to those over 18, but for younger patients as well (Planned Parenthood League of Massachusetts, n.d.).

Although following the informed consent model of care for hormones and surgeries for youth may diminish clinicians' ethical or moral unease (Vrouenraets et al., 2020), we believe this model is the antithesis of true informed consent, as it jeopardizes the ethical foundation of patient autonomy. Autonomy is not respected when patients consenting to the treatment do not have an accurate understanding of the risks, benefits, and alternatives.

b. *Assumptions held by professionals influence the integrity of the informed consent process*

Gender-dysphoric children and teens can intensely occupy the belief that their lives will be immensely improved by transition. Clinicians who have embraced the gender-affirmative model of care operate on the assumption that children and teens know best what they need to be happy and productive (Ehrensaft, 2017). These professionals, responding to the youths' passionate pleas, see their role as validating the young person's fervent wishes for hormones and surgery and clearing the path for gender transition. In doing so, they privilege the ethical principle of respect for patient autonomy (Clark & Virani, 2021) over their obligations for beneficence and non-maleficence.

Many of the gender-affirmative clinicians subscribe to the theory of *minority stress* – the supposition that the frequently co-occurring psychiatric symptoms of gender-dysphoric individuals are a result of prejudice and discrimination brought about by gender non-conformity (Rood et al., 2016; Zucker, 2019), and that gender transition will ameliorate these symptoms. Some even claim that gender-affirmative care will successfully treat not only depression and anxiety but will also resolve neurocognitive deficits frequently present in gender-dysphoric individuals (Turban, 2018; Turban, King, Carswell, & Keuroghlian, 2020; Turban & van Schalkwyk, 2018). These latter assertions have proven controversial even among the proponents of gender-affirmative interventions (Strang et al., 2018; van der Miesen, Cohen-Kettenis, & de Vries, 2018). The minority stress theory as the sole explanatory mechanism for co-occurring mental health illness has also been questioned in light of the evidence that psychiatric symptoms frequently predate the onset of gender dysphoria (Bechard, VanderLaan, Wood, Wasserman, & Zucker, 2017; Kaltiala-Heino, Sumia, Työläjärvi, & Lindberg, 2015; Kozlowska, Chudleigh, McClure, Maguire,

& Ambler, 2021). Other clinicians recognize the limits of gender-affirmative care and are aware that youth with underlying psychiatric issues are likely to continue to struggle post-transition (Kaltiala, Heino, Työläjärvi, & Suomalainen, 2020), but, unaware of alternative approaches such as gender-exploratory psychotherapy or watchful waiting (Bonfatto & Crasnow, 2018; Churcher Clarke & Spiliadis, 2019; Spiliadis, 2019), these well-meaning professionals continue to treat youth with gender-affirmative interventions despite lingering doubts.

It is common for gender-affirmative specialists to erroneously believe that gender-affirmative interventions are a *standard of care* (Malone, D'Angelo, Beck, Mason, & Evans, 2021; Malone, Hruz, Mason, Beck, et al:, 2021). Despite the increasingly widespread professional beliefs in the safety and efficacy of pediatric gender transition, and the endorsement of this treatment pathway by a number of professional medical societies, the best available evidence suggests that the benefits of gender-affirmative interventions are of very low certainty (Clayton et al., 2021; National Institute for Health & Care Excellence, 2020a; 2020b) and must be carefully weighed against the health risks to fertility, bone, and cardiovascular health (Alzahrani et al., 2019; Biggs, 2021; Getahun et al., 2018; Hembree et al., 2017; Nota et al., 2019). Recently, emphasis has also been placed on psychosocial risks and as yet unknown medical risks (Malone, D'Angelo, et al., 2021).

Five scientific observations question and refute the assumption that an individual's experience of incongruence of sex and gender identity is best addressed by supporting the newly assumed gender identity with psychosocial and medical interventions.

1. The most foundational aspect of the diagnoses of "gender dysphoria" (DSM-5) and "gender incongruence" (ICD-11), requisite for the provision of medical treatment, is in flux, as professionals disagree on whether the presence of distress is a key diagnostic criterion, as stated in the DSM-5, or is irrelevant, as is the case according to the latest ICD-11 criteria (American Psychiatric Association, 2013; World Health Organization, 2019). Further, these diagnoses have never been properly field-tested (de Vries et al., 2021).
2. There are no randomized controlled studies demonstrating the superiority of various affirmative interventions compared to alternatives. There isn't even agreement about which outcome measures would be ideal in such studies.
3. There are few long-term follow-up studies of various interventions using predetermined outcome measures at designated intervals. Studies that have been conducted are, at best, inconsistent. Higher quality studies with longer-follow-up fail to demonstrate durable positive impacts on mental health (Bränström & Pachankis, 2020a; 2020b).
4. Rates of post-transition desistance, increased mental suffering, increased incidence of physical illness, educational failure, vocational inconstancy, and social isolation have not been established.
5. Numerous cross-sectional and prospective studies of transgender adults consistently demonstrate a high prevalence of serious mental health and social problems as well as suicide (Asscheman et al., 2011; Dhejne et al., 2011). Controversies about how to deal with trans-identified youth must consider the well described vulnerabilities of transgender adults.

It is equally important to realize that to date, research about alternative approaches, such as psychotherapy or watchful waiting, shares the scientific limitations of the research of more invasive interventions: there are no control groups, nor is there systematic follow-up at predetermined intervals with predetermined means of measurement (Bonfatto & Crasnow, 2018; Churcher Clarke & Spiliadis, 2019; Spiliadis, 2019). Parents and patients need to be informed of this as well.

Perhaps the single most problematic assumption held by some gender clinicians is that the young patients have simply been "born in the wrong body." This assumption seemingly frees clinicians from having to contend with the ethical dilemmas of recommending body-altering

interventions that are based on very low-quality evidence. Despite the principle of development that biology, psychosocial factors, and culture generate behavior, these clinicians may believe that atypical genders are created by biology. This reductionistic approach has been criticized repeatedly (Kendler, 2019).

While the origins of childhood or adolescent onset of gender incongruence have not yet been fully elucidated, brain studies of increasing technical sophistication have yet to demonstrate a distinct structure or pattern that accounts for an atypical gender identity, after statistically controlling for sexual orientation and exposure to exogenous hormones (Frigerio, Ballerini, & Valdés Hernández, 2021). Twin studies also demonstrate that while biology plays a role in one's experience of "gender incongruence," it is far from deterministic (Diamond, 2013).

A growing number of clinicians and researchers are noting that the dramatic rise of teens declaring a trans identity appears to be, at least in part, a result of peer influence (Anderson, 2022; Hutchinson, Midgen, & Spiliadis, 2020; Littman 2018; Littman, 2020; Zucker, 2019). Some have noted yet another influx of trans-identified youth emerging during the COVID lockdowns, and have hypothesized that increased isolation coupled with heavy internet exposure may be responsible (Anderson, 2022). While the research into the phenomenon of social influence as a contributor to trans identification of youth is still in its infancy, the possibility that clinicians are providing treatments with permanent consequences to address what may be transient identities in youth poses a serious ethical dilemma.

c. *Poor evaluations*

There is a growing recognition that rapid evaluations which disregard factors contributing to the development of gender dysphoria in youth are problematic. In November 2021, two-leaders of the World Professional Organization for Transgender Health (WPATH) warned the medical community that the "The mental health establishment is failing trans kids" (Anderson & Edwards-Leeper, 2021). Frequently, evaluations provided by gender clinicians may only ascertain the diagnosis of *gender dysphoria* (DSM-5) or its ICD-11 counterpart *gender incongruence*, and screen for conspicuous mental illness prior to recommending hormones and surgeries. These limited, abbreviated evaluations overlook, and as a result fail to address, the relevant issue of the forces that may have influenced the young person's current gender identity.

Confirming the young person's self-diagnosis of gender dysphoria or gender incongruence is easy. Clarifying the developmental forces that have influenced it and determining an appropriate intervention are not. Contextualizing these forces involves an understanding of child and adolescent developmental processes, childhood adversity, co-existing physical and cognitive disadvantages, unfortunate parental or family circumstances (Levine, 2021), as well as the role of social influence (Anderson, 2022; Anderson & Edwards-Leeper, 2021; Littman, 2018; 2021).

The poor quality of mental health evaluations has been a point of significant discontent for a growing number of parents of gender-dysphoric youth. Increasingly, parents have formed dozens of support groups in North America, Europe, Australia and New Zealand, united in their objections to the idea that the best or the only treatment for their gender-dysphoric children is affirmation (Genspect, 2021). These distressed parents, recognizing that their son or daughter may eventually decide to present to others as a trans person, want a psychotherapeutic investigation to understand what contributed to the development of this identity and an exploration of noninvasive treatment options. Frequently, they cannot find anyone in their community who does not recommend immediate affirmation.

The American Academy of Pediatrics' Committee of Bioethics recognizes that "parents...are better situated than others to understand the unique needs of their children and to make appropriate, caring decisions regarding their children's health care" (Katz et al., 2016). The plight of the families unable to find specialists capable of conducting thorough evaluations draws attention to the widespread acceptance of medical interventions for gender-dysphoric youth as the first line of treatment. The problem is that such care has been established through precedent rather

than through scientific demonstrations of its efficacy. We contend that parents and patients have a right to know this, and that it is the professionals' responsibility and obligation to inform them of the state of knowledge in this arena of care.

d. *Incorrect information shared*

In sharing the information with patients and families, two key areas of uncertainty must be emphasized. The first one is the uncertain permanence of a child's or an adolescent's gender identity (Littman, 2021; Ristori & Steensma, 2016; Singh, Bradley, & Zucker, 2021; Vandenbussche, 2021; Zucker, 2017). The second is the uncertain long-term physical and psychological health outcomes of gender transition (National Institute for Health & Care Excellence, 2020a; 2020b). Unfortunately, gender specialists are frequently unfamiliar with, or discount the significance of, the research in support of these two concepts. As a result, the informed consent process rarely adequately discloses this information to patients and their families.

Problematically, it is common for gender clinicians to emphasize the risk of suicide if a young person's wish to transition gender is not immediately fulfilled. There is a significant amount of misinformation surrounding the question of suicidality of trans-identified youth (Biggs, 2022). Providers of gender-affirmative care should be careful not to unwittingly propagate misinformation regarding suicide to parents and youths. They should also be reminded that any conversations about suicide should be handled with great care, due to its socially contagious nature (Bridge et al., 2020; HHS, 2021).

i. High rate of desistance/natural resolution of gender dysphoria in children is not disclosed

There have been eleven research studies to date indicating a high rate of resolution of gender incongruence in children by late adolescence or young adulthood without medical interventions (Cantor, 2020; Ristori & Steensma, 2016; Singh et al., 2021). An attempt has been made to discount the applicability of this research, suggesting that the studies were based on merely gender non-conforming, rather than truly gender-dysphoric, children (Temple Newhook et al., 2018). However, a reanalysis of the data prompted by this critique confirmed the initial finding: Among children meeting the diagnostic criteria for "Gender Identity Disorder" in DSM-IV (currently "Gender Dysphoria in DSM-5), 67% were no longer gender-dysphoric as adults; the rate of natural resolution for gender dysphoria was 93% for children whose gender dysphoria was significant but subthreshold for the DSM diagnosis (Zucker, et al., 2018). It should be noted that high resolution of childhood-onset gender dysphoria had been recorded before the practice of social transition of young children was endorsed by the American Academy of Pediatrics (Rafferty et al., 2018). It is possible that social transition will predispose a young person to persistence of transgender identity long-term (Zucker, 2020).

The information regarding the resolution of gender dysphoria among those with adolescent-onset gender dysphoria, which is currently the predominant presentation, is less clear. A growing body of evidence suggests that for many teens and young adults, a post-pubertal onset of transgender identification can be a transient phase of identity exploration, rather than a permanent identity, as evidenced by a growing number of young detransitioners (Entwistle, 2020; Littman, 2021; Vandenbussche, 2021). Previously, the rate of detransition and regret was reported to be very low, although these estimates suffered from significant limitations and were likely undercounting true regret (D'Angelo, 2018). However, in the last several years since gender-affirmative care has become popularized, the rate of detransition appears to be accelerating.

According to a recent study from a UK adult gender clinic, 6.9% of those treated with gender-affirmative interventions detransitioned within only 16 months of starting treatment, and another 3.4% had a pattern of care suggestive of detransition, yielding a rate of probable detransition in excess of 10%. Another 21.7% of patients disengaged from the clinic without completing

their treatment plan (Hall, Mitchell, & Sachdeva, 2021). While some of these individuals later reengaged with the gender service, the authors concluded, "detransitioning might be more frequent than previously reported." Another study from a UK primary care practice found that 12.2% of those who had started hormonal treatments either detransitioned or documented regret, while the total of 20% stopped the treatments for a wider range of reasons. The mean age of their presentation with gender dysphoria was 20, and the patients had been taking gender-affirming hormones for the average 5 years (17 months-10 years) prior to discontinuing.

Comparing these much higher rates of treatment discontinuation and detransition to the significantly lower rates reported by the older studies, the researchers noted: "Thus, the detransition rate found in this population is novel and questions may be raised about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields" (Boyd, Hackett, & Bewley, 2022 p.15). Indeed, given that regret may take up to 8-11 years to materialize (Dhejne, Öberg, Arver, & Landén, 2014; Wiepjes et al., 2018), many more detransitioners are likely to emerge in the coming years. Detransitioner research is still in its infancy, but two recently published studies examining detransitioner experiences report that detransitioners from the recently-transitioning cohorts feel they had been rushed to medical gender-affirmative interventions with irreversible effects, often without the benefit of appropriate, or in some instances any, psychologic exploration (Littman, 2021; Vandenbussche, 2021).

Clinicians should also disclose to patients and parents that there is no test which can accurately predict who will persist in their transgender identification upon reaching mature adulthood (Ristori & Steensma, 2016). Families should be made aware that a period of strong cross-sex identification in childhood is commonly associated with future homosexuality (Korte et al., 2008). Research in desistance confirms that the majority of youth whose gender dysphoria resolves naturally do indeed grow up to be gay, lesbian, or bisexual adults (Cantor, 2020, Appendix; Singh et al., 2021).

ii. Implications of very low-quality evidence that underlies the practice of pediatric gender transition are not explained

The evidence underlying the practice of pediatric gender transition is widely recognized to be of very low quality (Hembree et al., 2017). In 2020, the most comprehensive systematic review of evidence to date, commissioned by the UK National Health System (NHS) and conducted by the National Institute for Health and Care Excellence (NICE), concluded that the evidence for both puberty blocking and cross-sex hormones is of very low certainty (National Institute for Health & Care Excellence, 2020a; 2020b).

According to the NICE review of evidence for puberty blockers, the studies "are all small, uncontrolled observational studies, which are subject to bias and confounding, and are of very low certainty as assessed using modified GRADE [Grading of Recommendations, Assessment, Development and Evaluations]. All the included studies reported physical and mental health comorbidities and concomitant treatments very poorly" (National Institute for Health & Care Excellence, 2020a, p.13). NICE reached similar conclusions regarding the quality of the evidence for cross-sex hormones (National Institute for Health & Care Excellence, 2020b).

Problematically, the implications of administering a treatment with irreversible, life-changing consequences based on evidence that has an official designation of "very low certainty" according to modified GRADE is rarely discussed with the patients and the families. GRADE is the most widely adopted tool for grading the quality of evidence and for making treatment recommendations worldwide. GRADE has four levels of evidence, also known as certainty in evidence or quality of evidence: very low, low, moderate, and high (BMJ Best Practice, 2021). When evidence is assessed to be "very low certainty," there is a high likelihood that the patients will not experience the effects of the proposed interventions (Balshem et al., 2011).

In the context of providing puberty blockers and cross-sex hormones, the designation of "very low certainty" signals that the body of evidence asserting the benefits of these interventions is

highly unreliable. In contrast, several negative effects are quite certain. For example, puberty blockade followed by cross-sex hormones leads to infertility and sterility (Laidlaw, Van Meter, Hruz, Van Mol, & Malone, 2019). Surgeries to remove breasts or sex organs are irreversible. Other health risks, including risks to bone and cardiovascular health, are not fully understood and are uncertain, but the emerging evidence is alarming (Alzahrani et al., 2019; Biggs, 2021).

iii. The question of suicide is inappropriately handled

Suicide among trans-identified youth is significantly elevated compared to the general population of youth (Biggs, 2022; de Graaf et al., 2020). However, the "transition or die" narrative, whereby parents are told that their only choice is between a "live trans daughter or a dead son" (or vice-versa), is both factually inaccurate and ethically fraught. Disseminating such alarmist messages hurts the majority of trans-identified youth who are not at risk for suicide. It also hurts the minority who are at risk, and who, as a result of such misinformation, may forgo evidence-based suicide prevention interventions in the false hopes that transition will prevent suicide.

The notion that trans-identified youth are at alarmingly high risk of suicide usually stems from biased online samples that rely on self-report (D'Angelo et al., 2020; James et al., 2016; The Trevor Project, 2021), and frequently conflates suicidal thoughts and non-suicidal self-harm with serious suicide attempts and completed suicides. Until recently, little was known about the actual rate of suicide of trans-identified youth. However, a recent analysis of data from the biggest pediatric gender clinic in the world, the UK's Tavistock, found the rate of completed youth suicides to be 0.03% over a 10-year period, which translates into the annual rate of 13 per 100,000 (Biggs, 2022). While this rate is significantly elevated compared to the general population of teens, it is far from the epidemic of trans suicides portrayed by the media.

The "transition or die" narrative regards suicidal risk in trans-identified youth as a different phenomenon than suicidal risk among other youth. Making them an exception falsely promises the parents that immediate transition will remove the risk of suicidal self-harm. Trans patients themselves complain about the so-called "trans broken arm syndrome" – a frustrating pattern whereby physicians "blame" all the problems the patients are experiencing on their trans status, and a result, fail to perceive and respond to other sources of distress (Paine, 2021). Clinicians caring for trans-identified youth should be reminded that suicide risk in all patients is a multi-factorial phenomenon (Mars et al., 2019). To treat trans youths' suicidality as an exception is to deny them evidence-based care.

A recent study of three major youth clinics concluded that suicidality of trans-identifying teens is only somewhat elevated compared to that of youth referred for mental health issues unrelated to gender identity struggles (de Graaf et al., 2020). Another study found that transgender-identifying teens have relatively similar rates of suicidality compared to teens who are gay, lesbian and bisexual (Toomey, Syvertsen, & Shramko, 2018). Depression, eating disorders, autism spectrum conditions, and other mental health conditions commonly found in transgender-identifying youth (Kaltiala-Heino, Bergman, Työläjärvi, & Frisen, 2018; Kozlowska, McClure, et al., 2021; Morandini, Kelly, de Graaf, Carmichael, & Dar-Nimrod, 2021) are all known to independently contribute to the probability of suicide (Biggs, 2022; Simon & VonKorff, 1998; Smith, Zuromski, & Dodd, 2018).

The "transition or suicide" narrative falsely implies that transition will prevent suicides. Clinicians working with trans-identified youth should be aware that although in the short-term, gender-affirmative interventions can lead to improvements in some measures of suicidality (Kaltiala et al., 2020), neither hormones nor surgeries have been shown to reduce suicidality in the long-term (Bränström & Pachankis, 2020a; 2020b). Alarmingly, a longitudinal study from Sweden that covered more than a 30-year span found that adults who underwent surgical transition were 19 times more likely than their age-matched peers to die by suicide overall, with female-to-male participants' risk 40 times the expected rate (Dhejne et al., 2011, Table S1).

Another key longitudinal study from the Netherlands concluded that suicides occur at a similar rate at all stages of transition, from pretreatment assessment to post-transition follow-up (Wiepjes et al., 2020). The data from the Tavistock clinic also did not show a statistically significant difference between completed suicides in the "waitlist" vs. the "treated" groups (Biggs, 2022). Luckily, in both groups, completed suicides were rare events (which may have been responsible for the lack of statistical significance). Thus, we consider the "transition or die" narrative to be misinformed and ethically wrong.

In our experience working with trans-identified youth, an adolescent's suicidality can sometimes arise as a response to parental distress, resistance, skepticism, or wish to investigate the forces shaping the new gender identity before social transition and hormone therapy. When mental health professionals or other healthcare providers fail to recognize the legitimacy of parental concerns, or label the parents as transphobic, this only tends to intensify intrafamilial tension. Clinicians would be well-advised that gender transition is not an appropriate response to suicidal intent or threat, as it ignores the larger mental health and social context of the young patient's life—the entire family is often in crisis. Trans-identified adolescents should be screened for self-harm and suicidality, and if suicidal behaviors are present, an appropriate evidence-based suicide prevention plan should be put in place (de Graaf et al., 2020).

The Dutch Study: the questionable basis for the gender affirmative model of care for youth

Few practitioners of gender-affirmative interventions, and even fewer patients and families, realize that the foundation of the practice of medically transitioning minors stems from a single Dutch proof of concept study, the outcomes of which were documented in two publications (de Vries, Steensma, Doreleijers, Cohen, & Kettenis, 2011; de Vries et al., 2014). The former (de Vries et al., 2011) reported on cases who underwent puberty blockade, while the latter (de Vries et al., 2014) reported on a subset of the cases who completed surgeries.

The Dutch study subjects' high level of psychological functioning at 1.5 years after surgery, which was the study end point, was an impressive feat. However, both of the studies suffer from a high risk of bias due to their study design, which is effectively a non-randomized case series—one of the lowest levels of evidence (Mathes & Pieper, 2017; National Institute for Health & Care Excellence, 2020a). In addition, the studies suffer from limited applicability to the populations of adolescents presenting today (de Vries, 2020). The interventions described in the study are currently being applied to adolescents who were not cross-gender identified prior to puberty, who have significant mental health problems, as well as those who have non-binary identities—all of these presentations were explicitly disqualified from the Dutch protocol. Despite these limitations, the Dutch clinical experiment has become the basis for the practice of medical transition of minors worldwide and serves as the basis for the recommendations outlined in the 2017 Endocrine Society guidelines (Hembree et al., 2017).

We contend that the Dutch studies have been misunderstood and misrepresented as providing evidence of the safety and efficacy of these interventions for all youth. It is important that both the strengths and the weaknesses of these two studies are understood, as to date, the Dutch experience presents the best available evidence behind the practice of pediatric gender transition.

Rationale for pediatric transition

Prior to the 1990s, gender transitions were typically initiated in mature adults (Dhejne et al., 2011). However, it was noted that particularly for natal male patients, hormonal and surgical interventions failed to achieve satisfactory results, and patients had a "never disappearing masculine appearance" (Delemarre-van de Waal & Cohen-Kettenis, 2006). The lack of adequate cosmetic outcomes was thought to contribute to the frequently disappointing outcomes of medical

gender transition, with persistently high rates of mental illness and suicidality post-transition (Delemarre-van de Waal & Cohen-Kettenis, 2006; Dhejne et al., 2011; Ross & Need, 1989).

In the mid 1990s, a team of Dutch researchers hypothesized that by carefully selecting a subset of gender-dysphoric children who would likely be transgender-identified for the rest of their lives, and by medically intervening before puberty left an irreversible mark on their bodies, the cosmetic outcomes would be improved—and as a result, mental health outcomes might be improved (Gooren & Delemarre-van de Waal, 1996).

Mixed study findings

In 2014, the Dutch research team published a key longitudinal study of mental health outcomes of 55 youths who completed medical and surgical transition (de Vries et al., 2014). The 2014 paper (sometimes referred to as the "Dutch study") reported that for youth with severe gender dysphoria that started in early childhood and persisted into mid-adolescence, a sequence of puberty blockers, cross-sex hormones, and breast and genital surgeries (including a mandatory removal of the ovaries, uterus and testes), with ongoing extensive psychological support, was associated with positive mental health and overall function 1.5 years post-surgery.

While the Dutch reported resolution of gender dysphoria post-surgery in study subjects, the reported psychological improvements were quite modest (de Vries et al., 2014). Of the 30 psychological measurements reported, nearly half showed no statistically significant improvements, while the changes in the other half were marginally clinically significant at best (Malone, D'Angelo, et al., 2021). The scores in anxiety, depression, and anger did not improve. The change in the Children's Global Assessment Scale, which measures overall function, was one of the most impressive changes—however it too remained in the same range before and after treatment (de Vries et al., 2014).

Problematic discordance between reduced gender dysphoria and lack of meaningful improvements in psychological measures

The discordance between the marked reduction in gender dysphoria, as measured by the UGDS (Utrecht Gender Dysphoria Scale), and the lack of meaningful changes in psychological function using standard measures, warrants further examination. There are three plausible explanations for this lack of agreement. Any one of these three explanations calls into question the widely assumed notion that the medical interventions significantly improve mental health or lessen or eradicate gender dysphoria.

One possible explanation is that gender dysphoria as measured by UGDS, and psychological function as measured by most standard instruments, are not correlated. This contradicts the primary rationale for providing gender-affirmative treatments for youth (which is to improve psychological health and functioning), and if true, ethically threatens these medical interventions. The other plausible explanation stems from the high psychological function of all the subjects at baseline; the subjects were selected because they were free from significant mental health problems (de Vries et al., 2014). As a result, there was little opportunity to meaningfully improve. This explanation highlights a key limitation in applying the study's results to the majority of today's gender-dysphoric youth, who often present with a high burden of mental illness (Becerra-Culqui et al., 2018; Kozlowska, McClure, et al., 2021). The study cannot be used as evidence that these procedures have been proven to improve depression, anxiety, and suicidality.

A third possible explanation for the discordance between only minor changes in psychological outcomes but a significant drop in gender dysphoria comes from a close examination of the UGDS scale itself and how it was used by the Dutch researchers. This 12-item scale, designed by the Dutch to assess the severity of gender dysphoria and to identify candidates for hormones

and surgeries, consists of "male" (UGDS-aM) and "female" (UGDS-aF) versions (Iliadis et al., 2020). At baseline and after puberty suppression, biological females were given the "female" scale, while males were given the "male" scale. However, post-surgery, the scales were flipped: biological females were assessed using the "male" scale, while biological males were assessed on the "female" scale (de Vries et al., 2014). We maintain that this handling of the scales may have at best obscured, and at worst, severely compromised the ability to meaningfully track how gender dysphoria was affected throughout the treatment.

Consider this example. At baseline, a gender-dysphoric biological female would rate items from the "female" scale such as: "I prefer to behave like a boy" (item 1); "I feel unhappy because I have to behave like a girl" (item 6) and "I wish I had been born a boy" (item 12). Positive answers to these questions would have contributed to a high baseline gender dysphoria score. After the final surgery, however, this same patient would be asked to rate items from the "male" scale, including the following: "My life would be meaningless if I had to live as a boy" (item 1); "I hate myself because I am a boy" (item 6) and "It would be better not to live than to live as a boy" (item 12). A gender-dysphoric female would not endorse these statements (at any stage of the intervention), which would lead to a lower gender dysphoria score.

Thus, the detected drop in the gender dysphoria scores for biological males and females may have had less to do with the success of the interventions, and more to do with switching the scale from the "female" to the "male" version (and vice-versa) between the baseline and post-surgical period. This, too, may explain why no changes in gender dysphoria were noted between baseline and the puberty blockade phase, and were only recorded after the final surgery, when the scale was switched.

It must be considered that had the researchers administered the "flipped" scale earlier, at the completion of the puberty blocker stage, UGDS scale could have registered a reduction in gender dysphoria. Likewise, however, one must consider the possibility that had *both sets of scales* been administered to the same individual at baseline, a "reduction" in gender dysphoria could have been registered upon switching of the scale, *well before any interventions began.* The question here is whether the diminishment of quantitative measures of gender dysphoria is largely an artifact of what scale was used.

It must be noted that the UGDS measure has been demonstrated only to effectively differentiate between clinically referred gender-dysphoric individuals, non-clinically referred controls, and participants with disorders of sexual development, and was not designed to detect changes in gender dysphoria during treatment (Steensma, McGuire, Kreukels, et al. 2013). The presence of items such as "I dislike having erections" (item 11, UGDS-aM), which would have to be rated by birth-females, and "I hate menstruating because it makes me feel like a girl (item 10, UGDS-aF), which would be presented to birth-males, neither of which could be meaningfully rated by either at any stage of the interventions, further illustrates that UGDS has questionable validity for the purpose of detecting meaningful changes in gender dysphoria as a result of medical and surgical treatment.

The updated UGDS scale (UGDS-GS), developed by the Dutch after the publication of their seminal study, has eliminated the two-sex version of the scale in favor of a single battery of questions applicable to both sexes (McGuire et al., 2020). This change may lead to a more reliable measurement of treatment-associated changes in future research. Other gender dysphoria scales also exist (Hakeem, Črnčec, Asghari-Fard, Harte, & Eapen, 2016; Iliadis et al., 2020) and may or may not be better suited for the purposes of measuring the impact of medical interventions on underlying gender distress. Gender dysphoria, of course, may also prove to be a more complex concept than can be measured by any scale.

Other limitations

The two Dutch studies were conducted without a control group (de Vries et al., 2011; de Vires et al., 2014). Nor could the researchers control for mental health interventions, which all the

subjects received in addition to hormones and surgery. The Dutch only evaluated mental health outcomes and did not assess physical health effects of hormones and surgery. The sample size was small: the final study reported the outcomes of only 55 children, and as few as 32 were evaluated on key measures of psychological outcomes.

It is important to realize that the Dutch sample was carefully selected, which introduced a source of bias, and also challenges the study's applicability. From the 196 adolescents initially referred, 111 were considered eligible to start puberty blockers, and of this group, only the 70 most mature and mentally stable who proceeded to cross-sex hormones were included in the study (de Vries et al., 2011). Of note, 97% of the selected cases were attracted to members of their natal sex at baseline. All were cross-sex identified, with no cases of nonbinary identities. The final study only followed 55, rather than the original 70 cases, further excluding from reporting the outcomes of subjects who had experienced adverse events, including: one death from surgery-related complications and three cases of obesity and diabetes that rendered subjects ineligible for surgery. Three more subjects refused to be contacted or dropped out of care, which may mask adverse outcomes (de Vries et al., 2014).

There is no knowledge of the fate of 126 patients who did not participate in the Dutch study. Longer term outcomes of the subjects who did participate are lacking. We are aware of only one case of long-term follow-up for a female-to-male patient treated by the Dutch team in the 1990s. The case study describing the subject's functioning at the age of 33 found that the patient did not regret gender transition. However, he reported struggling with significant shame related to the appearance of his genitals and to his inability to sexually function; had problems maintaining long-term relationships; and experienced depressive symptoms (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011). Notably, these problems had not yet emerged when the same patient was assessed at the age of 20, when he reported high levels of satisfaction in general, and was "very satisfied with the results [of the metoidioplasty]" in particular (Cohen-Kettenis & van Goozen, 1998, p.248). Since the last round of psychological outcomes of the individuals in the Dutch study was obtained when the subjects were around 21 years of age (de Vries et al., 2014), it raises questions how they will fare during the decade when new developmental tasks, such as career development, forming long-term intimate relationships and friendships, or starting families come into focus.

As to the unknown outcomes of the patients rejected by the Dutch protocol, one study did report on 14 adolescents who sought gender reassignment in the same clinic, but were disqualified from treatment due to "psychological or environmental problems" (Smith, Van Goozen, & Cohen-Kettenis, 2001, p. 473). The study found that at follow-up 1-7 years after the original application, 11 of the 14 no longer wished to transition, and 2 others only slightly regretted not transitioning (Malone, D'Angelo, et al., 2021; Smith et al., 2001). This further underscores the importance of conducting research utilizing control groups and following the subjects for an extended period.

A recent attempt to replicate the results of the first Dutch study (de Vries et al., 2011) found no demonstrable psychological benefit from puberty blockade, but did find that the treatment adversely affected bone development (Carmichael et al., 2021). The final Dutch study (de Vries et al., 2014) has never been attempted to be replicated with or without a control group.

The scaling of the Dutch Protocol beyond original indications

The medical and surgical sequence of Dutch protocol has been aggressively scaled worldwide without the careful evaluations and vetting practiced by the Dutch. The protocol's original investigators have recently expressed concern that the interventions they described have been widely adopted on four continents without several of the protocol's essential discriminatory features (de Vries, 2020).

The extensive multi-year multidisciplinary evaluations of the children have been abbreviated or simply bypassed. The medical sequence is routinely used for children with post-pubertal onset of transgender identities complicated by mental health comorbidities (Kaltiala-Heino et al., 2018), and not just for those high-functioning adolescents with persistent early life cross-identifications, as was required by the Dutch protocol (de Vries & Cohen-Kettenis, 2012). Further, it has become increasingly common to socially transition children before puberty (Olson, Durwood, DeMeules, & McLaughlin, 2016), even though this was explicitly discouraged by the Dutch protocol at the time (de Vries & Cohen-Kettenis, 2012).

In addition, medical transition is frequently initiated much earlier than recommended by the original protocol (de Vries & Cohen-Kettenis, 2012). The authors of the protocol were aware that most children would have a spontaneous realignment of their gender identity with sex by going through early- to mid-stages of puberty (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008). The average age of initiating puberty blockade in the Dutch study was around 15. In contrast, currently the age limit has been lowered to the age of Tanner stage II, which can occur as early as 8-9 years (Hembree et al., 2017). Irreversible cross-sex hormones, initiated in the Dutch study at the average age of nearly 17, are currently commonly prescribed to 14-year-olds, and this lower age threshold has been recommended by WPATH Standard of Care 8 draft, the final version of which is due to be released in early 2022. The fact that children are transitioned before their identity is tested against the biological reality and before natural resolution of gender dysphoria has had a chance to occur is a major deviation from the original Dutch protocol. Systematic follow-up, reassessments, and tracking and publishing of outcomes are not performed.

As the lead Dutch researchers have begun to call for more research into the novel presentation of gender dysphoria in youth (de Vries, 2020; Voorzij, 2021) and question the wisdom of applying the hormonal and surgical treatment protocols to the newly presenting cases, many recently educated gender specialists mistakenly believe that the Dutch protocol proved the concept that its sequence helps all gender-dysphoric youth. Although aware of the Dutch study's importance, they seem to be unaware of its agreed upon limitations, and the Dutch clinicians' own discomfort that most new trans-identified adolescents presenting for care today significantly differ from the population the Dutch had originally studied. These facts, of course, underscore the need for a robust informed consent process.

The recommendations for informed consent process for children, adolescents, and young adults

Consent for all stages of gender transition should be explicit, not implied

Noninvasive medical care or care that carries little risk of harm does not require a signed informed consent document; rather, consent is implied through the act of a patient presenting for care. For example, when a parent brings in a child for a skin laceration or abscess, consent for sutures or simple incision and drainage is implied. Similarly, when a child presents with pneumonia and is hospitalized, consent for chest x-ray, IV fluids, and antibiotics is also implied. It is assumed that patients or their guardians agree to the interventions and understand the benefits and risks. When risks are greater, such as prior to surgery, chemotherapy, or another invasive procedure, an informed consent document is signed. Such situations require an explicit, or express informed consent.

In the context of interventions for gender dysphoria or gender incongruence, the uncertainties associated with puberty blocking, cross-sex hormones, and gender-affirmative surgeries are well-recognized (Manrique et al., 2018; National Institute for Health & Care Excellence, 2020a; 2020b; Wilson et al., 2018). In these cases, consent should be explicit rather than implied because of the complexity, uncertainty, and risks involved.

Informed consent for social transition represents a gray area. Evidence suggests that social transition is associated with the persistence of gender dysphoria (Hembree et al.,

2017; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013). This suggests that social gender transition is a form of a psychological intervention with potential lasting effects (Zucker, 2020). While the causality has not been proven, the possibility of iatrogenesis and the resulting exposure to the risks of future medical and surgical gender dysphoria treatments, qualifies social gender transition for explicit, rather than implied, consent.

Full unbiased disclosure of benefits, risks and alternatives is requisite

When mental health professionals are involved in evaluations and recommendations, the informed consent process begins either as part of an extended evaluation or is integrated in a psychotherapeutic process, separately or together, with the parents and patient. When pediatricians, nurse practitioners, or primary care physicians perform the initial evaluation, the informed consent process is more likely to be labeled as such in a briefer series of meetings.

In all settings, the informed consent discussions for gender-affirmative care should include three central ideas:

1. The decision to initiate gender transition may predispose the child to persist in their transgender identity long-term.
2. Many of the physical changes contemplated and undertaken are irreversible.
3. Careful long-term studies have not been done to verify that these interventions enable better physical and mental health or improved social functioning, or that they do not cause harm.

The informed consent process, culminating with a signed document, signifies that parents and patient have been educated about the short- and long-term risks, benefits and uncertainties associated with all relevant stages of the gender-affirmative interventions. The process must also inform the patients and families about the full range of alternative treatments, including the choice of not socially or medically treating the child's or adolescent's current state of gender/body incongruence.

Decisional capacity to consent needs to be assessed and family should be involved

Trans-identified youth typically present themselves as strongly desiring hormones and ultimately, surgery. It should not be assumed that their eagerness is matched with the capacity to carefully consider the consequences of their realized desires. Trans-identified youth younger than the age of consent should be part of the informed consent process, but they may not be mature enough to recognize or admit their concerns about the proposed intervention. For this reason, it is the parents who, after careful consideration, are responsible for signing an informed consent document.

The issue of the exact age at which adolescents are mature enough to consent to gender transition has proven contentious: courts have been asked to decide about competence to consent to gender-affirmative hormones for youth in the United Kingdom and Australia (Ouliaris, 2021). In the United States, the legal age for medical consent for gender-affirmative interventions varies by state.

When patients are age 18 and older, and in some jurisdictions as young as age 15 (Right to medical or dental treatment without parental consent, 2010), they do not legally require parental approval for medical procedures. But because an individual's change of gender has profound implications for parents, siblings, and other family members, it is usually prudent for clinicians to seek their input directly or indirectly during the informed consent process. This is done by requesting a meeting with the parents.

A recent study by a Dutch research team attempted to evaluate the decisional capacity of adolescents embarking on gender transition (Vrouenraets, de Vries, de Vries, van der Miesen, & Hein, 2021). The researchers administered the MacCAT-T tool, comprised of the *understanding*, *appreciating*, *reasoning*, and *expressing a choice* domains, to 74 adolescents who were 14.7 years old on average (with the minimum age of 10). They concluded that the adolescents were competent to consent to starting pubertal suppression, calling for similar research for the <12 group, particularly because "birth-assigned girls ... may benefit from puberty suppression as early as 9 years of age" (Vrouenraets et al., 2021 p.7).

This study suffers from two significant limitations involving the MacCAT-T tool. It was never designed for children. Rather, it was designed to assess medical consent capacities of adults suffering from conditions such as dementia, schizophrenia, and other psychiatric disorders. There is a fundamental lack of equivalency between consenting to treatment by adults with cognitive impairments and obtaining consent from healthy children whose age-appropriate cognitive capacities are intact, but who lack the requisite life experiences to consent to profound life-changing medical interventions. We doubt, for example, whether even highly intelligent children who have not had sexual experiences can meaningfully comprehend the loss of future sexual function and reproductive abilities.

In addition, even for adults, the MacCAT-T tool has been criticized for its exclusive focus on cognitive aspects of capacity, failing to account for the non-cognitive aspects such as values, emotions and other biographic and context specific aspects inherent in the complexity of the decision process in real life (Breden & Vollmann, 2004). Children's values and emotions undergo tremendous change during the process of maturation.

The authors' conclusion about their young patients' competence to consent should be compared with what a panel of judges wrote in the challenge to the Tavistock treatment protocol (Bell v Tavistock, 2020):

> ...the clinical intervention we are concerned with here is different in kind to other treatments or clinical interventions. In other cases, medical treatment is used to remedy, or alleviate the symptoms of, a diagnosed physical or mental condition, and the effects of that treatment are direct and usually apparent. The position in relation to puberty blockers would not seem to reflect that description. [para 135]
>
> ...we consider the treatment in this case to be in entirely different territory from the type of medical treatment which is normally being considered. [para 140]
>
> ... the combination here of lifelong and life changing treatment being given to children, with very limited knowledge of the degree to which it will or will not benefit them, is one that gives significant grounds for concern. [para 143]

It seems clear that perceptions of children as young as 10 years of age as medically competent vary by country, state, and the institution where the doctor works, and, by clinicians' beliefs about the long-term benefits of these interventions. We maintain that the claim that children can consent to extremely life-altering intervention is fundamentally a philosophical claim (Clark & Virani, 2021). Our view in this matter is that consent is primarily a parental function.

Informed consent should be viewed as a process rather than an event

Most institutions that care for transgender-identified individuals have devised obligatory consent forms that outline the risks and uncertainties of hormonal and surgical gender-affirmative interventions. However, the requisite signatures are frequently collected in a perfunctory manner (Schulz, 2018), akin to signatures collected ahead of a common surgical procedure. The purpose of such informed consent documents appears to be to protect practitioners from lawsuits, rather than attend to the primary ethical foundation of the process.

Although obtaining the signatures is important, the signed document should signify that the process of informed consent has been undertaken over an extended time period and is not simply quickly completed (Vrouenraets et al., 2021). We believe the latter approach poses an ethical concern (Levine, 2019).

The internal dynamics of the trans-identified young person and their families vary considerably. Parental capacities, their private marital and intrafamilial relationships, their cultural awareness, religious and political sensibilities all influence the amount of time necessary to undertake a thorough informed consent process. It is not prudent to suggest a specific duration for the process of informed consent, other than to emphasize that it requires a slow, patient, thoughtful question and answer period as the parents and patient contemplate the meaning of what is known and unknown and whether to embark on alternative approaches to the management of gender dysphoria before the age of full neurological maturity has been reached, mental health comorbidities have been addressed, and a true informed consent by the patient is more likely.

Final thoughts

Sixty years of experience providing medical and surgical assistance to transgender-identified persons have seen many changes in who is treated, when they are treated, and how they are treated. Today, the emphasis has shifted to the treatment of the unprecedented numbers of youth declaring a trans identity. As adolescents pursue social, medical, and surgical interventions, health care providers may experience unease about patients' cognitive and emotional capacities to make decisions with life-changing and enduring consequences. An unrushed informed consent process helps the provider, the parents, and the patient.

Three issues tend to obscure the salience of informed consent: conspicuous mental health problems, uncertainty about the minor's personal capacity to understand the irreversible nature of the interventions, and parental disagreement. Physical and psychiatric comorbidities can contribute to the formation of a new identity, develop as its consequence, or bear no connection to it. Assessing mental health and the minor's functionality is one of the reasons why rapid affirmative care may be dangerous for patients and their families. For example, when situations involve autism, learning disorders, sexual abuse, attachment problems, trauma, separation anxiety, previous depressed or anxious states, neglect, low IQ, past psychotic illness, eating disorders or parental mental illness, clinicians must choose between ignoring these potentially causative conditions and comorbidities and providing appropriate treatment before affirmative care (D'Angelo et al., 2020).

For youth less than the age of majority, informed consent via parents provides a legal route for treatment but it does not make the decision to socially transition, provide hormones, or surgically remove breasts or testes less fraught with uncertainty. The best that health professionals can do is to ensure that the consent process informs the patient and parents of the current state of science, which is sorely lacking in quality research. It is the professionals' responsibility to ensure that the benefits patients and parents seek, and the risks they are assuming, are clearly appreciated as they prepare to make this often-excruciating decision.

Young people who have reached the age of majority, but who have not reached full maturation of the brain represent a unique challenge. It is well-recognized that brain remodeling proceeds through the third decade of life, with the prefrontal cortex responsible for executive function and impulse control the last to mature (Katz et al., 2016). The growing number of detransitioners who had been old enough to legally consent to transition, but who no longer felt they were transgender upon reaching their mid-20's, raises additional concerns about this vulnerable age group (Littman, 2021; Vandenbussche, 2021).

When the clinician is uncertain whether a young person is competent to comprehend the implications of the desired treatment—that is, when informed consent cannot inform the patient—the clinician may need more time with the patient. When parents or guardians do

not agree about whether to use puberty blockers or cross-sex hormones, clinicians are in an uneasy spot (Levine, 2021). This occurs in both intact and divorced families. Australia has given legal instructions to clinicians facing these uncertainties: the court is to be asked to decide (Ouliaris, 2021). The court system in the UK has been grappling with similar issues in recent years. While it is a rare case that ends up in a courtroom, clinicians devoted to a deliberate informed consent process are still likely to encounter ethical dilemmas that they cannot resolve.

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This is **Exhibit "D"** referred to in the Affidavit

of [redacted] sworn before me this

18th day of March, 2024.

Barrister & Solicitor

FEATURE

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BMJ INVESTIGATION

Gender dysphoria in young people is rising—and so is professional disagreement

More children and adolescents are identifying as transgender and are being offered medical treatment, especially in the US—but some providers and European authorities are urging caution because of a lack of strong evidence. Jennifer Block reports

Jennifer Block *investigations reporter*

Last October the American Academy of Pediatrics (AAP) gathered inside the Anaheim Convention Center in California for its annual conference. Outside, several dozen people rallied to hear speakers including Abigail Martinez, a mother whose child began hormone treatment at age 16 and died by suicide at age 19. Supporters chanted the teen's given name, Yaeli; counter protesters chanted, "Protect trans youth!" For viewers on a livestream, the feed was interrupted as the two groups fought for the camera.

The AAP conference is one of many flashpoints in the contentious debate in the United States over if, when, and how children and adolescents with gender dysphoria should be medically or surgically treated. US medical professional groups are aligned in support of "gender affirming care" for gender dysphoria, which may include gonadotrophin releasing hormone analogues (GnRHa) to suppress puberty; oestrogen or testosterone to promote secondary sex characteristics; and surgical removal or augmentation of breasts, genitals, or other physical features. At the same time, however, several European countries have issued guidance to limit medical intervention in minors, prioritising psychological care.

The discourse is polarised in the US. Conservative politicians, pundits, and social media influencers accuse providers of pushing "gender ideology" and even "child abuse," lobbying for laws banning medical transition for minors. Progressives argue that denying access to care is a transphobic violation of human rights. There's little dispute within the medical community that children in distress need care, but concerns about the rapid widespread adoption of interventions and calls for rigorous scientific review are coming from across the ideological spectrum.[1]

The surge in treatment of minors

More adolescents with no history of gender dysphoria—predominantly birth registered females[2]—are presenting at gender clinics. A recent analysis of insurance claims by Komodo Health found that nearly 18 000 US minors began taking puberty blockers or hormones from 2017 to 2021, the number rising each year.[3 4] Surveys aiming to measure prevalence have found that about 2% of high school aged teens identify as "transgender."[5] These young people are also more likely than their cisgender peers to have concurrent mental health and neurodiverse conditions including depression, anxiety, attention deficit disorders, and autism.[6] In the US, although Medicaid coverage varies by state and by treatment, the Biden administration has warned states that not covering care is in violation of federal law prohibiting discrimination.[7] Meanwhile, the number of private clinics that focus on providing hormones and surgeries has grown from just a few a decade ago to more than 100 today.[4]

As the number of young people receiving medical transition treatments rises, so have the voices of those who call themselves "detransitioners" or "retransitioners," some of whom claim that early treatment caused preventable harm.[8] Large scale, long term research is lacking,[9] and researchers disagree about how to measure the phenomenon, but two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years.[10 11] The World Professional Association for Transgender Health (WPATH) asserts that detransition is "rare."[12]

Chloe Cole, now aged 18, had a double mastectomy at age 15 and spoke at the AAP rally. "Many of us were young teenagers when we decided, on the direction of medical experts, to pursue irreversible hormone treatments and surgeries," she read from her tablet at the rally, which had by this time moved indoors to avoid confrontation. "This is not informed consent but a decision forced under extreme duress."

Scott Hadland, chief of adolescent medicine at Massachusetts General Hospital and Harvard Medical School, dismissed the "handful of cruel protesters" outside the AAP meeting in a tweet that morning. He wrote, "Inside 10 000 pediatricians stand in solidarity for trans & gender diverse kids & their families to receive evidence-based, lifesaving, individualized care."[13]

Same evidence, divergent recommendations

Three organisations have had a major role in shaping the US's approach to gender dysphoria care: WPATH, the AAP, and the Endocrine Society (see box). On 15 September 2022 WPATH published the eighth edition of its Standards of Care for the Health of Transgender and Gender Diverse People, with new chapters on children and adolescents and no minimum age requirements for hormonal and surgical treatments.[2 12] GnRHa treatment, says WPATH, can

be initiated to arrest puberty at its earliest stage, known as Tanner stage 2.

The Endocrine Society also supports hormonal and surgical intervention in adolescents who meet criteria in clinical practice guidelines published in 2009 and updated in 2017.[14] And the AAP's 2018 policy statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, says that "various interventions may be considered to better align" a young person's "gender expression with their underlying identity."[15] Among the components of "gender affirmation" the AAP names social transition, puberty blockers, sex hormones, and surgeries. Other prominent professional organisations, such as the American Medical Association, have issued policy statements in opposition to legislation that would curtail access to medical treatment for minors.[16-19]

These documents are often cited to suggest that medical treatment is both uncontroversial and backed by rigorous science. "All of those medical societies find such care to be evidence-based and medically necessary," stated a recent article on transgender healthcare for children published in *Scientific American*.[20] "Transition related healthcare is not controversial in the medical field," wrote Gillian Branstetter, a frequent spokesperson on transgender issues currently with the American Civil Liberties Union, in a 2019 guide for reporters.[21] Two physicians and an attorney from Yale recently opined in the *Los Angeles Times* that "gender-affirming care is standard medical care, supported by major medical organizations . . . Years of study and scientific scrutiny have established safe, evidence-based guidelines for delivery of lifesaving, gender-affirming care."[22] Rachel Levine, the US assistant secretary for health, told National Public Radio last year regarding such treatment, "There is no argument among medical professionals."[23]

Internationally, however, governing bodies have come to different conclusions regarding the safety and efficacy of medically treating gender dysphoria. Sweden's National Board of Health and Welfare, which sets guidelines for care, determined last year that the risks of puberty blockers and treatment with hormones "currently outweigh the possible benefits" for minors.[24] Finland's Council for Choices in Health Care, a monitoring agency for the country's public health services, issued similar guidelines, calling for psychosocial support as the first line treatment.[25] (Both countries restrict surgery to adults.)

Medical societies in France, Australia, and New Zealand have also leant away from early medicalisation.[26,27] And NHS England, which is in the midst of an independent review of gender identity services, recently said that there was "scarce and inconclusive evidence to support clinical decision making"[28] for minors with gender dysphoria[29] and that for most who present before puberty it will be a "transient phase," requiring clinicians to focus on psychological support and to be "mindful" even of the risks of social transition.[30]

Box: The origins of paediatric gender medicine in the United States

The World Professional Association for Transgender Health (WPATH) began as a US based advocacy group and issued the first edition of the Standards of Care in 1979, when it was serving a small population of mostly adult male-to-female transsexuals. "WPATH became the standard because there was nobody else doing it," says Erica Anderson, a California based clinical psychologist and former WPATH board member. The professional US organisations that lined up in support "looked heavily to WPATH and the Endocrine Society for their guidance," she told *The BMJ*.

The Endocrine Society's guidance for adolescents grew out of clinicians' research in the Netherlands in the late 1990s and early 2000s. Peggy Cohen-Kettenis, a Utrecht gender clinic psychologist, collaborated with endocrinologists in Amsterdam, one of whom had experience of prescribing gonadotrophin releasing hormone analogues, relatively new at the time. Back then, gender dysphoric teens had to wait until the age of majority for sex hormones, but the team proposed that earlier intervention could benefit carefully selected minors.[40]

The clinic treated one natal female patient with triptorelin, published a case study and feasibility proposal, and began treating a small number of children at the turn of the millennium. The Dutch Protocol was published in 2006, referring to 54 children whose puberty was being suppressed and reporting preliminary results on the first 21.[41] The researchers received funding from Ferring Pharmaceuticals, the manufacturer of triptorelin.

In 2007 the endocrinologist Norman Spack began using the protocol at Boston Children's Hospital and joined Cohen-Kettenis and her Dutch colleagues in writing the Endocrine Society's first clinical practice guideline.[42] When that was published in 2009, puberty had been suppressed in just over 100 gender dysphoric young people.[40]

American Academy of Pediatrics (AAP) committee members began discussing the need for a statement in 2014, four years before publication, says Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and the statement's lead author. "The AAP recognised that it had a responsibility to provide some clinical guidance, but more importantly to come out with a statement that said we need research, we need to integrate the principles of gender affirmative care into medical education and into child health," he says. "What our policy statement is not meant to be is a protocol or guidelines in and of themselves."

"Don't call them evidence based"

"The brief history of guidelines is that, going back more than 30 years ago, experts would write articles and so on about what people should do. But formal guidelines as we think of them now were seldom or non-existent," says Gordon Guyatt, distinguished professor in the Department of Health Research Methods, Evidence, and Impact at McMaster University, Ontario.

That led to the movement towards developing criteria for what makes a "trustworthy guideline," of which Guyatt was a part.[31] One pillar of this, he told *The BMJ*, is that they "are based on systematic review of the relevant evidence," for which there are also now standards, as opposed to a traditional narrative literature review in which "a bunch of experts write whatever they felt like using no particular standards and no particular structure."

Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University, says, "An evidence based recommendation requires two steps." First, "an unbiased, thorough, critical systematic review of all the relevant evidence." Second, "some commitment to link the strength of the recommendations to the quality of the evidence."

The Endocrine Society commissioned two systematic reviews for its clinical practice guideline, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*: one on the effects of sex steroids on lipids and cardiovascular outcomes, the other on their effects on bone health.[32,33] To indicate the quality of evidence underpinning its various guidelines, the Endocrine Society employed the GRADE system (grading of recommendations assessment, development, and evaluation) and judged the quality of evidence for all recommendations on adolescents as "low" or "very low."

Guyatt, who co-developed GRADE, found "serious problems" with the Endocrine Society guidelines, noting that the systematic reviews

didn't look at the effect of the interventions on gender dysphoria itself, arguably "the most important outcome." He also noted that the Endocrine Society had at times paired strong recommendations—phrased as "we recommend"—with weak evidence. In the adolescent section, the weaker phrasing "we suggest" is used for pubertal hormone suppression when children "first exhibit physical changes of puberty"; however, the stronger phrasing is used to "recommend" GnRHa treatment.

"GRADE discourages strong recommendations with low or very low quality evidence except under very specific circumstances," Guyatt told *The BMJ*. Those exceptions are "very few and far between," and when used in guidance, their rationale should be made explicit, Guyatt said. In an emailed response, the Endocrine Society referenced the GRADE system's five exceptions, but did not specify which it was applying.

Helfand examined the recently updated WPATH Standards of Care and noted that it "incorporated elements of an evidence based guideline." For one, WPATH commissioned a team at Johns Hopkins University in Maryland to conduct systematic reviews.[34 35] However, WPATH's recommendations lack a grading system to indicate the quality of the evidence—one of several deficiencies. Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and what the results were. But Helfand remarked that neither was made clear in the WPATH guidelines and also noted several instances in which the strength of evidence presented to justify a recommendation was "at odds with what their own systematic reviewers found."

For example, one of the commissioned systematic reviews found that the strength of evidence for the conclusions that hormonal treatment "may improve" quality of life, depression, and anxiety among transgender people was "low," and it emphasised the need for more research, "especially among adolescents."[35] The reviewers also concluded that "it was impossible to draw conclusions about the effects of hormone therapy" on death by suicide.

Despite this, WPATH recommends that young people have access to treatments after comprehensive assessment, stating that the "emerging evidence base indicates a general improvement in the lives of transgender adolescents."[12] And more globally, WPATH asserts, "There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures," procedures that "are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria."[12]

Those two statements are each followed by more than 20 references, among them the commissioned systematic review. This stood out to Helfand as obscuring which conclusions were based on evidence versus opinion. He says, "It's a very strange thing to feel that they had to cite some of the studies that would have been in the systematic review or purposefully weren't included in the review, because that's what the review is for."

For minors, WPATH contends that the evidence is so limited that "a systematic review regarding outcomes of treatment in adolescents is not possible." But Guyatt counters that "systematic reviews are always possible," even if few or no studies meet the eligibility criteria. If an entity has made a recommendation without one, he says, "they'd be violating standards of trustworthy guidelines." Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and lead author of the AAP statement, remarks that the AAP's process "doesn't quite fit the definition of systematic review, but it is very comprehensive."

Sweden conducted systematic reviews in 2015 and 2022 and found the evidence on hormonal treatment in adolescents "insufficient and inconclusive."[24] Its new guidelines note the importance of factoring the possibility that young people will detransition, in which case "gender confirming treatment thus may lead to a deteriorating of health and quality of life (i.e., harm)."

Cochrane, an international organisation that has built its reputation on delivering independent evidence reviews, has yet to publish a systematic review of gender treatments in minors. But *The BMJ* has learnt that in 2020 Cochrane accepted a proposal to review puberty blockers and that it worked with a team of researchers through 2021 in developing a protocol, but it ultimately rejected it after peer review. A spokesperson for Cochrane told *The BMJ* that its editors have to consider whether a review "would add value to the existing evidence base," highlighting the work of the UK's National Institute for Health and Care Excellence, which looked at puberty blockers and hormones for adolescents in 2021. "That review found the evidence to be inconclusive, and there have been no significant primary studies published since."

In 2022 the state of Florida's Agency for Health Care Administration commissioned an overview of systematic reviews looking at outcomes "important to patients" with gender dysphoria, including mental health, quality of life, and complications. Two health research methodologists at McMaster University carried out the work, analysing 61 systematic reviews and concluding that "there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people." The body of evidence, they said, was "not sufficient" to support treatment decisions.

Calling a treatment recommendation "evidence based" should mean that a treatment has not just been systematically studied, says Helfand, but that there was also a finding of high quality evidence supporting its use. Weak evidence "doesn't just mean something esoteric about study design, it means there's uncertainty about whether the long term benefits outweigh the harms," Helfand adds.

"Evidence itself never tells you what to do," says Guyatt. That's why guidelines must make explicit the values and preferences that underlie the recommendation.

The Endocrine Society acknowledges in its recommendations on early puberty suppression that it is placing "a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm."[14]

WPATH acknowledges that while its latest guidelines are "based upon a more rigorous and methodological evidence-based approach than previous versions," the evidence "is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion." In the absence of high quality evidence and the presence of a patient population in need—who are willing to take on more personal risk—consensus based guidelines are not unwarranted, says Helfand. "But don't call them evidence based."

An evidence base under construction

In 2015 the US National Institutes of Health awarded a $5.7m (£4.7m; €5.3m) grant to study "the impact of early medical treatment in transgender youth."[36] The abstract submitted by applicants said that the study was "the first in the US to evaluate longitudinal

outcomes of medical treatment for transgender youth and will provide essential evidence-based data on the physiological and psychosocial effects and safety" of current treatments. Researchers are following two groups, one of participants who began receiving GnRHa in early puberty and another group who began cross sex hormone treatment in adolescence. The study doesn't include a concurrent no-treatment control group.

Robert Garofalo, chief of adolescent medicine at the Lurie Children's Hospital in Chicago and one of four principal investigators, told a podcast interviewer in May 2022 that the evidence base remained "a challenge . . . it is a discipline where the evidence base is now being assembled" and that "it's truly lagging behind [clinical practice], I think, in some ways." That care, he explained, was "being done safely. But only now, I think, are we really beginning to do the type of research where we're looking at short, medium, and long term outcomes of the care that we are providing in a way that I think hopefully will be either reassuring to institutions and families and patients or also will shed a light on things that we can be doing better."[37]

While Garofalo was doing the research he served as "contributor" on the AAP's widely cited 2018 policy statement, which recommends that children and adolescents "have access to comprehensive, gender-affirming, and developmentally appropriate health care," including puberty blockers, sex hormones, and, on a case-by-case basis, surgeries.[15]

Garofalo said in the May interview, "There is universal support for gender affirming care from every mainstream US based medical society that I can think of: the AMA, the APA, the AAP. I mean, these organisations never agree with one another." Garofalo declined an interview and did not respond to *The BMJ*'s requests for comment.

The rush to affirm

Sarah Palmer, a paediatrician in private practice in Indiana, is one of five coauthors of a 2022 resolution submitted to the AAP's leadership conference asking that it revisit the policy after "a rigorous systematic review of available evidence regarding the safety, efficacy, and risks of childhood social transition, puberty blockers, cross sex hormones and surgery." In practice, Palmer told *The BMJ*, clinicians define "gender affirming" care so broadly that "it's been taken by many people to mean go ahead and do anything that affirms. One of the main things I've seen it used for is masculinising chest surgery, also known as mastectomy in teenage patients." The AAP has told *The BMJ* that all policy statements are reviewed after five years and so a "revision is under way," based on its experts' own "robust evidence review."

Palmer says, "I've seen a quick evolution, from kids with a very rare case of gender dysphoria who were treated with a long course of counselling and exploration before hormones were started," to treatment progressing "very quickly—even at the first visit to gender clinic—and there's no psychologist involved anymore."

Laura Edwards-Leeper, a clinical psychologist who worked with the endocrinologist Norman Spack in Boston and coauthored the WPATH guidelines for adolescents, has observed a similar trend. "More providers do not value the mental health component," she says, so in some clinics families come in and their child is "pretty much fast tracked to medical intervention." In a study of teens at Seattle Children's Hospital's gender clinic, two thirds were taking hormones within 12 months of the initial visit.[38]

The British paediatrician Hilary Cass, in her interim report of a UK review into services for young people with gender identity issues, noted that some NHS staff reported feeling "under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters."

Eli Coleman, lead author of WPATH's Standards of Care and former director of the Institute for Sexual and Gender Health at the University of Minnesota, told *The BMJ* that the new guidelines emphasised "careful assessment prior to any of these interventions" by clinicians who have appropriate training and competence to assure that minors have "the emotional and cognitive maturity to understand the risks and benefits." He adds, "What we know and what we don't know has to be explained to youth and their parents or caregivers in a balanced way which really details that this is the evidence that we have, that we obviously would like to have more evidence, and that this is a risk-benefit scenario that you have to consider."

Joshua Safer, director of the Center for Transgender Medicine and Surgery at Mount Sinai Hospital in New York and coauthor of the Endocrine Society guidelines, told *The BMJ* that assessment is standard practice at the programme he leads. "We start with a mental health evaluation for anybody under the age of 18," he says. "There's a lot of talking going on—that's a substantial element of things." Safer has heard stories of adolescents leaving a first or second appointment with a prescription in hand but says that these are overblown. "We really do screen these kids pretty well, and the overwhelming majority of kids who get into these programmes do go on to other interventions," he says.

Without an objective diagnostic test, however, others remain concerned. The demand for services has led to a "perfunctory informed consent process," wrote two clinicians and a researcher in a recent issue of the *Journal of Sex and Marital Therapy*,[39] in spite of two key uncertainties: the long term impacts of treatment and whether a young person will persist in their gender identity. And the widespread impression of medical consensus doesn't help. "Unfortunately, gender specialists are frequently unfamiliar with, or discount the significance of, the research in support of these two concepts," they wrote. "As a result, the informed consent process rarely adequately discloses this information to patients and their families."

For Guyatt, claims of certainty represent both the success and failure of the evidence based medicine movement. "Everybody now has to claim to be evidence based" in order to be taken seriously, he says—that's the success. But people "don't particularly adhere to the standard of what is evidence based medicine—that's the failure." When there's been a rigorous systematic review of the evidence and the bottom line is that "we don't know,'" he says, then "anybody who then claims they do know is not being evidence based."

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This is **Exhibit "E"** referred to in the Affidavit of **Darren Leung** sworn before me this 20th day of March, 2024.

Barrister & Solicitor

Court File No.: FM-76-2023

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Applicant (Respondent on motion)

-and-

THE PROVINCE OF NEW BRUNSWICK, as represented by the MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

AFFIDAVIT OF [redacted]

COUR DU BANC DU ROI DU NOUVEAU-BRUNSWICK

DIVISION DE PREMIÈRE INSTANCE

CIRCONSCRIPTION JUDICIAIRE DE FREDERICTON

DANS L'AFFAIRE d'une requête en revision judiciare et de jugement déclaratoire en vertu de la règle 69 et la règle 38 des *Règles de procedure* du Nouveau-Brunswick

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Requérant (intimé â la requête)

-et-

LA PROVINCE DU NOUVEAU BRUNSWICK, représentée par le MINISTRE DE L'ÉDUCATION ET DU DÉVELOPPEMENT DE LA PETITE ENFANCE

Intimée (intimé â la requête)

-et-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Intervenants eventuelles (parties requérantes)

AFFIDAVIT OF [redacted]

AFFIDAVIT OF [redacted]
(Hereinafter, "A.A.")

I, [redacted], of the [redacted] in the Province of Alberta **MAKE OATH AND SAY AS FOLLOWS:**

Introduction

1. I am a [redacted] year old biological woman and use "she/her" pronouns. I have personal knowledge of the facts hereinafter deposed except where stated to be based on information, in which case, I believe the same to be true.

2. I am a biological female. I socially transitioned[1] between 20[redacted] and 20[redacted], asserting during that time when I was between the ages of [redacted] and [redacted], that I was a male. I started to socially de-transition in February, 2018 and for approximately the last 5 and one-half years, I have identified and still identify as a female to match my biological status as a female. Since that time, I no longer identify as a transman.

3. I am also in a unique position to provide evidence in this Court proceeding as I have personal and direct experience with: (a) being a neurodivergent/disabled person having been diagnosed with Autism as young child; (b) living with anorexia nervosa (an eating disorder), and body dysmorphia, both of which conditions began when I was about 7 years old and were overcome when I was about 11 years old; (c) socially transitioning my gender at school, including using male pronouns; (d) coming out to my family in circumstances where my parents were not being told by me or the school about what was going on in terms of my social transition process; (e) teachers trying to take or keep me away from my family, including one of them suggesting they would adopt me; and (f) as a person of faith, school personnel trying to get me to turn my back on my faith and beliefs during my social transition process.

4. Living with Autism has had a major impact on my life growing up, and still does, now that I am an adult. I receive from the Alberta Government what is called "Assured Income for the Severely Handicapped", commonly known as "**AISH**". AISH recognizes my disability

[1] By that term or its derivatives, throughout this Affidavit, I mean that I used male pronouns, used a masculine name, and sometimes used washroom facilities for gender neutral individuals.

is permanent, has no cure, and affects my ability to be financially independent and support myself. I am financially dependent on funding from AISH and therefore I must not do anything that would jeopardize that.

5. As an adolescent, I was deluded about who I am and I wasn't sure if it was a result of the Autism or something else. At the time I was going through puberty, there was a growing movement to bring awareness to LGBTQ rights. I was intrigued by the LGBTQ community because, like them, I did not fit into the mainstream society. At that time, the only lunchtime activity available at the school was a weekly Gay Straight Alliance ("**GSA**") club where I was surrounded by kids who were older than I was. The members of the GSA club would often meet each other informally over the lunch hour on an almost daily basis. I benefited by the GSA and the people there who accepted me as I was unable to easily make other friends.

6. I support the LGBTQ community and the individual's right to choose to self-identify. I have personally experienced gender dysphoria so I can speak about the discomforting sense that my physical body did not match my personal identity, that it is real and, at times, overwhelming.

7. However, based on my personal experience, in my view, if the individual experiencing gender dysphoria is a child (by that I mean a person under the age of 18 years old), and especially if the child is someone like me with a mental disability such as Autism, ensuring the involvement of the child's parent(s) regarding their gender dysphoria is critical.

8. For as long as I remember, I felt that I was not a typical female and did not express myself that way to the outside world. Part of my social transition from female to male included dressing in male clothing, wearing male hair styles, choosing to hang out with males rather than females, doing activities that are generally considered to be enjoyed by males (which I still like to do), using male pronouns, using a masculine name, and sometimes using washroom facilities for gender neutral individuals (depending upon whether I was "out" in that venue).

9. However, I have concluded that I am a woman and not a man and therefore I do not want or need a medical procedure (like getting an artificial phallus constructed out of my female genitals) to somehow affirm my identity.

10. The details of my experience during the social transition of my gender at school and the effects it had on me, and my family, are documented in an Affidavit ("**My First Affidavit"**) that I swore in (then) Court of Queen's Bench of Alberta Action No. 1808-00144 (the "**Alberta Court Proceedings**") in 2018 when was [redacted] years old. A copy of my First Affidavit is attached hereto and marked as **Exhibit "A"**. The statements in My First Affidavit continue to be true and accurate today. As part of the Alberta Court Proceedings, I was cross-examined on my First Affidavit. I am including as part of this Affidavit, the redacted transcripts from that examination, a copy of which is attached hereto and marked as **Exhibit "B"**.

Why I am Writing This

11. As a result of my Autism, my participation in the GSA club, the conduct of school officials and teachers, keeping things secret from my parents, the disrespect of my faith, and my related experiences which I have detailed in my First Affidavit, I suffered tremendously.

12. I am sharing my story to be an example for others in New Brunswick and across the country who have suffered with gender dysphoria and provide a voice for them, including those with disabilities, and people of faith, who remain silent and, for whatever reason, cannot speak up. I can speak to the personal struggle that I was going through during my situation that I explain in the First Affidavit. I was depressed and suicidal. I did not have the words to describe the trauma I was experiencing. Based on my personal experience, I think it is possible that there are many other children in New Brunswick and around Canada that are going through similar experiences to mine but who are too afraid or depressed to share their stories.

13. I am one voice, but I likely speak for many. I do not want others to suffer the way that I have.

14. I understand that the decision in this New Brunswick court case could have wide-ranging effects on parents and children throughout Canada and it is important that the Court hear and learn about my experience and take it into account when deciding the case.

15. Ultimately, it was my mother and father who saved my life. When I finally told my parents that I was socially transitioning and suffering mental health issues, it was my father who provided me with the best care of all. He was and has been supportive of me from the beginning until the present. As I no longer attend my middle school, I no longer speak with any of my teachers from those days and I have no more contact with the psychiatrist. However, I still have contact with my parents and they accept me for who I am.

16. I acknowledge that I broke my parent's trust when I did not tell them about the things that were happening to me at school when I was going through the transitioning, after being encouraged to lie to them and breaching their confidence in me. I have spent the last few years trying to re-build my relationship with my most loved and valued supporters, my parents. I love my parents both very dearly and am thankful that they have protected me throughout the years.

Partial Publication Ban

17. As a young adult with Autism, and having gone through what I have, I feel extremely vulnerable. I do not want to be known in adulthood for the events that took place when I was in middle school. My Autism makes me resile from conflict and I am very uncomfortable with any sort of confrontation. I do not want to offend anyone on either side of this debate and I am not taking a position on either side of the debate. I am only speaking from my personal experience. I do not want to be known in a political way which is what would happen if my identity was published. I would also likely lose friends and could even put my AISH funding support at risk if someone in a position of power wanted to punish me for my views, all of which would make my life unmanageable. I could be verbally attacked, verbally bullied and even physically harmed by people who disagree with me. The same could happen to my family.

18. The bottom line is that I do not want my involvement in this matter and name and any identifying information like the name of my father, exposed to the public. If that happened, I would be very worried about my safety and wellbeing.

19. I was able to sign My First Affidavit using my initials. Identifying information was redacted. I am writing this Affidavit requesting that this Court permit me that same protection now in respect of this Affidavit as I had then in the Alberta Court Proceedings in terms of a limited publication ban. Because I could be identified by my father's (P.T.'s) Affidavit if his name were public, I would need his name and any information he provides in these proceedings that could identify me to be similarly protected through a Court order granting an acceptable publication ban.

20. I swear this Affidavit for no improper purpose.

SWORN BEFORE ME AT THE [redacted], IN THE PROVINCE OF ALBERTA, THIS _____ DAY OF APRIL, 2024)

_____)

A Commissioner for Oaths in and for Alberta)

_____

[redacted]

Exhibit “A”

COURT FILE NUMBER:	1808-00144
COURT:	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE:	MEDICINE HAT
APPLICANTS:	P.T., and others, see attached Schedule "A"
RESPONDENT:	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
INTERVENORS:	CALGARY SEXUAL HEALTH CENTRE and ASSOCIATION for REFORMED POLITICAL ACTION
DOCUMENT:	**AFFIDAVIT OF A.A.**

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Schedule "A": Full Style of Cause

APPLICANTS:	P.T., D.T., F.R., K.R., P.H., M.T., J.V., A.S., R.M., UNIVERSAL EDUCATION INSTITUTE OF CANADA, HEADWAY SCHOOL SOCIETY OF ALBERTA, THE CANADIAN REFORMED SCHOOL SOCIETY OF CALGARY, GOBIND MARG CHARITABLE TRUST FOUNDATION, CONGREGATION HOUSE OF JACOB MIKVEH ISRAEL, KHALSA SCHOOL CALGARY EDUCATION FOUNDATION, CENTRAL ALBERTA CHRISTIAN HIGH SCHOOL SOCIETY, SADDLELAKE INDIAN FULL GOSPEL MISSION, ST. MATTHEW EVANGELICAL LUTHERAN CHURCH OF STONY PLAIN, ALBERTA, CALVIN CHRISTIAN SCHOOL SOCIETY, CANADIAN REFORMED SCHOOL SOCIETY OF EDMONTON, COALDALE CANADIAN REFORMED SCHOOL SOCIETY, AIRDRIE KOINONIA CHRISTIAN SCHOOL SOCIETY, DESTINY CHRISTIAN SCHOOL SOCIETY, KOINONIA CHRISTIAN SCHOOL-RED DEER SOCIETY,COVENANT CANADIAN REFORMED SCHOOL SOCIETY, LACOMBE CHRISTIAN SCHOOL SOCIETY, PONOKA CHRISTIAN SCHOOL, PROVIDENCE CHRISTIAN SCHOOL SOCIETY, LIVING WATERS CHRISTIAN ACADEMY, NEWELL CHRISTIAN SCHOOL SOCIETY, SLAVE LAKE KOINONIA CHRISTIAN SCHOOL, YELLOWHEAD KOINONIA CHRISTIAN SCHOOL SOCIETY, THE RIMBEY CHRISTIAN SCHOOL SOCIETY, LIVING TRUTH CHRISTIAN SCHOOL SOCIETY, LIGHTHOUSE CHRISTIAN SCHOOL SOCIETY, DEVON CHRISTIAN SCHOOL SOCIETY, LAKELAND CHRISTIAN SCHOOL SOCIETY, 40 MILE CHRISTIAN EDUCATION SOCIETY, HIGH LEVEL CHRISTIAN EDUCATION SOCIETY, PARENTS FOR CHOICE IN EDUCATION, and ASSOCIATION OF CHRISTIAN SCHOOLS INTERNATIONAL – WESTERN CANADA
RESPONDENT:	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
INTERVENORS:	CALGARY SEXUAL HEALTH CENTRE and ASSOCIATION for REFORMED POLITICAL ACTION

AFFIDAVIT OF A.A.

Sworn on January 18 2019

I, A.A., of the [redacted], in the Province of Alberta, SWEAR AND SAY THAT:

1. I am a [redacted]-year-old girl, currently in grade [redacted]. P.T. and D.T. are my parents. I have personal knowledge of the facts herein deposed except where based on information and belief, in which case I verily believe same to be true.

Background

2. I was diagnosed with Autism at the age of five. Attached to this Affidavit as **Exhibit "A"** is a psychological assessment that discusses this diagnosis. I struggle with social skills. I have a hard time making and keeping friends. I really want to have friends and be liked, but that doesn't always happen.

3. I go to church every week with my family. I really like my religion and my church.

4. I believe that God creates people either male or female, and this is also a biological reality. Prior to entering middle school, I believed this was true, but had not really thought about it. I questioned this belief during [redacted] school, however, I have learned over the last three years that this is true. From my experiences I know that I am a girl; that I have a girl's body and a girl's brain and that boys are different from girls, biologically.

5. I am a girl who could be described as a "tomboy". I like typical boys' clothes and athletic girls' clothes. I really enjoy breakdancing, something that a lot of boys do and very few girls do. I don't like make-up or sitting around gossiping and talking about boys. I like to exercise and lift weights and be in good shape. I am comfortable being a tomboy. I do not think it is unfortunate in any way for a girl to be a tomboy, just as I do not think it is unfortunate for a girl to be really "girlie".

6. My parents love me and have always accepted me for who I am, including all my tomboy characteristics. They have never held me back from weight-lifting or breakdancing because they think these activities are too masculine. They have always taught me that I am a girl and that I cannot change that, but that being a girl does not mean I cannot do typically masculine things, if I want to.

7. I started being a tomboy in grade [redacted]. During grade [redacted], I was in a special class for students with Autism and other learning disabilities. In grade [redacted], I was one of [redacted] girls in the special class and, for some of grade [redacted], I was the only girl. This meant that I spent a lot of time playing with boys and with boys' toys, such as action figures. When I played outside with the boys we would all pretend we had superpowers, or pet dragons. I enjoyed playing with the boys the way they played with each other.

8. I, unfortunately, hit puberty early, when I was only [redacted] years old and in grade [redacted]. Puberty was distressing for me for the first couple of years. It was scary, I wasn't ready for it and I wanted to make it stop. I did not like the changes my body was experiencing. I especially did not like that my breasts were growing; I did not want to have large breasts. I often felt uncomfortable in my own skin and that my body was out of control. I became fearful of putting on too much body fat. I wanted to develop muscle, not fat. Before puberty, I was skinny, and I liked that, but puberty caused my body to change its shape. I grew jealous of boys because most boys had more muscle than me just because they were boys. It was after I hit puberty, in grade [redacted], that I began to try breakdancing and lifting weights.

Fall 2015

9. In September of 2015, I entered grade [redacted] and began attending a [redacted] Board of Education [redacted] school. Due to my Autism diagnosis and learning difficulties, I was placed in a special program (the [redacted]). Several other students with Autism and other learning disabilities were also in the program. Most of the time, the other [redacted] students and I were in a special room (the [redacted]). The teachers were [redacted] and an assistant, [redacted]. I was [redacted] years old at the time.

10. One day in October, [redacted] announced, very excitedly, that there was a new school club that met over the lunch break. She said it was called a Gay-Straight Alliance, or GSA for short. I was curious. I thought GSAs were about supporting gay kids and I thought that was a good thing. I had no idea that GSAs were a lot more about transgenderism than supporting gay students and reducing bullying.

11. I decided I would go to the GSA because I badly wanted to make friends and [redacted] made it sound like I would make new friends at the GSA. In September, I had become friends with a girl, who was somewhat of a tomboy like me, but it didn't last. By October, we weren't friends anymore and I had no other friends. I was lonely. I thought going to the GSA might help. I had never been popular and struggled to make friends as an autistic person.

12. On the first Monday in November 2015, I attended the GSA for the first time. [redacted] went with me. When I arrived, everybody was making nametags. We were supposed to write our names, our gender, and our preferred pronouns on the nametags. I wrote down my first name, my real gender (girl) and "she". I sat with a group of girls who were in grade [redacted]. During the meeting, three of the grade [redacted] girls said they were bi-sexual. The environment at the GSA was welcoming, but somewhat mischievous and sometimes I couldn't tell if the grade [redacted] girls were being sincere or sarcastic.

13. I continued to attend the GSA meetings throughout November and December. I was taught at the first few GSA meetings about gender, and how they said it is not based on biology, but on feelings only. I was told that gender was a "social construct" and was "on a spectrum". I was taught about bisexuality; that it meant "being in love with" both boys and girls. I was also taught about transgenderism. I was taught about packers and binders. A packer is a fake penis and testicles that girls can wear to appear to be a boy. Binders are something that girls can wear to flatten their breast to appear as though they do not have breasts. They work by tightly pressing the breasts back against the body. I did not want a packer, but I was interested in binders because I wanted a flatter chest.

14. Due to my young age and my Autism, I did not fully understand everything I was being taught at the GSA meetings. When I first heard about what it meant to be bisexual, I thought that I must be bisexual because I once had a "crush" on a female teacher in grade [redacted]. I didn't want to kiss her or do anything sexual with her; I just wanted to be around her because I thought she was pretty and a really neat person. I thought experiencing that emotion meant that I was bisexual.

15. Similarly, based on what I was being taught in the GSA regarding gender and transgenderism, I began to think that I must be transgender because I liked boys' things and wanted muscles. If gender was all based on feelings, then I thought, at the time, that I might be a boy. I liked to breakdance and weightlift, and I often wore boys' clothes. I didn't fit in with most girls; I didn't like wearing make-up, talking about "crushes" on boys or dresses. I felt awkward about my breasts and wore a tight sports bra, so people wouldn't notice my breasts. Because of all these things, and the feelings I had at the time, I thought, after attending the GSA, that I didn't classify as a girl and must be transgender.

16. At one of the GSA meetings before Christmas, a grade [redacted] boy gave me a little booklet called "I think I Might Be Transgender, Now What Do I Do?" (attached to this Affidavit as **Exhibit "B"**). I read the booklet. I hid it under my mattress, so my parents wouldn't find out about it.

Events of January – June 2016

17. I continued to attend the GSA. In January 2016, I decided to "come out" as transgender. I told the other students in the GSA. I thought the other students in the GSA would think I was cool if I told them I was transgender, and I was right. They all approved of my new identity and one of the grade [redacted] girls "fist-bumped" me. It felt great; I felt like I was finally fitting in. I felt like I was experiencing popularity for the first time.

18. I also told [redacted] that I was transgender. She was happy and said she was very proud of me. I talked to her about taking testosterone, coming out to my parents and pronouns. She said I could take testosterone; that it would be fine. I had learned about testosterone near the end of grade [redacted] when I became interested

in having more muscle. I knew it was one of the reasons boys had more muscle than girls.

19. I didn't want to be a boy, biologically; I didn't want facial hair, and I really didn't want a penis and testicles. But, I really wanted muscles and I thought I would become stronger if I took testosterone.

20. I started to pretend to be a boy in the GSA. The other students in the GSA, who were mostly in grade [redacted], started using male pronouns to refer to me. Then the other students in the GSA encouraged me to "transition" into being a boy outside of the GSA. At one of the GSA meetings, they said that if I felt more like a boy than a girl, then I should be referred to as a boy. The GSA leader agreed.

21. Around this time, I felt that school was great; being trans, I was finally popular. But outside of school was very different. I couldn't seem to escape the reality that I was a girl. I told my dad that I thought I could never wear make-up, dresses or high heels, but he always said that was fine; I didn't need to look like other girls if I didn't want to. He told me that even if I didn't look like other girls, I still was one biologically. I knew he was right about that. Also, I never felt like a boy at breakdancing practice or had a problem with being a girl while breakdancing. I never came out as transgender to my breakdancing friends and didn't feel the need to.

22. After I came out as trans at school, I found myself living a kind of double life: at school I was trans and pretended to be a boy, but everywhere else I was a girl and knew it. Sometimes, at school, it felt wrong to pretend to be a boy, and, at breakdancing, it almost always felt right to be a girl, but I ignored those feelings.

23. As grade [redacted] went on, it became harder and harder to untangle everything going on in my head. I was confused and became anxious and stressed. I felt like I think the man must have felt in the movie "Mrs. Doubtfire". Like him, I was living in two worlds. It got so bad that some days I felt like dying.

24. I talked to [redacted] a lot in the second half of grade [redacted] just me and her. I told her how I was feeling. She told me, more than once, that my parents were abusing me by not letting me transition. That didn't help; it just made things worse. I had

mixed feelings about [redacted]. I liked that she treated me like a boy, but I didn't like the way she talked about my parents.

25. My parents were worried about me. They knew something was wrong with me. I met with a child psychiatrist, [redacted] several times in the spring of 2016. I met with him alone sometimes. He encouraged me to take testosterone. Around this time, he asked me if I wanted a penis and I said "no". I believe [redacted] is a professor at the University of Calgary.

26. One day, near the end of school year, one of the grade [redacted] girls in the GSA talked to me in the bathroom. She said she thought my real name, even the shortened nickname version of it, sounded too feminine for me. She suggested I use a more masculine sounding name. Influenced by the girl, I decided to start using a male name that was somewhat similar to my real name.

27. Things were pretty bad by the end of grade [redacted] I was a wreck; I was still upset about puberty and how my breasts were growing, and I was upset that I wasn't getting the muscle that I wanted. I was stressed and anxious about the double life I was trying to live. I thought that if I started living as if I was a boy, things might get better.

28. Because of everything I was told in the GSA, I had come to think that I could just transition to being a boy and everything would be some sort of rainbow fairyland. I realize now how foolish I was at the time. On the last day of grade [redacted], I told my mom that I wanted to be a boy and that I wanted her to call me a "he". I thought she would, but she didn't, and it made me really upset. Later that evening, my dad and I talked about how I was biologically a girl and that I needed to understand that.

29. That night, on the last day of grade [redacted], I tried to kill myself in the bathroom at home. I tried to strangle myself with my resistance exercise bands, but my dad came in and pulled them off my neck. I was really thankful for my dad and that he loves me so much.

Summer 2016

30. Summer of 2016 was better. I no longer wanted to kill myself and I enjoyed summer camp, where I was able to make a friend with a girl. But, I still badly wanted more muscle and was jealous of boys because they had muscle, which made me sad.

Events of September to December 2016

31. When I started grade [redacted] in the fall of 2016, I still felt a lot like a boy. I decided to take things a step further. I stopped using the female bathrooms at school and started using the gender-neutral bathroom. I joined the boys during gym class. None of the teachers or staff at the school told me I couldn't or shouldn't join the boys. I started hanging out with only boys; trying to fit in with them and be "one of the bros". I realized how different boys are from girls. Boys are rough and competitive; they actually try to win at sports, instead of just pretending to play, like a lot of girls, who spend most of the time in gym class just gossiping. I liked that.

32. I continued to attend the GSA. I also decided that I wanted to start using the male name [redacted]. I had been using a more masculine nickname version of my real name, but I wanted a new name. I choose [redacted] because I like it as a boy's name. I told [redacted] and [redacted] that I wanted to be called [redacted] and they called me that. They encouraged me to use my new male name with everybody.

33. Also, around this time, I attended a GSA meeting at which the adult leading the meeting was new; it was the only time she led a GSA meeting that I attended. I happened to mention at this GSA meeting that I was religious and that I went to a particular church. The GSA leader started talking bad about my church. She said that my church was holding me back and that my church was the reason I wasn't transitioning. I asked her if she thought I should leave my church. She didn't say if I should or not, but she said my church wasn't doing a very good job.

34. I felt really disrespected by that GSA leader. I felt like she broke the GSA rules about being inclusive and not discriminating. I was told that one of the main

reasons GSAs exist, and why they are needed, is to reduce discrimination, be inclusive and accept everybody the way they are. I thought GSAs were supposed to be a place where there was no discrimination against anything, including religion. The GSA leader wasn't being inclusive of my religion, or respecting that I was religious.

35. I didn't realize it at the time, but now that I look back, the GSA was like a church and many of the students and adults who went to the meetings were like missionaries; trying to convert people to believe what they believe about gender and attend the GSA meetings.

36. By November of 2016 only a few people were still attending the GSA. There was a lot of concern about how to grow the GSA and we talked about how those still attending should invite other kids because it seemed like kids didn't want to come on their own.

37. I remember a time when I was playing Pokémon cards at lunch and [redacted] came up to me and asked me to go to the GSA meeting with her. I didn't want to go. I liked playing Pokémon cards and just wanted to do that instead of attend the GSA that day. I told her I wanted to play Pokémon instead, but she said "I insist", so I decided to go with her to the GSA.

38. My parents found out that I was pretending to be a boy at school and that I was now using a male name. My parents and I talked about it. We agreed that I wouldn't use the name [redacted] anymore or use male pronouns. But I lied, and I kept on using the name [redacted] at school and most of the students and staff at the school referred to me as a "he". [redacted] and [redacted] said they wouldn't tell my parents and they helped me to keep it all a secret from my parents. I felt uncomfortable about this, however, it felt like I was being naughty. None of this helped me feel any better. I was still anxious and stressed all the time. I wish now that my parents had known about everything. They were always so caring and loving and they truly wanted what was best for me.

39. My depression became really bad and I had thoughts of killing myself. When I spoke with [redacted] about how I felt she told me that I should move out of my

parents' house and that I could move in with her and she would adopt me. That didn't help either; the thought of that gave me the shivers.

40. Sometime before Christmas, [redacted] told me that if I was to go to the children's hospital, they would "accept" me and they would help me; they would give me testosterone and do surgery on me. Then I found out that [redacted] had told my dad that he should take me to the children's hospital.

41. My dad and I went for a drive and we had a long talk. He told me that what I was doing wasn't good for me and that I needed to stop. We talked about what would happen to me if he took me to the children's hospital. He didn't take me, and I'm glad he didn't.

42. After that, I stayed home from school for about 2 months, until February 2017. During the first week that I was at home, a social worker came to the house and then some police officers came. I told all of them that I was fine. They talked with my mom some and then left.

43. I started to feel better while I was at home with my parents. I felt less anxious and less depressed. I talked a lot with them and they told me how much they loved me and that it was okay to be a tomboy.

44. I kept going to breakdancing, even while I wasn't in school, because it helped me. When I went to breakdancing practice, I forgot all about my gender problems.

Return to School in Early 2017

45. My parents eventually decided that I was well enough to go back to school. Being back at school was difficult. When I wasn't in school, things were simpler, but at school, I always seemed to get tangled up with ideas about gender and transitioning. However, I stopped attending the GSA, and that helped. I did not attend the GSA at my school ever again.

46. All through grade [redacted] even before I left school for two months, there was a woman named [redacted] who came to school to see me many times. I believe she was a government social worker. We talked a lot, just me and her. In the fall of 2016 I told her that I was trans. I met with her again, more than once, when I went back

to school in February 2017. She called me a "young man" a few times. I cringed when she did that; it didn't feel right. We talked a lot about my family and my church. She told me that I should leave my church, even though I told her I didn't want to. She said my family didn't seem to be "accepting" me and she asked me how much longer I would wait for my family to "accept" me. She told me that in a few months I would be able to move in with another family who "accepts" me. That thought gave me the shivers too. I felt like she was trying to steal my identity. I'm glad I stayed with my family and in my church.

47. Around this time, I tried talking to [redacted] and [redacted] about science and biology. I asked them if and how boys and girls are biologically different and if science showed that girls could become boys. They didn't really answer my questions; they just told me that my biological sex did not determine my gender, and that just because I was born female, that didn't make me a girl.

48. On the last day of grade [redacted], something happened in the [redacted] that really bothered me. [redacted] told me that [redacted] a girl a grade younger than me that was also in the [redacted], wanted to show me a video. It was just me, [redacted] and [redacted] in the room. They put on a video of a girl around my age getting up to speak at a mic in a church. I knew from the video that the church was part of my religion. She got up to the mic and said she was gay. Then she started talking about how she wanted to have a wife someday. At that point, the girl was asked to sit down. This bothered me because it felt like they were trying to turn me against my religion. It was clear to me that the video was trying to make my religion look bad.

49. It was very frustrating for me that everybody in the GSA and in the [redacted] seemed to dislike my religion and think it was bad for me and that my church was the reason I wasn't happier or wasn't fully transitioning to being a boy. I love my church and it has been good for me. I came out as trans to a few of the girls in my church during that time in my life. They weren't mean to me, they weren't angry, they just listened. They didn't agree with transgenderism, but they didn't cause me to feel bad about myself.

Summer 2017

50. I became friends with an older girl that also did breakdancing in the summer of 2017. She had short hair and didn't look feminine, but she had no issues with her gender and neither did anybody else, including her husband. She was a role model to me and trained me to get better at breakdancing. During the summer, I sometimes felt like a boy, but never at breakdancing, where I just felt like me; like the girl that I was.

Grade [redacted]: The 2017-2018 School Year

51. When I started grade [redacted], I still felt more like a boy than a girl. But, during the Christmas break, that began to change; I started to feel better about myself and that I was a girl. I was getting used to the changes my body had undergone and I had been able to build some muscle. I was identifying more with being a girl who is a tomboy than with being a boy or being trans.

52. Things changed even more in January of 2018. I had been seeing a psychiatrist named [redacted] for about a year, usually alone. I believe [redacted] works at the Alberta Children's Hospital. He told me many times that I was transgender and that doing things to become a boy would help me. He suggested that I take puberty-blocking drugs and talked with me about "bottom" surgery, which means a surgery to remove my private parts and get a fake penis. He told me that my problems were my family and my religion, even though I had never complained to him about my religion.

53. In January, there was another meeting with [redacted], but this time, my parents were there too. [redacted] and my dad started talking about gender. My dad asked [redacted] if what he was telling us about gender was based on settled science. [redacted] admitted that it was not. My dad then said that it was based on beliefs, or on an "ideology". That conversation surprised me. I listened to everything that was said, and I realized that my dad was right, that I was a girl, even though I had struggled with feelings of wanting to be a boy. I realized that science and feelings were two different things and that [redacted] was basing everything on feelings, not science.

54. After that meeting, I realized that I wasn't trans and wasn't a boy, even if I felt like it sometimes. I knew, from then on, that I wanted to be a girl and a tomboy. The problem was that everybody at school still thought I was trans. I was afraid to come out as a girl, as "cisgendered", which is the word that the kids in the GSA use to describe someone who's gender identity is the same as their biological sex.

55. Shortly after this, [redacted] said to me, "Great news! Next year, it's going to be illegal for parents to know about students attending GSAs, so you can go to a GSA when you go to [redacted] school." That comment gave me the shivers. I didn't ever want to go to a GSA again.

56. In February of 2018, [redacted] gave me a book called "George" (attached to this affidavit as **Exhibit "C"**). She said she thought it would be good for me because it was about a transgender boy who felt like he was a girl. She told me I could keep it at school so my parents wouldn't find out. I didn't read the book, but I told my parents about it.

57. It was the next day that I decided to come out as a girl and tell [redacted] that I wasn't transgender anymore. She burst into tears when I told her that I was "cis". While she was crying, she told me that I was pushing everybody away from me that was trying to "support" me. I told her I didn't need that kind of "support" anymore because I wasn't trans anymore and I was a girl, not a boy.

58. It was scary to come out as a normal girl. I felt like it was a lot harder to come out as cis than it was to come out as trans. It seemed to me that people are a lot less supportive of cis people.

59. Once I came out as a girl, I wasn't popular anymore. Most students didn't want to talk to me anymore. I spent a lot of time alone and even did a group project alone because nobody wanted to sit with me. I was sad and wished I could be invisible.

60. I was glad when the school year finally ended. Life outside of school had gotten better and better; I went to breakdancing more often, got my ears pierced and became more comfortable with being a girl and a tomboy. But school had been awful.

Conclusion

61. When I hit puberty and my gender problems started, my two biggest issues were my breasts and muscles. I wanted so badly to not have breasts. I realize now that my obsession with these things is part of the reason I got tangled up with transgenderism. Over time, through weight lifting and doing breakdancing, I built more muscle and got used to doing those things while having breasts. As that happened I realized that I never wanted to be a boy, I just wanted the muscles that boys have, and I didn't want the breasts that girls have.

62. I know that I am a girl and that nothing can change that, and I am completely fine with that. What matters to me is that I have muscle and low body fat, and I now realize that I can have that, even while being a girl. I just want to be fit. It is fun being a girl and being strong and fit.

63. For a month after grade [redacted] ended, I had nightmares about what happened to me in [redacted] school. I wish I had thought things through better. I'm so glad and thankful that I didn't take any hormones or get taken away from my family. I realize now the kind of risk I was in. I'm glad I listened to my parents, instead of all the adults at school, who seemed more interested in turning me into somebody I am not, instead of helping me. I'm glad it's over. I will never go to another GSA meeting again.

64. I swear this Affidavit bona fide and for no improper purpose.

SWORN BEFORE ME at [redacted], Alberta,)
this 18 day of January 2019.)
)
)
)
)
)

James Kitchen
Barrister and Solicitor
A Commissioner for Oaths in and for
the Province of Alberta

A.A.

[redacted] Board of Education

CONFIDENTIAL

PSYCHOLOGICAL ASSESSMENT REPORT

Principal
Assistant Principal
Resource Teacher
[redacted] Classroom Teacher

STUDENT IDENTIFICATION INFORMATION

Student Name	:	[redacted]
[redacted] Student Number	:	[redacted]
Alberta Education Number	:	[redacted]
Date of Birth	:	[redacted]
CA	:	9 years, 11 months
Grade/Program	:	4
School	:	[redacted]
Dates of Assessment	:	March 12th, April 3rd, 8th, 11th, 2013
Date of Report	:	April 19th, 2013

Reason for Referral:

School personnel are requesting updated information regarding [redacted] cognitive, academic and social-emotional functioning in order to better inform them as to best options as [redacted] transitions out of [redacted] next fall.

Assessment tools:

- Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV)
- Wechsler Individual Achievement Test – Third Edition (WIAT-III)
- Behaviour Assessment Scale for Children – Second Edition (BASC-2) (parent, teacher and child reports)
- Sentence Completion Test
- House-Tree-P Drawings

Background Information:

As there is a significant amount of information in [redacted] file, relevant family history and past professional involvement will be summarized below. This may not represent a complete accounting.

- [redacted] is the youngest [redacted] children, with an [redacted] diagnosed with Asperger's Syndrome, an [redacted] with no noted developmental concerns and a number of male members of the family noted to be "socially gauche":

- [redacted] was reportedly born twenty days early following an induced labour, weighing 6 lbs. 13 oz. with no postnatal concerns noted;

- Assessed and treated by speech-language pathologist in early 2007, while [redacted] was enrolled in [redacted] (attended since 2006). Concerns focussed around attention, language comprehension, social communication abilities and topic maintenance;

- At 4 ½, [redacted] was referred by a speech-language pathologist to the Preschool Autism Assessment and Resource Team (PAART) to query autism due to various behaviours reminiscent of ASD such as lack of social reciprocity, repetitive interests, preoccupations and at times impulsivity and disinhibition;

- Attended a multidisciplinary Preschool Treatment Program for further diagnostic assessment and intervention (January – March, 2008). Was referred back to PAART to continue investigating ASD;

- **Psychological assessment completed June, 2008 through PAART.** Intellectual functioning was assessed with the [redacted] Preschool and Primary Scale of Intelligence. Findings revealed Low Average verbal and nonverbal functioning (scores falling at the 19th and 27th percentiles respectively), with Processing Speed scoring in the Extremely Low range, at the 1st percentile. Assessment was felt to be a possible underestimate of [redacted]'s abilities;

- Referred to developmental paediatrician Dr. [redacted] through the Child Development Centre of the [redacted] Health Region. Seen July 2nd, 2008;

- Based on psychological inquiry using the ADI-R (Autism Diagnostic Interview – Revised) and ADOS (Autism Diagnostic Observation Schedule) as well as consultation with Dr. [redacted] on August 11, 2008, [redacted] difficulties in the areas of social interaction and communication, together with some restricted and repetitive patterns of behaviour, interests and activities were felt to be consistent with an Autism Spectrum Disorder diagnosis, best described as a **Pervasive Developmental Disorder Not Otherwise Specified (PDD NOS);**

- Enrolled at [redacted] for ECS (2008 – 2009), where [redacted] has remained through her current grade [redacted] year;

- **Speech-language reassessment (December, 2008)** revealed overall Average receptive language skills and Low Average expressive language skills. Limited social skills and negative behaviours (perseverating on inappropriate topics, using negative self-talk, complaining about the environment – e.g. "the room is too short and it is hurting my head") were of concern and treatment focussing on the use of social language ensued;

- in grade [redacted], teacher concerns around [redacted]'s language comprehension and expression surfaced: it was documented that she had difficulty grasping assignment parameters and required one-on-one assistance to understand expectations, which she would then ignore.

- inappropriate behaviours were frequent, i.e. wandering aimlessly, speaking loudly (yelling) when confronted with new people or situations; hand-flapping, making shocking statements, withdrawing from gym activities, inattention and frequently asking "What? What do I do?"

- **Speech-language reassessment (March, 2010) and treatment** around social communication skills; further treatment was recommended for the fall of 2010, which focussed on reading body language and facial expressions as well as strategies to assist with her ability to reflect on her own behaviour and its appropriateness;

- Referral by Dr. [redacted] to Dr. [redacted] through the Alberta Children's Hospital Developmental Services. Apparently seen by **Dr.** [redacted] in 2008 (no documentation on file) at which time she found [redacted] as presenting with high anxiety, rigidity and significant oppositional behavioural, as well as Attention Deficit with Hyperactivity Disorder;

- **Re-assessment by Dr.** [redacted] **in May, 2011,** wherein she determined a significant ADHD component, perseveration, very poor social judgement and very poor reading of social cues. A medication trial was recommended. Self-image preoccupations ([redacted]'s concern with her appearance, her preoccupation with being skinny) were seen to cause her significant emotional distress – Dr. [redacted] felt that her preoccupations in this area were not evidence of an early eating disorder but rather [redacted]'s "unique" solution to her social and friendship issues – i.e. the concrete and perseverative belief that if she looked prettier, she would be more accepted by others;

- Letter to the school from Dr. [redacted] [redacted] paediatrician confirming PDD-NOS as well as ADHD (March 2012);

- Dr. [redacted] prescribed Prozac and is following [redacted] for medication purposes;

- Dr. [redacted] [redacted], a paediatrician who specializes in eating disorders, has seen [redacted] at the eating disorders clinic (unclear who made the referral). Follow-up is every four-to-six weeks until her target weight is reached; by [redacted] made the referral. She is a practice trainee in Dr [redacted] clinic.

- Involvement of **SCOPE** worker to support parents with their concerns about [redacted]'s social skills; provision of feedback from different social events wherein [redacted]'s perceptions regarding being ignored were objectively challenged;

- Academically, [redacted] has been on an IPP as well as a behaviour support plan to address her lack of ability to sustain focus and work independently, her need for adult guidance and support when working with others; her need for significant feedback, her resistance to learning when such is perceived to be beyond her comfort zone, and her overall very minimal social interaction skills;

- [redacted] continues to experience difficulties in respecting the boundaries of others, in interacting positively with peers and adults, in reading and responding appropriately to the social cues of others; in transitioning from unstructured to structured situations and in reacting to unexpected events during the day.

According to [redacted]'s current grade [redacted] teacher, her main concerns around [redacted] are three-fold: the first pertains to [redacted]s lack of social skills and inability to pick up on social cues. She describes [redacted] as dominating and highly egocentric – which leads peers to tire of her – and when her peers (the ones with whom she wishes to associate) don't include her, she'll push them all away.

The teacher's second major concern revolves around [redacted]'s emotional lability (anger, crying, oppositional defiance) and volatility – "she can turn on a dime ' – which can totally disrupt the class. Her teacher indicated, for example, that when [redacted] feels miserable, "everyone feels it".

The teacher's third concern (no less paramount in order of importance) relates to [redacted]'s self-harming behaviours. Last year [redacted] engaged in cutting behaviours: she would use scissors to dig them into her hands and frequently had bleeding fingers. Currently, she has begun to pick at her scalp/forehead and has a series of open/scabbed wounds across the forehead hairline.

[redacted]'s grade [redacted] teacher also indicated that [redacted] "hates" school and often pronounces some paranoidal ideation that others are watching her.

Medical/Health/Physical Factors:

PDD NOS (including ADHD)

Reportedly on both Prozac and Vivance currently.

Behavioural Observations:

[redacted] was initially observed in class prior to commencing assessment work with her. This was during math class, during which [redacted] reportedly experiences quite a bit of anxiety. As it happened, she was sitting beside the education assistant when this author came into the class, and she immediately focussed on this new person in the familiar classroom environment. She did not appear to be listening to the math lesson being discussed; she was, however, very keen on picking up something the teacher said to another child. [redacted] said out loud to the teacher, "when *he's* tired, it's poor you, but when *I'm* tired you send me to the office"; she did not, however, appear to expect a response from the teacher. Apparently [redacted]'s focus went in and out during the lesson, at one point she again directed a comment out loud to the teacher: " you actually didn't spell 'favourite' correctly....you put in a 'u' ". Subsequent to the teacher's explanation of the American versus British spellings, [redacted] again answered out loud, to the room in general "*I* spell it the American way".

During one interval when she actually was focussed on the math assignment, despite the one-on-one help of the education assistant, [redacted] seemingly could not understand what she was expected to do; she started rocking and yawning and tuned out very rapidly, despite the assistant's attempts to lead her through the work.

When introduced to this author, [redacted] compliantly followed her from the classroom to the testing (conference) room, talking constantly in a running patter which allowed for little opportunity for the latter to interject or dialogue. Once seated, and asked about her understanding for the current assessment – i.e. to help with transition placement plans – [redacted] immediately identified that she doesn't have any friends", adding that "she never smiles and frowns a lot". She then spontaneously added that she is afraid of the third graders...."they tell on me". This led to some tangential thinking and her stating that she thinks she is "possessed....I keep rolling my eyes". She clearly intimated feeling ostracized and rejected by her peers, and indicated that she loves her squishees (small rubber animals) because "I can control them...I can tease them....I can hurt their feelings".

When asked how she spends her free time, with no friends, [redacted] answered that she plays on the trampoline in the summer and plays video games, adding that "I can't think of anything good in the world except for video games".

[redacted] rated school a zero out of ten, loudly whining that "I can't change *anything* at this school....they know me....some people act like I'm crazy or a weirdo". She then stated that she feels the need for being in a smaller class (room).

[redacted] worked her way with reasonable attention and investment at the outset of the cognitive testing, most of which was completed on the first morning of the assessment. She demonstrated surprisingly good frustration tolerance as she worked her way through ceiling (i.e. most difficult) items on the first few subtests, but became somewhat more resistant as the testing went on. By the time we had reached the seventh subtest, she claimed her voice "hurt" and she began to just mouth the various letters and numbers she was required to recall on the Letter-Number Sequencing task. She was, by this point, almost devoid of any investment and as her effort waxed and waned, she reached a ceiling very early. Testing of the limits, however, revealed that she was capable of more than her ceiling suggested. As such, her score on this particular subtest – Letter-Number Sequencing - cannot be seen as representative of her capability in the area of working memory.

Similarly, when finishing up with the cognitive testing on the second morning of the assessment, it was felt that [redacted] spoiled the Symbol Search subtest by stopping and asking questions – which had just been explained in the instructions – while being timed. As such, it is entirely unclear as to what [redacted]'s true capabilities are and this testing was deemed to be a possible under-representation of her cognitive potential.

The majority of the second morning's testing consisted of the personality tests and questions, as it was not clear as to how [redacted] would respond to the achievement testing. While she continued to manifest a desire for egocentric monologuing, she was able – and willing – to refocus each time the examiner asked her to. She was compliant throughout.

The third and fourth sessions were devoted to the achievement testing, on which [redacted] appeared to be very invested and trying her best -- in contrast to her erratic motivation on the cognitive test. All told, then, it is felt that the achievement test scores are a truer reflection of [redacted]'s capabilities than the cognitive test score. *Her variable motivation on the intellectual assessment was a significant mitigating factor which was felt to negatively impact the WISC-IV scores, such that the results are deemed to be very much an underestimate of her true abilities in some areas.*

Assessment Results & Interpretation:

W.I.S.C.-IV

				95% Confidence Interval
Full Scale I.Q.	79	**Borderline**	8th %ile	74 - 85
General Ability Index	88	**Low Average**	21st %ile	82 - 95
Verbal Comprehension	91	**Average**	27th %ile	84 - 99
Similarities	12	75th %ile		
Vocabulary	6	9th %ile		
Comprehension	7	16th %ile		
(Information	5	5th %ile)		
(Word Reasoning	7	16th %ile)		
Perceptual Reasoning	89	**Low Average**	23rd %ile	82 - 98
Block Design	8	25th %ile		
Picture Concepts	10	50th %ile		
Matrix Reasoning	7	16th %ile		
Working Memory	74	**Borderline**	4th %ile	68 - 84
Digit Span	8	25th %ile		
Letter-Number Sequencing	3	1st %ile		
Processing Speed	73	**Borderline**	4th %ile	67 - 84
Coding	7	16th %ile		
Symbol Search	3	1st %ile		

Average scaled score is 10.

W.I.A.T.-111

			95% Confidence Interval
Reading	95	37th %ile	87 - 103
Word Reading	96	39th %ile	92 - 100
Reading Comprehension	80	9th %ile	68 - 92
Oral Reading Fluency	113	81st %ile	105 - 121
Written Language	96	39th %ile	89 - 103
Sentence Composition	114	82nd %ile	104 - 124
Essay Composition	87	19th %ile	77 - 97
Spelling	93	32nd %ile	86 - 100
Math	75	5th %ile	67 - 83
Numerical Operations	85	16th %ile	76 - 94
Math Problem-Solving	68	2nd %ile	58 - 78
Addition – Fluency	77	6th %ile	64 - 90
Subtraction – Fluency	82	12th %ile	72 - 92
Multiplication – Fluency	91	27th %ile	82 - 100
Listening Comprehension	70	2nd %ile	57 - 83
Receptive Vocabulary	65	1st %ile	
Oral Discourse Comprehension	84	14th %ile	
Oral Expression	98	45th %ile	87 - 109
Expressive Vocabulary	77	6th %ile	
Oral Word Fluency	120	91st %ile	
Sentence Repetition	98	45th %ile	

Inspection of [redacted] performance on the WISC-1V reveals that she is, overall, assessed to be a student of Borderline intellectual functioning, with a Full Scale I.Q. of 79, which falls at the 8th percentile in relation to other nine year olds. There is a ninety-five percent likelihood that her "true" Full Scale I.Q. falls between 74 and 85.

These scores are marginally different than those based on the pre-school cognitive assessment (WPPSI-111) on which [redacted] scored in the Low Average range on both the verbal and nonverbal indexes, scores falling at the 19th and 27th percentiles respectively). On this testing, [redacted]'s Verbal Comprehension Index score was 91, which falls within the lower end of the Average range of intelligence, at the 27th percentile for her age. Her Perceptual Reasoning Index score was similar to that obtained when she was a pre-schooler: she achieved a Low Average score of 89, which falls at the 23rd percentile for her age.

Because of the major discrepancies between [redacted]'s scores on the verbal and nonverbal reasoning and problem-solving subtests with her performance on the tests of working memory

and processing speed, the **General Ability Index**, based only on the subtests of higher verbal and nonverbal reasoning, was also calculated. [redacted]'s GAI was calculated to be 88, which falls in the Low Average range of intellectual functioning, at the 21st percentile for her age. There is a ninety-five percent likelihood that her 'true' GAI falls between 82 and 95.

This GAI score is more in keeping with [redacted]'s results on the pre-school testing.

Because of the major discrepancies in scores both within and between Index scores, each will be discussed below.

The Verbal Comprehension Index is comprised of three core subtests measuring verbal facility, the ability to reason with words, verbal conceptualization, word knowledge and practical judgement. This score relies heavily on educational learning and experience. It is the most robust of the four Index scores to predict to academic achievement.

[redacted] earned a very strong score falling at the 75th percentile on one of these subtests – Similarities, which requires the ability to conceptually relate seemingly disparate concepts/objects. She simply breezed through many of the items on this subtest. However, this was the only Verbal subtest on which [redacted] achieved an Average-to-above-Average score: all the rest fell within the Borderline range – including the two supplementary subtests, which were administered because of the huge discrepancy between the Similarities and all the other subtests. Her standard scores on the vocabulary, comprehension, information and word reasoning subtests fell between the 5th and 16th percentiles.

It is entirely unclear as to what to make of this. What is clear is that *the Verbal Comprehension Index is not measuring a unitary dimension and therefore must be interpreted cautiously.* It is also clear that [redacted]'s strong score on the Similarities subtest inflated her Verbal Comprehension Index score of 91 somewhat: without this score, her VC index score would have fallen within the Borderline range.

Yet [redacted]'s capability resulting in the High Average score on the Similarities subtest strongly suggests good verbal conceptual reasoning, which would correlate with some of her Average to above Average scores in various academic areas. The Verbal Comprehension scores whereupon she received Borderline Scores – i.e. lack of a strong base of background/general knowledge, a weak expressive vocabulary, poor practical and social judgement – all of these are most certainly associated with [redacted] Pervasive Developmental Disorder diagnosis, including primary attentional problems.

The Perceptual Reasoning Index is comprised of three core subtests measuring nonverbal reasoning and problem-solving through fluid thought and visual processing. These subtests tap visual-perceptual skills, the ability to think in images and to manipulate visual data spatially.

[redacted]'s scores were internally consistent on these three subtests, which earned her a Perceptual Reasoning Index score of 89, which falls at the upper end of the Low Average range, at the 23rd percentile in relation to her age group. This score is not significantly different from that obtained through her pre-school testing with the WPPSI.

The Working Memory Index is comprised of two subtests measuring the ability to apprehend, hold and manipulate information in short-term memory. It was on the second of these subtests – Letter-Number Sequencing – wherein [redacted]'s motivation not only dropped but seemed to abruptly end: testing of the limits subsequent to her ceiling indicated that she could have performed better than she did, which is frustrating because in standardized testing, the latter score, strictly speaking, does not count. So the combined scores on the Working Memory Index yield a Borderline score of 74, which falls at the 4th percentile for her age. Of clinical interest, utilizing the score derived after testing the limits does not change things significantly: the scores would have yielded a Working Memory Index of 80, which falls at the 9th percentile for her age.

The fourth index is termed Processing Speed and is comprised of two subtests measuring the ability to fluently and automatically perform simple cognitive tasks, especially when under pressure to maintain focussed attention and concentration. Each subtest requires the integration of skills in visual-motor coordination, visual discrimination, short-term visual memory, concentration and visual scanning speed. As multiple nonverbal skills must be integrated to successfully complete these subtests quickly, fluidity and efficiency in nonverbal processing is also reflected by the scores.

Here again, [redacted] spoiled the second subtest (Symbol Search) by stopping during the timed task and asking questions of the examiner *which had just been explained not a minute before.* It is unclear if [redacted] wasn't listening and didn't hear the explanation or she was using a delaying tactic to avoid doing the mental work involved. So, her overall Processing Speed Index score of 73, which falls within the Borderline range at the 4th percentile in relation to other students her age, must be seen as a possible underestimate of her capabilities in this area.

In summary, [redacted]*s performance on the intelligence testing suggests that the derived scores may not be an optimal and valid representation of her current functioning in the different domains.* As it stands, she demonstrates a personal strength in the area of verbal classification and conceptualization, but Borderline scores across the rest of the verbal subtests. She also manifests a solidly Average score (50th percentile) on the test of pictorial classification and conceptualization, earning her a Low Average Perceptual Reasoning Index score. Her scores on the verbal versus the visual-spatial portions of the test are not significantly different, statistically speaking.

The two cognitive "booster" functions of working (short-term) memory and speed of processing information both fall within the Borderline range – *although these scores may be under-representations* – and are significantly lower than either her verbal or nonverbal reasoning and problem-solving capabilities. However, the magnitude of the differences in all cases, statistically speaking, is greater than ten percent and therefore not considered abnormally large/discrepant.

As it stands, however, both working memory as well as visual processing speed test as areas of personal weakness for [redacted] – it is difficult to know if the inherent weaknesses led to a diminishing of effort or the drop in motivation negatively impacted her scores. Her Processing Speed as measured by the pre-school cognitive test tested at the 1st percentile. One wonders, however, the degree to which lack of focus or sustained attention affected both that and the current scores.

Inspection of [redacted]'s performance on the WIAT-111 suggests more consistency than cognitive test scores. In most areas, [redacted]'s scores reflect Low Average to Average functioning, in line with what would be expected based on her GAI of 88. This was the case with sight word vocabulary, reading comprehension, reading fluency, spelling, written expression, numerical calculation (although basic addition facts are not highly automatic), and oral expression.

There were two areas in which [redacted] s performance was significantly lower than would have been predicted: listening comprehension and math problem-solving, wherein her performance falls within the Extremely Low Range (2nd percentile).

The Listening Comprehension composite scored is comprised of two subtests; Receptive Vocabulary – which was [redacted] s downfall – wherein she scored in the Extremely Low Range at the 1st percentile for her age and Oral Discourse Comprehension. This latter subtest requires listening to various passages of increasing length and complexity and answering questions about them. [redacted] scored in the Low Average range on this subtest, at the 14th percentile in relation to her age cohort.

As such, it can be seen that it was the Receptive Vocabulary subtest which significantly lowered her Listening Comprehension Score. Of clinical interest, one of the Oral Expression subtests – Expressive Vocabulary – was also one wherein [redacted] performed extremely poorly: she obtained a Borderline score falling at the 6th percentile on this subtest.

This information, in conjunction with the knowledge that her oral expression and fluency and language comprehension test as Low Average to Average, strongly suggests that [redacted] s vocabulary is not expanding at an age-appropriate rate. Given that reading comprehension tests as much lower than reading rate and fluency, it is very possible that [redacted] is not picking up and incorporating much new vocabulary.

The other area in which [redacted] tested as significantly below predicted values was on the Math Problem-Solving subtest, wherein her performance fell at the 2nd percentile. Inspection of [redacted] s responses on this subtest indicate that she has difficulty with monetary value, telling the time and extrapolating numerical value. It is hypothesized that because reading – i.e. the decoding process – comes so much more easily for [redacted] than math reasoning, her motivation is predicted to be significantly weaker for the latter subject. This testing is clear that *once [redacted] s motivation is gone, focus, effort and application are gone as well.*

As such, it is not clear as to whether the 'math motivation' or the math difficulty comes first, and, as such, whether there is a true math learning disability. Given that her standard score is so significantly discrepant from predicted values based on her General Ability Index of 88 – predicted to occur in less than five percent of the general population – one perhaps must give the benefit of the doubt and identify a mathemathical disability.

Given that [redacted] s working memory and processing speed are also very low, the application of a special needs designation based on a learning disability is very appropriate.

[redacted]'s personality work-up dramatically demonstrates her PDD status, insofar as her thinking and perceptions are highly egocentric and often atypical and bizarre, her ability to relate interpersonally in an appropriate reciprocal manner virtually nil and her emotionality labile, driven by significant anxiety and dysthymia.

[redacted]s cognitive functioning could not be accurately assessed due to her mood, level of receptivity and degree of motivation, which significantly affects her focus and attention. She is, however, without doubt, a highly verbal child. Although she can listen and comprehend others' language to a point (her receptive and expressive vocabulary fall at or below the 6th percentile). [redacted]s language emanates from her own very self-centred thinking and does not encompass the reciprocity or give-and-take found in normal social discourse.

Similarly, [redacted] cannot, perceptually or emotionally, adopt the perspective of the other. As such, she has an acutely difficult time establishing interpersonal connections because of her egocentricity and lack of ability to read social cues. She is, however, painfully aware of her lack of friends and holds the belief that people think she is "crazy". She identified that she hangs out by herself at school (recess, lunch): "other kids have school friends...but (not) me". She shared of her wish that others would be nicer to her but has no ability to relate others' reactions to her own idiosyncratic behaviour and alter it in adaptive fashion.

As such, [redacted] carries tremendous anxiety around her not fitting in, not having friends, her preoccupation with not being pretty enough and this interpersonal void exacerbates her retreat into atypical mental ideation as well, likely, her self-harming behaviours. She hurts, but she cannot share and benefit from others' input, because of her egocentricity and inability to adopt a reciprocal social view.

In the school setting, [redacted] feels misunderstood and picked on. She describes what she experiences as conflict between herself and her teacher, indicating that in her subjective perception her teacher isn't honest with her – i.e. thinks [redacted] avoids doing her work – and doesn't listen to or believe [redacted] when the latter communicates that she believes her peers are staring at her. She indicated that her teacher "never gets the other girls in trouble – only me – that's why I'm better with boys".

[redacted] fantasizes about being famous, about having actors as friends, as being able to tele-transport herself to other worlds, and to be able to communicate "with my fish". Clearly, she is a lonely and sad child who is not really anchored to anything or anyone. Within her family constellation, [redacted] identified that family members "don't get along" and that she gets upset when her mother "screws things up" – by which [redacted] meant her mom breaking into her fantasy life by making real demands on [redacted] (e.g. to clean up). She indicated that she does experience sadness when her mom attempts to discipline her – it sounds as though at times, out of pure frustration, [redacted]'s mother is reduced to ineffective overcontrol – i.e. yelling at [redacted] – which [redacted] indicated "really bugs me....my ears don't like it". [redacted] further indicated that her father "never gets mad at me...he talks to me and gives me a lesson without yelling". It is hypothesized, however, that mom, who has the brunt of discipline and interaction with [redacted] on a day-to-day basis, is forced to be the primary disciplinarian and that

"lessons", to which [redacted] refers, while received, do not alter [redacted]'s behaviour significantly.

[redacted]'s responses on the self-report BASC questionnaire yielded highly significant results in several areas. Both **Attitude towards School** and **Attitude towards Teachers** were significantly elevated (scores falling at the 99th percentile), indicating [redacted]'s experience of disliking school intensely and wishing she could be elsewhere, as well as subjectively experiencing her teacher as unfair and overly demanding. She also identified significant **Social Stress** (score falling at the 98th percentile) revealing her own experiencing of her difficulty in establishing and maintaining close relationships with others and consequently feeling lonely and isolated. This led to a significant score on the **Interpersonal Relations** subtest (score falling at the 5th percentile).

Further, the **Locus of Control** subscale was also highly elevated (score falling at the 98th percentile) indicating [redacted]'s own belief in her inability to control events in her life and her perception of being blamed for things she has not done. She further identified an extreme dissatisfaction with her ability to cope with various tasks, even when putting forth substantial effort (score on the **Sense of Inadequacy** subscale falling at the 99th percentile). As a result, she reports having very low confidence in her own ability to make decisions, solve problems, and be dependable compared to others her age (score on the **Self-Reliance** subscale falling at the 1st percentile).

Further, [redacted] reports feeling detached from family life and in her relationship with her parents, conveying a sense of feeling incidental to family life and decision-making.

It is not surprising, then, that [redacted] reports clinically significant levels of both **anxiety** and **depression** (scores falling at the 98th and 99th percentiles respectively), indicating her own identification of excessive worrying and generally feeling sad, misunderstood and pessimistic that life can get better.

BASC reports completed by both [redacted]'s mom as well as her teacher yielded very clinically elevated scores across **atypicality** (99th and 98th percentiles respectively), hyperactivity (99th and 97th percentiles respectively) **withdrawal** (99th and 97th percentiles respectively) **anxiety** and **depression** (99th percentile by both raters). [redacted] also identified significant *somatization* (score falling at the 96th percentile) wherein [redacted] continues to present with a high number of health-related concerns as well as *attentional* concerns (score falling at the 98th percentile). Interestingly, the teacher's ratings on the Attention Subscale fell within the borderline clinically significant range, at the 89th percentile, although her score on the **Hyperactivity** subscale was significant, as was mother's (scores falling at the 97th and 99th percentiles respectively. Further, both [redacted] and [redacted]'s teacher's ratings strongly indicate concern around [redacted]'s *adaptive functioning* and psychosocial adjustment, with scores falling within the borderline significant range (5th and 13th percentiles respectively).

Both [redacted] and [redacted]'s teacher further indicated concern around [redacted]'s lack of emotional self-control, her negativity in the face of changes in everyday activities or routines, and her executive functioning – i.e. her lack of ability to voluntarily control and maintain her

behaviour and mood. Both also indicate significant concern around their perceptions of [redacted]'s lack of resiliency and difficulty in 'bouncing back' from stress and adversity.

[redacted]'s teacher's ratings also yielded a clinically elevated score on the *Aggression* subscale, (97th percentile) indicating a high number of aggressive behaviours and argumentativeness and defiance in the class setting, as well as a significantly elevated score on the secondary content subscale of *bullying* (score falling at the 97th percentile), indicating that [redacted] has a marked tendency to be disruptive, intrusive and/or threatening to other students in class.

Relative Strengths & Weaknesses:

Relative Strengths	Relative Weaknesses
-verbal and nonverbal conceptualization	-receptive and expressive vocabulary
-verbal fluency	-working memory
-reading fluency	-visual processing speed
-sentence composition & spelling	-mathematics (especially problem-solving)
	-reading comprehension
	-listening comprehension
	-social interactive skills

CONCLUSIONS & RECOMMENDATIONS:

[redacted] is an ASD student whose presentation includes clinically significant levels of both anxiety and depressive affect. The diagnostic conceptualization would be as follows:

Axis I	299.80 Pervasive Developmental Disorder –NOS with pronounced anxiety and depressive symptomatology
	315.10 Mathematics Disorder
Axis II	-
Axis III	314.01 Attention Deficit/Hyperactivity Disorder, Combined Type
Axis IV	Problems with primary support group Problems related to the social environment Educational problems
Axis V	Global Assessment of Functioning (GAF = 40 – 45)

[redacted] REPORT CONFIDENTIAL

[redacted]'s presentation, in conjunction with current psychological data, strongly contra-indicates a transition into a regular [redacted]-school environment (as such would be within her community school). It is believed that such would only serve to exacerbate her anxiety and depressive symptomatology and might serve to heighten current self-harming behaviours.

A mental health classroom is recommended, in the hopes of assisting [redacted]'s transition from division 1 into division 11, providing her the safety of a protected and protective environment and a teacher-student ratio which would encourage and enable [redacted] to be exposed to and learn stronger coping strategies, as well as attend to academic work in a productive and more motivated manner.

It is entirely unclear as to the degree or extent to which [redacted] can learn more adaptive social behaviours; however, her placement in a mental health class would be the most advantageous in terms of helping her with such learning.

In terms of **mathematics**, the following recommendations may be beneficial:

-utilize as systematic and concrete a teaching approach as possible in introducing new math concepts;

-for problem-solving, the more effectively opportunities can be found to apply and integrate math with real life experiences, the greater the likelihood that [redacted] will be able to grasp the concept/process;

-work in small, incremental steps to allow for overlearning of each new unit;

-assist [redacted] in developing 'inner language' (when she is focussed) to mediate her way through math problems (e.g. what is the problem asking? which pieces of information do I need? what operation(s) is/are required? does this answer look right? does it fit?) ;

-manipulatives may also prove helpful so that [redacted] can learn through the tactile-kinesthetic as well as the visual and auditory channels. When possible, provide [redacted] with a permanent model/referent for different types of operations, outlining in clear detail the sequential order of the steps needed, to which she can refer when the need arises;

-adjust curriculum expectations so as to take into account [redacted]'s lack of consolidated mastery of concepts covered to date.

In terms of [redacted]'s weak **working memory**:

-reinforce auditorily-presented information with concrete visual reminders in the form of checklists, charts, pictures, graphs, etc.;

-whenever possible, encourage time for brief daily review (e.g. a daily warm-up quiz) which encourages long-term storage;

-teach [redacted] (when receptive) to use repetition procedures, recitation aloud (whispering to herself) and brief, intermittent rehearsal of newly learned material;

-teach [redacted] the use of mnemonic devices (rhythm/song, acronyms, abbreviations, etc.), visualization of material which needs to be remembered (i.e. creating a mental picture as a way to remember the information) and association (i.e. remembering how things relate to one another) to enable short-term memory;

-check in after the oral delivery of instructions to ensure [redacted] has heard them all;

-teach her to jot down key words/ideas when the teacher is presenting;

-evaluate each teaching/learning unit and 'chunk down' into smaller, more manageable segments when appropriate.

In terms of [redacted]'s **graphomotor speed,** assuming she is invested and focussed, if she requires extra time to complete the work, such should be given.

SUMMARY

These findings were shared with [redacted] at the parent meeting held on April 23rd, 2013. Also present were [redacted] principal, [redacted] IRT, [redacted] [redacted]'s teacher, and this psychologist.

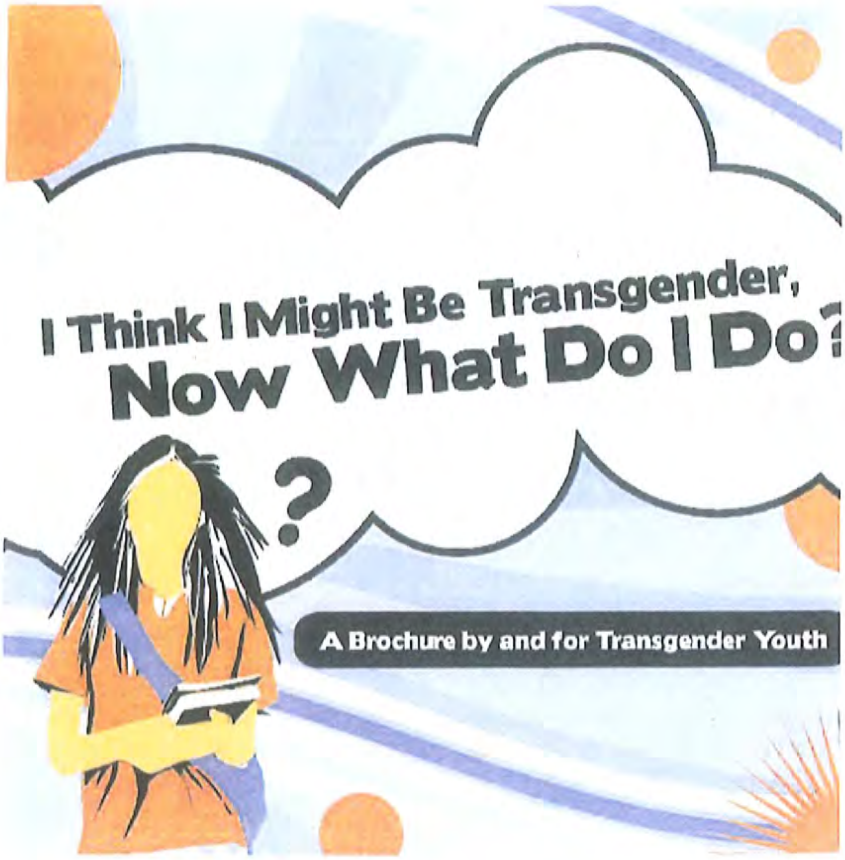
Results were discussed within the context of [redacted]'s PDD and [redacted] were very receptive to the recommendation of a mental health class setting, although they were informed that the referral process itself does not guarantee a placement therein.

[redacted] Ph.D., R. Psych. Report Date: 04/19/ 2013 Parent Consultation: April 23rd, 2013
Registered Psychologist

Note: Due to the developing and changing nature of children's/students' skills and abilities, circumstances, and mental health, the results, diagnosis, and recommendations contained in this report are meant for current use. Any reference to these results and recommendations in the future should be made with these reservations in mind.

THIS IS EXHIBIT " B "
referred to in the Affidavit of
A A
Sworn before me this 18th
day of January A.D. 20 19
A Commissioner in and for the Province of Alberta

James Kitchen
Barrister & Solicitor



What Does It Mean to Be Transgender?

Transgender people feel that the gender to which they were born, or assigned at birth, does not fit them. Transgender people include people born female who identify as male (female-to-male) and people born male who identify as female (male-to-female).

You may feel more comfortable relating to people who perceive you as the gender you see yourself. You may simply feel you would be more truly yourself in another gender. People who are transgender may feel any or all of these emotions.

Am I Normal?

Since identifying myself as gender variant, I've met several other people my age who do, as well as lots of adults and also lots of other people who respect and love gender variant people. It may not be 'normal' to many people, but it's certainly healthy and widespread. And despite how it feels sometimes, I know I'm not the only one who feels the way I do.
Mark, 18

It's normal for me. I couldn't stand living the rest of my life in my biological gender. I have been through reams of depression and low spots, and I have looked over my past; all these spots were caused by my deep need to be male.
Riley, 22

Being transgender is as normal as being alive. Throughout history, many people have felt they were transgender. Transgender people are everywhere. They are teachers, doctors, construction workers, and waiters. They attend college, have children, and enjoy careers.

You may interact with other transgender people every day and not know it! Certainly, being transgender is not "typical," and you may encounter many people who do not understand or who feel uncomfortable or even discriminatory. However, you are certainly normal.

What Will Happen When I Come Out?

That depends on your family. Mine is fairly accepting of me and now, almost six years after I came out, mostly treats me as if I had been born a girl.
Tasha, 19

I cannot continue living inside this male body. My femininity has been repressed too long.
I need to be free of my cage.
Lana, 26

I plan to medically transition. I don't feel that I will ever be comfortable being viewed as female.
Riley, 22

Some people who come out as transgender are comfortable telling a close circle of friends. Other people choose to change their name, their pronouns, their style of dress, and their appearance to be congruent with their gender identity. Still others choose to take hormones and have surgery to medically alter their appearance.

As you decide which, if any, steps to take, it can help to talk about these feelings with others, such as a mental health professional who is competent with gender identity issues, friends and family members you trust, and other transgender people. You should express yourself the way you feel most comfortable, without pressure from others.

Medical transition, the taking of hormones and having one or more surgeries, is a big step. For some, it is absolutely necessary. Most people who choose to transition medically strongly need identity and body to match. They want to be seen all the time and without question, as the gender they feel they are. To medically transition, you must first see a therapist and, in most cases, be diagnosed with Gender Identity Disorder. In most states, if you are under 18, you will need a parent's permission to undertake medical transition.

Who Should I Tell?

I tell myself first, repeatedly. I keep it up until I love myself. Once I'm bored, that means that my mind has completely come to terms with what I'm telling it. Then I'll be ready to tell others.
Lane, 26

People had all sorts of reactions to my coming out. I lost a few friends and a lot of dates, but most people really tried to understand. Not everyone can get it, but with time and respect, people have learned to understand.
Mark, 16

The first person I told was my girlfriend at the time. I told her before we got serious. I also told two close friends, my sister, and then my parents. After that, I considered myself out and didn't hide it anymore.
Chris, 19

There is no obligation to tell anyone about your identity. However, many people find it very important to share who they are with others, especially if they plan to transition publicly. If you decide to share your identity, first tell people with whom you are comfortable and that you feel will understand. They might include a trusted teacher, counselor, sister, brother, parent, friend, or people at a youth group for gay, lesbian, bisexual, and transgender (GLBT) people.

Some young people stop there and choose to transition more fully later in life, but other youth choose to begin to live full-time as their identified gender. If you choose to do this, you may need to come out to many different people. You should definitely look for support when going through this process, from a therapist, a youth group, friends, family, and others.

What Is It Like To Be Young And Transgender?

Until I graduated from high school, it was horrible. Afterwards, it has been wonderful being seen as a woman wherever I go.
Trisha, 20

Most people will doubt your judgment because of your age. It may take a lot more talking to convince the 'adults' that you really know who you are.
Chris, 19

Being young and transgender is just like being young and anything else. People our age accept us more readily than adults do, just like all other kids who are different. We do the same sorts of things that other kids do for fun, like playing sports, reading, writing, dating, and listening to music.
Mark, 16

Some young people who are transgender feel a great relief that they have discovered how they are most comfortable expressing themselves. Other youth feel frustrated at being discriminated against or because they aren't yet able to transition.

Still other young people find that being transgender is just one part of who they are and that they mostly think about all the things that many youth think about—school, dating, work, and family. There are as many ways to be young and transgender as there are ways to be young.

What About Sexually Transmitted Infections, HIV, And Pregnancy?

Remember that not having sex is the surest way to avoid unintended pregnancy as well as HIV and other sexually transmitted infections (STIs). In fact, many youth choose to show affection through activities such as hugging, kissing, talking, and massage. If you choose to have sex, be responsible and talk with your partner about methods of protection for both of you. It's your responsibility and your partner's to protect both of you from unwanted outcomes.

Transgender people can have a hard time finding safer sex information that speaks in language that reflects how they feel about their body. Because many may feel that their biological body doesn't reflect their gender identity, they may use different terms for body parts. Finding information that corresponds to an internal/emotional body concept can be difficult. No matter how transgender youth label sexual body parts, some or all of the following tips apply to each:

- For vaginal intercourse where there is a risk of pregnancy, use a latex or polyurethane condom and also another effective method of contraception, such as birth control pills or Depo-Provera.
- When touching someone else's genitals with your hands, use a latex or polyurethane barrier, such as surgical gloves.
- For oral sex, regardless of the genital area that the mouth touches, use a condom, a dental dam, or saran wrap.

- For anal intercourse, always use a latex or polyurethane condom with non-petroleum based lubrication, such as KY Jelly.
- When sharing sex toys, always use a latex or polyurethane condom with non-petroleum based lubrication

Two Important Tips:

- Lubrication—Do not use petroleum- or oil-based lubricants with latex condoms because such lubricants weaken and/or destroy the latex. Use only water-based lubricants, such as KY Jelly. Avoid using nonoxynol-9, because it may cause irritation and increase the risk of infection with HIV or other STIs.
- Remember that blood-to-blood contact is the surest route for HIV infection. Sharing drug paraphernalia or needles—whether for piercing or tattooing the body, taking medications, or using drugs—is highly dangerous, since blood left on the used equipment or needle will come into contact with your blood as soon as you use the equipment or needle. Avoid sharing needles, razors, or other such paraphernalia, for any purpose.

How Do I Learn to Like Myself?

For me, it's a matter of continuing to focus on what I like about myself, what I think is great about my body, hanging out with positive people, and avoiding as much as I can the negative messages directed towards women (particularly transwomen) in the media.
Bryan, 23

Coming to terms with who you really are is the most important step that anyone can make in this situation. How far you decide to go with it is important, but never as important as accepting yourself because accepting yourself will lead to liking yourself. Riley, 22

If you have just discovered or recognized that you are transgender, remember that you are normal and you are likeable, just as you are. With big discoveries come big life changes, and it is normal to feel nervous, apprehensive, and upset about the days ahead. Remember, too, that discovering something this important about yourself can be a truly amazing experience. You are one step ahead on the journey of discovering who you truly are, and with that journey, the world becomes full of possibilities as well as challenges. You are getting to know another part of yourself, and this is truly a wonderful opportunity!

What Resources Exist for Transgender Youth?

Remember that you're not alone, and there is help out there:

www.youthresource.com is a Web site for youth who are gay, lesbian, bisexual, and transgender. It has some great information for transgender youth, as well as online message boards where you can talk with other young people who are facing the same or similar issues.

www.pflag.org offers lots of information for friends and family of transgender people.

Talking to others who face the same issues can help you learn to like yourself while, at the same time, giving you opportunities to help others.

If you plan to pursue medical transition, it is important that your transition be supervised by a medical professional. Undertaking transition without professional medical guidance can have severe health risks.

What Does Transgender Mean About my Sexual Orientation? Am I Gay or Straight or What?

I love guys!! I love to look at them, love how they move. I see myself as a heterosexual female.
Tasha, 19

I have always been attracted to females, but transgender people may be attracted to the opposite or to the same sex, and some are bisexual.
Riley, 22

I thought I was a lesbian, because I was primarily attracted to women. Now I identify as 'queer' as an umbrella term, and avoid a label, though I am bisexual. Since coming out as male, my attraction has risen to other males.
Mark, 19

Being transgender has to do with your gender identity: how you feel about who you are. It has nothing to do with your sexual orientation, which is about who attracts you. Some transgender people are attracted to men, some to women, some to other transgender people, and some to people regardless of their gender. People may define themselves with different labels, depending on who attracts them. For example, some transgender women who are attracted to men define themselves as straight, because they are attracted to the opposite gender.

That depends on your family. Mine is fairly accepting of me and now, almost six years after I came out, mostly treats me as if I had been born a girl.
Tasha, 19

Coming out as trans was the hardest thing I've ever done. Sometimes, I can't believe I ever did it. Since then, everything has happened very quickly. It depends on your financial situation and what you want to do. I started therapy shortly after coming out, and within eight months (of coming out), I started testosterone therapy. What matters is that you do what you're ready to do and at the pace that makes you comfortable.
Chris, 19

Some people feel relieved and happy when they come out. Others feel as if they are thrown into a lion's den, with challenges from parents, friends, and family. You will most likely experience a bit of both. Some transgender youth may face violence at school or in their home.

Please, make sure you have people you can talk to before you come out publicly, just for this reason. As you come out, you may find PFLAG (Parents, Families, and Friends of Lesbians and Gays) a useful resource. To make coming out easier, surround yourself with as much information, knowledge, and support as possible.

What Does it Mean to Transition? Should I do it?

I know lots of people who have gone through medical transition and lots who haven't. I have not and I don't plan to. People whom I really care about tend to accept me as I am, so I don't feel that I need to. People who are happiest seem to just do what feels right for them.
Mish, 18

Transgender people also include people who identify as "genderqueer", gender neutral, and/or gender-free—people who may not identify as either male or female.

Transsexual people are those who choose to medically transition to the gender that is right for them. Cross-dressers are people who like to wear the clothes of another gender but who don't identify as another gender. You may find yourself identifying with one or more of these definitions pretty strongly or with none of them at all. No one has to rush to self-label, now or ever, and some people choose different labels that express more clearly how they see themselves.

How Do I Know If I'm Transgender?

I've always felt that I was a girl from the time I can first remember.
Rocky, 19

I know I'm transgender because my brain knows it's female, and my body disagrees.
Lena, 26

You may feel that you are more comfortable expressing yourself as a gender other than the gender you were born or assigned at birth. This gender might be the "opposite" of the gender you were born or assigned, or it might be neither male nor female but something else entirely! You may feel extremely uncomfortable with the gender-specific parts of your body. For example, you may have breasts and prefer not to have them. Or, you might not feel uncomfortable with your gender-specific body parts and, at the same time, feel a deep need to have other body parts.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A *School Library Journal* Best Book of the Year

A *Kirkus Reviews* Best Book of the Year

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A *Publishers Weekly* Flying Start

GEORGE

ALEX GINO

Scholastic Inc.

TO YOU, FOR WHEN YOU FELT DIFFERENT

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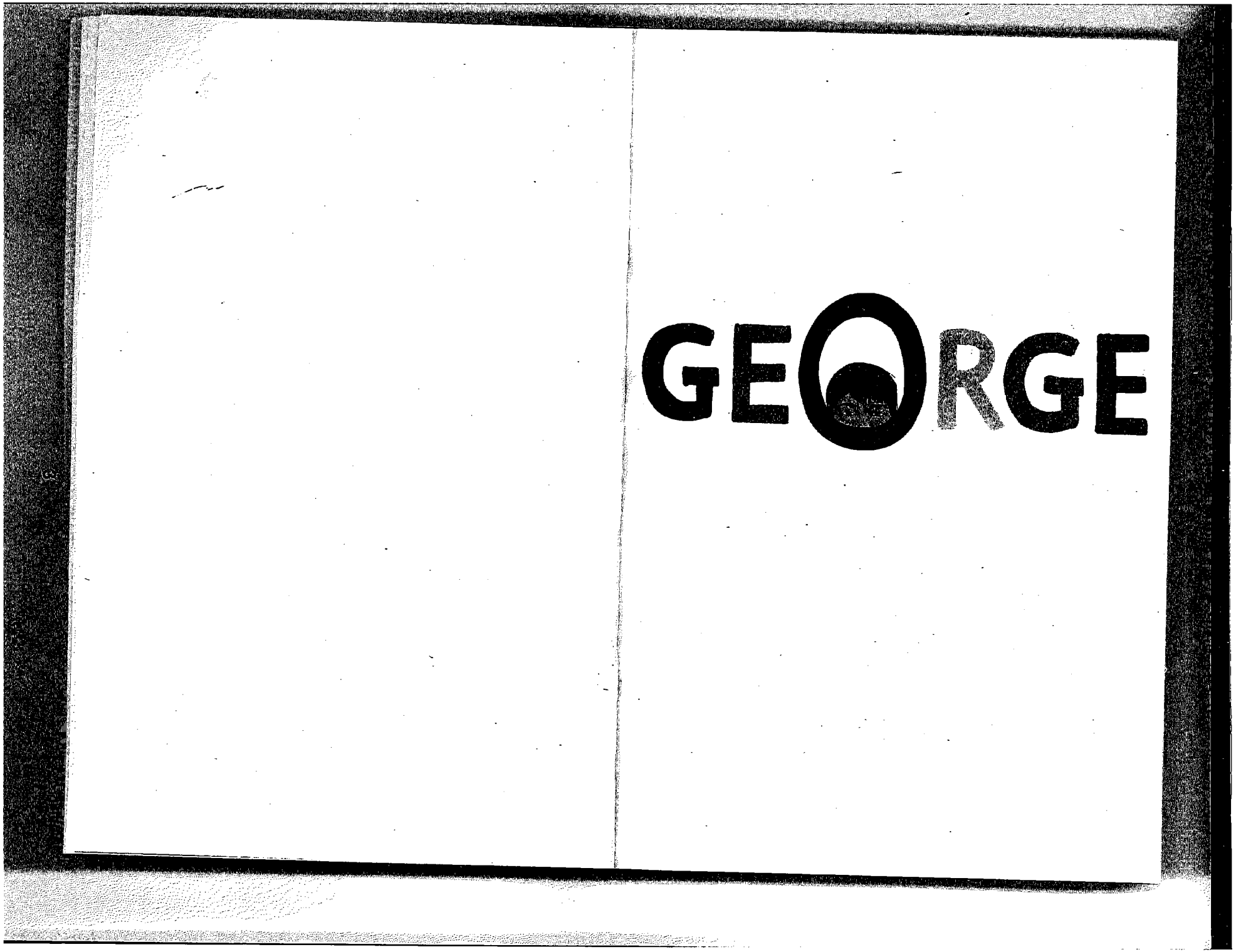
GEORGE

chapter 1

SECRETS

George pulled a silver house key out of the smallest pocket of a large red backpack. Mom had sewn the key in so that it wouldn't get lost, but the yarn wasn't quite long enough to reach the keyhole if the bag rested on the ground. Instead, George had to steady herself awkwardly on one foot while the backpack rested on her other knee. She wiggled the key until it clicked into place.

Stumbling inside, she called out, "Hello?" No lights were on. Still, George needed to be certain the house was empty. The door of Mom's room was open and the bedsheets were flat. Scott's room was unoccupied as

well. Sure that she was alone, George went into the third bedroom, opened the closet door, and surveyed the pile of stuffed animals and assorted toys inside. They were undisturbed.

Mom complained that George hadn't played with any of the toys in years, and said that they should be donated to needy families. But George knew they were needed here, to guard her most prized and secret collection. Fishing beneath the teddy bears and fluffy bunnies, George felt for a flat denim bag. Once she had it in hand, she ran to the bathroom, shut the door, and turned the lock. Clutching the bag in tightly wrapped arms, George slid to the ground.

As she tipped the denim bag on its side, the silky, slippery pages of a dozen magazines fell out onto the tiled bathroom floor. Covers promised HOW TO HAVE PERFECT SKIN, TWELVE FRESH SUMMER HAIRCUTS, HOW TO TELL A HOTTIE YOU LIKE HIM, and WILD WINTER WARDROBES. George was only a few years younger than the girls

smiling at her from the glossy pages. She thought of them as her friends.

George picked up an issue from last April that she had looked through countless times before. She browsed the busy pages with a crisp *flip-flip-flip* that stirred up the faint smell of paper.

She paused on a photo of four girls at the beach. They modeled swimsuits in a line, each striking a pose. A guide on the right-hand side of the page recommended various styles based on body type. The bodies looked the same to George. They were all girls' bodies.

On the next page, two girls sat laughing on a blanket, their arms around each other's shoulders. One wore a striped bikini; the other wore a polka-dot one-piece with cutouts at the hips.

If George were there, she would fit right in, giggling and linking her arms in theirs. She would wear a bright-pink bikini, and she would have long hair that her new friends would love to braid. They would ask her name,

and she would tell them, *My name is Melissa.* Melissa was the name she called herself in the mirror when no one was watching and she could brush her flat reddish-brown hair to the front of her head, as if she had bangs.

George flipped past flashy ads for book-bag organizers, nail polish, the latest phones, and even tampons. She skipped over an article on how to make your own bracelets and another on advice for talking to boys.

George's magazine collection had started by accident. Two summers ago, she had noticed an old issue of *Girls' Life* in the recycling bin at the library. The word *girl* had caught her eye instantly, and she had slipped the magazine in her jacket to look at later. Another girls' magazine soon followed, this time rescued from a trash can down the block from her house. The very next weekend, she had found the denim bag at a yard sale for a quarter. It was just the size of a magazine, and had a zipper along the top. It was as if the universe had wanted her to be able to store her collection safely.

George settled on a two-page spread about FRAMING YOUR FACE WITH MAKEUP. George had never worn makeup, but she pored over the range of colors on the left side of the page. Her heart raced in her chest. She wondered what it would feel like to really wear lipstick. George loved to put on ChapStick. She used it all winter, whether or not her lips were really chapped, and every spring she hid the tube from Mom and wore it until it ran out.

George jumped when she heard a clatter outside. She looked out the window to the front door directly below. No one was in sight, but Scott's bike lay in the driveway, the back wheel still spinning.

Scott's bike! That meant Scott! Scott was George's older brother, a high school freshman. The hair on George's neck stood up. Soon, heavy footsteps climbed the stairs to the second floor. The locked bathroom door rattled. It was as if Scott were rattling George's heart inside her rib cage.

Bang! Bang Bang!

"You in there, George?"

"Y-yeah." The shiny magazines were spread across the tile floor. She gathered them into a pile and stuffed them into the denim bag. Her heart was thumping almost as loudly as Scott's foot against the door.

"Yo, bro, I gotta go!" Scott yelled from the far side.

George zipped up the bag as quietly as she could and looked for a place to stash it. She couldn't walk out with it. Scott would want to know what was inside. The bathroom's one cabinet was stuffed with towels and didn't shut all the way. No good either. Finally, she hung the bag from the showerhead and closed the curtain, desperately hoping that this wouldn't be the moment Scott discovered personal hygiene.

Scott rushed in as soon as George opened the door, unzipping his jeans before he reached the toilet. George exited quickly, closed the door, and leaned on the wall

outside to catch her breath. The bag was probably still swinging in the shower. George hoped it wouldn't hit against the curtain or, worse, fall and land in the bathtub with a thud.

George didn't want to be standing near the bathroom when Scott came out, so she went down to the kitchen. She poured herself a glass of orange juice and sat at the table, her skin tingling. Outside, a cloud passed overhead and the room grew darker. When the bathroom door banged open, George jumped in her seat, splashing juice on her hand. She realized she had barely been breathing.

Thump, thump, thump-thump-thump-thump-thump. Scott tromped downstairs, a DVD case in his hand. He opened the refrigerator door, pulled out the carton of orange juice, and took a long swig. He wore a thin black T-shirt and jeans with a small hole in the knee. He hadn't gotten a haircut in months, and dark-brown curls formed a mop on his head.

"Sorry if I busted in on you while you were taking a dump." Scott wiped the juice off his lips with his bare forearm.

"I wasn't taking a dump," George said.

"Then what took you so long?"

George hesitated.

"Oh . . . I know," Scott said. "I'll bet you had a magazine in there."

George froze, her mouth half-open and her brain mid-thought. The air felt warm and her mind swirled. She put her hands on the table to make sure she was still there.

"That's it." Scott grinned, oblivious to George's panic. "That's my little bro! Growing up and looking at dirty magazines."

"Oh," George said out loud. She knew what dirty magazines were. She almost laughed. The girls in the magazines she was looking at wore a lot more clothes than

that, even the ones at the beach. George relaxed, at least a little.

"Don't worry, George. I won't tell Mom. Anyway, I'm heading back out. Just had to get this." Scott shook the black plastic box he held in his hand, and the DVD inside rattled. "Haven't even seen it yet, but it's supposed to be a classic. It's German. The title means something like *The Blood of Evil*. When the zombies gnaw this one guy's arm off and kill him, this other guy has to use the gnawed-off arm of his dead best friend to fight the zombies. It's awesome."

"It sounds gross," George said.

"It is!" Scott nodded enthusiastically. He took another gulp of orange juice, put the carton back into the fridge, and headed for the door.

"I'll let you get back to thinking about girls," Scott joked on the way out.

George dashed up to the bathroom, rescued her bag,

and buried it deep inside her closet, under the toys and stuffed animals. She put a pile of dirty clothes on top, just in case. Then she closed the door and collapsed face-first onto her bed, her hands crossed over her head, pressing her elbows to her ears and wishing she were someone else—anyone else.

chapter II

CHARLOTTE DIES

Ms. Udell leaned against her giant desk, reading to her fourth-grade class from a tattered copy of *Charlotte's Web* by E. B. White. She wore her shiny black hair in a loose bun, and wooden earrings dangled from her long earlobes.

In her seat by the window, George couldn't listen. She couldn't think. Charlotte, the wonderful, kind spider, was gone and nothing was good. The whole book was about Charlotte saving the runt pig Wilbur, and then she goes and dies. It wasn't fair. George pushed her fists into her eyes, rubbing until rows and rows of tiny triangles twirled and twinkled brightly in the darkness.

A tear dropped onto George's book and spread into a spiderweb on the page. She breathed in carefully, trying not to make a sound. Shallow breath followed shallow breath until she was dizzy. She inhaled deeply, and as she did, she sniffled. Loudly. George heard whispers, clear in the quiet room.

"Heh, some girl is crying over a dead spider."

"That ain't no girl. That's George."

"Close enough," followed by laughter.

George didn't turn to look. She didn't need to. She knew exactly what she would see. Rick sat two rows over from George, and Jeff sat behind Rick. Jeff would be leaning forward in his seat, with his spiky hair nearly on Rick's shoulder. Rick would be leaning back in his shiny black baseball jacket. They would both be holding their hands to their mouths, halfheartedly trying to keep quiet.

Once, George and Rick had been friends, or at least friendly. In second grade, there had been a class

checkers tournament, and George and Rick had been the two best players. The final match of the competition had been close, with Rick barely winning after he'd been able to king his final piece. Even though George had lost, the two had still called each other Checkers Champs for weeks.

In third grade, Jeff joined the class. Jeff had moved from California and wasn't happy about it. He started a few fistfights and threatened most of the boys at first, including George. But Jeff settled in by October, and once Jeff and Rick became buddies, Rick wasn't so friendly with George anymore. By winter break, Jeff and Rick were inseparable, and now it was as if the Checkers Champs were two kids who had known each other once, but had never met either George or Rick.

Ms. Udell glared at the snickering boys, cleared her throat, and read the final paragraph of the chapter. Her students were old enough that she rarely read aloud to them, but today she wanted them to be able to

focus on what she called the "magnificent melancholy of Charlotte's final moments."

When she was finished, Ms. Udell closed the book, placed it on top of a pile of papers on her desk, and removed her glasses. "I'd like all of you to take out your journals and spend a few minutes with your reactions to this chapter. You may take a moment to reflect, but then get your pencils moving. I want you to dig deep and use some *feeling* words."

Room 205 filled with the sounds of journals being removed from desks, pages being turned, and pencils being searched for. Ms. Udell walked down the aisle toward Jeff and Rick, and spoke to them privately. Her voice blended in with the noise of the room, so George could barely hear her even though she was only two seats away.

"Some of us take death very seriously." Ms. Udell's words were icy. She looked at Jeff and Rick in turn; they each stared at their sneakers. "It is a solemn topic, and I

hope that you will respect yourselves, your classmates, and life itself by treating it as such."

Jeff and Rick mumbled apologies. George wasn't sure whether their halfhearted *sorrys* were meant for her, Ms. Udell, or Charlotte. She wasn't sure she cared. The moment Ms. Udell turned away, Jeff rolled his eyes. Jeff was always rolling his eyes at something, usually with a snide comment to match.

Ms. Udell passed by George's desk. "To be honest, I'm not sure what I think of a person who doesn't cry at the end of *Charlotte's Web*."

"You didn't," George mumbled.

"I did the first three times . . . and a good number of times since." Ms. Udell paused, and for a moment it looked as if she might tear up right then. "My point is, it takes a special person to cry over a book. It shows compassion as well as imagination." Ms. Udell patted George's shoulder. "Don't ever lose that, George, and I know you'll turn into a fine young man."

The word *man* hit like a pile of rocks falling on George's skull. It was a hundred times worse than *boy*, and she couldn't breathe. She bit her lip fiercely and felt fresh tears pounding against her eyes. She put her head down on her desk and wished she were invisible.

Ms. Udell returned with the bathroom pass. It was a worn wooden block from a kindergarten class and read BOYS in thick green permanent marker on one side. George flipped the block over with a hollow *slap* so the side facing her read ROOM 205.

Ms. Udell put her hand on George's shoulder, but George shook her off and stood up. She could barely see her way to the classroom door through her tear-blurred eyes, and she navigated the hallway more from memory than sight. She stumbled, sobbing, into the bathroom—the boys' bathroom. Her lips trembled and salty tears dripped into her mouth.

George hated the boys' bathroom. It was the worst room in the school. She hated the smell of pee and

bleach, and she hated the blue tiles on the wall to remind you where you were, as if the urinals didn't make it obvious enough. The whole room was about being a boy, and when boys were in there, they liked to talk about what was between their legs. George tried never to use it when there were any boys inside. She never drank from the water fountains at school, even if she was thirsty, and some days, she could make it through the school day without having to go once.

George put her head down close to the faucet and splashed cold water over her neck until she shivered. Then she rubbed a clump of paper towels on her head. She combed strings of still-wet hair with her fingers and smiled weakly at herself in the mirror.

Back in the hallway, George held the hall pass loosely in her fingers and let it drag along the wall, sending vibrations up her hand. The rhythmic *click* echoed down the hall as the wooden block skipped over the thin strips of cement between the tiles.

George opened the classroom door slowly, fearing laughter, but students were too focused on their journals to notice her return. The topic, "Personal Reactions," was written on the board in Ms. Udell's careful print. George pulled out her journal and wrote the date and the topic. By the time she had written *Charlotte is dead*, journal time was over.

Ms. Udell didn't ask anyone to read aloud. Instead, she addressed the class. "Tomorrow the real fun begins! For now, I am pleased to say that we are done for the day." She spoke the rhyme as if it were a short poem. "Put away your notebooks, and we'll see which row is ready to get its things."

By *fun*, Ms. Udell was referring to the play version of *Charlotte's Web* that the two fourth-grade classes would perform for the younger grades. It was a school tradition that each spring, every student in the first through fourth grades read the same book. The first graders had the story read to them by their teachers, and sometimes

even the kindergartners participated. Every grade then did some sort of project. As the oldest students participating, the fourth graders put on a play of the book for the younger grades as well as for the parent-teacher association. Only the fifth grade wasn't involved, because they needed to focus on the spring tests to make sure they graduated and moved on to middle school.

Ms. Udell had called four rows of students, and the room was filled with the sounds of zippers and backpacks being dropped onto wooden desks. George's row was the last to be called, and the kids in it had their eyes trained on Ms. Udell.

"Row one."

Chairs screeched against the floor. George gathered her things slowly, stalling as long as she could before joining the boys' line. She wanted as much distance from Jeff and Rick as possible.

Ms. Udell's class walked through the halls of the school and down to the yard. The bus kids were released

as a group, while other children waited with Ms. Udell to meet up with their parents, grandparents, or baby-sitters. George headed to her bus line.

"George, wait up!" a voice called from behind her. Kelly, George's best friend, wore her hair in braids and smelled like oranges and pencil shavings. She wore a T-shirt that read:

99% GENIUS

1% CHOCOLATE

"My dad said you could come over this weekend to practice," she said as soon as she got to George. She had been chattering about the auditions all week. "You do still want to be in the play together, right?"

George did want to be in the play. More than anything. But she didn't want to be some smelly pig. She wanted to be Charlotte, the kind and wise spider, even if

it was a girl's part. Her mouth was open, but she couldn't speak.

Kelly held up her hands, palms in front of George's eyes. "I am Kelly the All-Wonderful and All-Knowing," she intoned. "I can sense that you are not well. Now, my child, what seems to be your problem?" She closed her eyes and slowly brought her hands to the sides of George's head, peeking just a little bit to make sure she didn't poke her best friend in the eye.

"If you're all-knowing, then don't you already know?" George asked.

Kelly opened her eyes long enough to cross them so that they pointed at her nose. Then she fluttered her eyelids shut.

"Fine. I am Kelly the All-Wonderful and Mostly Knowing. I will try to sense your problem." She opened her eyes again and dropped her hands. "I know! You've got stage fright. I know all about stage fright. My uncle

Bill says my dad has terrible stage fright and that's why he lets other people get rich performing his songs."

"It's not stage fright."

"Okay, maybe not. I don't think my dad has stage fright either. He's just a different kind of artist." Kelly shook George's shoulder. "But then, what *is* it? You *know* I can't handle suspense. Tell me or I'll . . ."

"Or you'll what?"

Kelly's eyes gleamed with inspiration. "Or I'll bring out my army of beasts to attack you in the night, and suck out your brains with a crazy straw, and make you one of my minions so you have to do everything I say. Including telling me what you're thinking about! What is it? What is it? What is it?"

George looked around to make sure no one else could hear.

"Okay, okay, calm down! Here's the thing. I don't really want to be *Wilbur* in the play," she told Kelly.

"Oh. That's not a problem. There are a lot of other parts in the play. They're called supporting roles. My dad says the best star performers would be nothing without an excellent supporting cast. Let Ms. Udell hear you and decide what part you should have."

"I don't want just any part," said George.

"Well, who do you want to be? Templeton the rat?"

George shook her head.

"Avery?" Kelly guessed. "Mr. Zuckerman? Mr. Arable?"

George still shook her head.

"Who else is there?" Kelly asked incredulously.

"I want to be Charlotte," George whispered.

Kelly shrugged. "That's cool. If you want to be Charlotte, you should try out for Charlotte. You make such a big deal out of everything. Who cares if you're not really a girl?"

George's stomach dropped. She cared. Tons.

On the street, one of the buses started its engine.

"I gotta go!" Kelly broke into a run. "One-two-three!" she called behind her.

"Zoot," George replied. Back in first grade, Kelly and George had decided that saying *one-two-three-zoot* was a lot more fun than saying *good-bye*. They had heard it on a cartoon, and it had made them laugh all day. Neither of them could remember anymore what show it was from, and sometimes it seemed silly to still be saying *one-two-three-zoot*, but neither wanted to be the first one to stop.

● ● ●

That night, George dreamed she was onstage as Charlotte. She wore all black, with extra limbs running down her sides, and she recited the most beautiful words for the entire auditorium to hear. Her first line was delivered perfectly, as was the second. But then there was a strange noise overhead. George looked up, but all

she could see was the heavy stage curtain, which enveloped her in a stuffy darkness before knocking her off the ladder. Then she was falling and couldn't breathe for what felt like a very long time.

George woke up in a sweat. It took a moment to realize she was awake, in her bed, and not suffocating. Her bedsheet was twisted around her legs.

Still, she couldn't shake the image of being Charlotte. As she ate her cereal and milk, as she dressed in jeans and a T-shirt, as she brushed her teeth, she pictured herself greeting the audience with a fine "Salutations." She should be the one to declare Wilbur *terrific*. And she should be the one to make people cry with her final farewell.

chapter III

ACTING IS JUST PRETEND

George lived in the left side of a two-unit house with Mom and Scott. When George referred to her family, Mom and Scott were usually who she meant. Dad lived with his new wife, Fiona, in a house in the Pennsylvania Pocono Mountains, a few hours away. Scott and George visited every summer for two weeks, like sleepaway camp. Dad made a better part-time father than a full-time one.

Mr. and Mrs. Williams lived in the other half of the house. They were a retired couple whose adventures outdoors generally consisted of a daily slipper-clad shuffle to pick up the mail and newspaper. George found them

calm and likable, and hoped they never moved away. If a new family moved in next door, they might have a boy her age. Then Mom would expect George and the boy to be best friends.

You two will have so much fun, Mom would say. *Just introduce yourself and smile.* Mom was smart, and George loved her a lot, but Mom didn't know about boys. Boys didn't like George, and George wasn't so sure what she thought about them, either.

George walked her bike from the shed in the backyard, along the cracked cement path, and up to the street. It was Sunday afternoon, and Kelly had invited her over to practice for Monday's auditions. Kelly said they could take turns playing Charlotte, and George's stomach danced at the idea of reading the spider's words aloud. George biked to Kelly's house, her short afternoon shadow leading the way down the main road.

Kelly and her father lived in a two-room basement

apartment, and their front door was really a back door. The backyard was more pavement than grass, though tufts of green sprouted eagerly through cracks in the concrete.

George propped her bike against the back wall of the house, hung her helmet from the handlebar, and guided herself down the three treacherously steep concrete steps, holding on to the thin metal railing for support. She knocked hard on the wooden door to compete with the rock music blasting inside.

Kelly greeted her with a giant smile. The apartment opened directly into a large, messy room. Kitchen appliances and a sink full of dishes lined one wall. In another corner sat an unmade daybed. Cardboard boxes were stashed everywhere. Piles of books and papers were stacked up wherever they would fit: on the desk, on the bookcases, in shoe boxes above the bookcases, on top of the TV, pouring out of the open closet. George had even seen sheet music peeking out of the freezer a few times.

(Kelly had said that was for when her dad needed to let a piece of music cool down before he could work on it some more.) A single standing lamp attempted to light the room, but the corners of the apartment were encased in shadows.

Kelly's father was a musician, but he didn't play onstage very often. Instead, he wrote music for other people to perform. Kelly swore the people her dad had written for were famous, but George never recognized their names. When Kelly came over to George's for dinner, she loved to rattle off the singers and bands to George's mom, who recognized a few.

Today, Kelly's father sat in the middle of the floor, his eyes intent on the paper in his hands. He was surrounded by dozens of stacks of sheet music stretching across the room, both loose and bound into books. Some of the stacks were over two feet tall. He added the page he was holding to a pile behind him that looked ready to topple.

"My dad's cleaning!" Kelly announced. "What do you think?"

"Wow," said George. That seemed to cover the extent of the damage.

"Got to mess it up before you can fix it up," Kelly's dad yelled over the music. He picked his way over to the stereo to turn down the volume. "Hey, George."

"Hey." George never knew what to call Kelly's father. *Mr. Arden* was too formal for a person like him, but George felt funny calling an adult by his first name, even though he had said "Call me Paul" more than once. To George, he was just Kelly's dad, but she didn't think he really wanted to be called that.

"So, you here to be a big-time actor?" he asked as he lifted a box off a pile and added it to the mess on the ground.

"I guess so," said George.

"C'mon, let's get started." Kelly took George by the

hand and walked her across the stained beige carpet to the door of her room. "Have fun with your project, Dad. Knock if you need us. And try to keep it down. We've got lines to rehearse, and you know how important those are."

"Yes, ma'am!" Kelly's dad gave a firm nod and returned his attention to the next piece of sheet music on the pile in front of him.

Walking inside Kelly's room was like entering another world. The desk and bureau were spotless, her bed was neatly made, and dozens of framed photographs hung stylishly on the walls. Fresh vacuum lines streaked across the rose-pink carpeting, and the air smelled like lemons.

"Wow, Kelly. Your room's even neater than usual."

"I went on a cleaning binge. It's what inspired my dad."

"Maybe you should give him lessons."

"Ha! He thinks finding lost stuff is half the fun. He says it's like digging for gold. Anyway, I think you've got a great idea."

"What idea?"

"Trying out for Charlotte. Ms. Udell will love that you care so much about the character that you want to play her onstage, even though she's a girl and you're a boy. Plays are all about pretending, right?"

"Um . . ." was all George could say. Playing a girl part wouldn't really be pretending, but George didn't know how to tell Kelly that. Besides, it was hard to stop Kelly once she got started. Mom said that Kelly should be a lawyer. Kelly said her dad would sue her if she tried.

"You know," Kelly continued, "she'll probably give you the part just to make the point. She's always going on about how we're not supposed to let people's expectations limit our choices."

"But it's more than just the play," George tried to explain.

"Of course it is. There's a whole history of boys playing girls in *thee-ay-trah.* Did you know that all the characters in Shakespeare's plays were played by men? Even the girl parts. Even when they had to kiss! Can you believe it?"

George thought for a moment about kissing a boy, and the idea made her tingle. Living in Shakespeare's time didn't sound so bad, even if you had to poop outdoors.

Kelly went on. "Romeo and Juliet were both played by boys. Boys! Just think. William Shakespeare himself might have played Juliet. If you want to be Charlotte, you should get to try out, like anyone else. It's only fair. And if you get nervous, my dad says you just have to picture the audience naked."

George didn't see how that would help. "Kelly?" she said.

"Yeah?"

"Your dad is weird."

"I know *that*."

Kelly stood in the center of the room and took a few bows, as if she were onstage. She looked around nervously and then pointed at her imaginary audience, yelling, "How can I act in front of you people? You're all naked! This is extremely rude!"

Kelly started to giggle, and George joined her until the two of them curled into howling balls of laughter, occasionally shouting things like "I can't perform under these conditions!", "Where's my limo?", and "Get me my agent!" until finally, winded and with sore cheeks, their chuckles grew further apart. Suddenly, Kelly jumped up, determination in her face.

"Okay, let's get to work." She opened the bottom drawer of her desk. Inside, a rainbow of hanging file folders kept numerous papers in place. Kelly took a pair of pages from a file in the front, then rolled the drawer shut.

"I made a copy on my dad's printer last night." Kelly thrust a page at George. The word ***CHARLOTTE*** stood

in capital letters at the top, originally written with a thick marker. Below it was the first conversation between Charlotte and Wilbur. All of the girls, no matter what part they wanted, would be auditioning with Charlotte's lines, and the boys would be auditioning with Wilbur's.

"Why don't you play Charlotte first?" Kelly dropped to her hands and knees, laying her script on the carpet in front of her.

She oinked up at George, who perched herself as high as she could on the pillows at the head of the bed. As they acted out the scene, George surprised herself. She thought she would be nervous, but it seemed natural to say Charlotte's words aloud. They were finished too quickly.

"Switch places!" Kelly called, flopping onto the bed and lying on her back with her head hanging off the side. She held the paper out at arm's length in front of her, upside down so she could read it. "Ready," she called.

George climbed off the bed and sat cross-legged on the floor. She read Wilbur's lines and heard Kelly echo back the words she had read aloud moments ago. George was delighted when it was time to switch back. She climbed majestically up to the peak of the bed, stretching her limbs out like a spider's, while Kelly jumped onto the floor and snorted.

"Salutations!" George cried, and the scene began again. The words felt good on her lips.

The two friends ran the dialogue back and forth until they could say most of the lines without looking at the page. Eventually, Kelly refused to give up her spot as Wilbur, and George happily repeated the role of Charlotte.

"You don't mind?" asked George. She could have read Charlotte's words all day long.

"I'm having fun!" Kelly said. "Besides, you make a better Charlotte than I do. I keep goofing up the first line!"

Kelly was right. She kept saying "Sa-lu-ta-TA-tions" instead of "Sal-u-TA-tions." *Salutations* was the fancy way Charlotte first greeted Wilbur and showed off her magnificent vocabulary. It was an important first line.

"There are other parts. I could be Fern. I'll be all 'Pa! Where are you going with that ax?'" She held up her hands in imaginary protest.

"Ax? What ax?" Kelly's father had opened the door and popped his head in. "I ain't got no ax. I'm strictly a bass man. *Da-dum-dum-dum-dum-dum.*" He slapped his fingers against his waist, playing an imaginary instrument. "Get it? Ax? Bass?"

"Really, Dad?" Kelly gave her father a look. George smiled blankly.

Kelly turned to George. "Hotshot lead guitarists like to call their guitars *axes*. It makes them think they're cool." She refocused her attention on her father. "Didn't I tell you to knock first? We're trying to rehearse."

"You've been at it a while. I thought you might be thirsty. There's white grape juice in the fridge."

"Well, in that case, my dear father," Kelly proclaimed, "I don't mind you bothering us at all. Why, with all this rehearsing, I'm downright parched."

"I'll bet your co-star is too, Ms. Arden. What do you say, Mr. Mitchell? Care for a beverage?"

George nodded. She hated being called Mr. Mitchell. She wanted to shout, *Mr. Mitchell lives in the Poconos with a woman named Fiona!* Mr. Mitchell was her dad's name. It would be her brother Scott's name someday too, but it would never be hers.

Instead, George followed Kelly into the main room of the apartment and over to the fridge, where Kelly poured juice into two plastic cups that had come from a local barbecue shack. Most of the dishes in the cabinets were made of plastic. There were a few real glasses at the back of the shelf, the remnants of several different sets, but no one ever seemed to use them. Given how often

cups were knocked over in the Arden home, this was probably a good idea.

Kelly gulped her juice down in three swallows. "Ahhhhhhhhhhh! White grape juice. My favorite!" She wiped her hand across her mouth, added the cup to the pile of dishes filling the sink, and set herself in the empty space on the floor where her father had been sitting among a chaos of paper. She oinked several times and pushed the nearest piles carefully out of her way before rolling onto her back and rocking back and forth, a pig gleefully wallowing in mud.

Kelly's father snatched her cup from the top of the dish pile and poured a glass of grape juice for himself. He chuckled at his daughter's antics.

"Are you trying to say that my room is a pigsty?"

Kelly oinked and nodded vigorously.

Kelly's dad turned to George. "Care to stay for dinner? I'm making *Super Special Surprise!*"

"Um, thanks, but I think my mom wants me home."

"As you wish."

Kelly took her best friend by the hand and escorted her back to her room. They ran through their lines once more. George would have liked to play the role of Charlotte all day long, but Kelly declared boredom and pulled out her camera.

The camera was small and silver, with a lens in the front that zoomed in and out. She had gotten it for her birthday last summer, and there hadn't been a day since that she hadn't taken a picture of something. She loved framing the shot—deciding just where the picture should start and what should stay unseen.

Some of the photographs on her walls were portraits. One of Kelly's dad onstage playing his bass. Another of her uncle Bill painting in a field of dandelions like a hippie. And a grainy photo of a tall, dark-skinned woman in heels and a shiny blue dress, holding a microphone. It was the only picture on the

wall that Kelly hadn't taken herself, and while she almost never talked about it, George knew it was a photo of Kelly's mom.

Not all of the pictures were of people Kelly knew, though. There was a kid smiling on the monkey bars, a man in a suit drinking coffee while deep in thought, and an old couple holding hands on a park bench. Other photographs were images of everyday objects so close up that you could barely tell what they were anymore. There was a worn-down pencil eraser, a pile of Q-tips, the strings of a guitar, and a shadowy shape with a shimmering silver triangle in the middle. Even Kelly didn't remember what that object had originally been, but it was George's favorite.

Kelly directed George to stand against the back of her door and began to shoot.

"Put your left foot in front of your right," she told George. George did, but Kelly frowned. "Nah, put it

back." She took a few more shots. "Look up in the sky. No, not like you're looking at a plane. Like you're looking at a leaf on a tree."

George didn't mind so much when Kelly took a few pictures of her, but she hated it when Kelly tried to pose her. Kelly was persistent, though, and it was faster to let her take her pictures than to argue with her, lose, and have Kelly take even more shots to prove her point.

Kelly modeled George with a book, and shot close-ups of the spaces between her fingers. She gave George a baseball cap and sunglasses to wear and took pictures until George couldn't take it anymore and begged her to stop.

"What if we take some outside?" Kelly asked.

"Nah," George replied. "I gotta get home."

"Fine. Anyway, you better go before my dad announces that *Super Special Surprise* is ready and insists that you stay."

"What is *Super Special Surprise*, anyway?"

"My dad fries up a bunch of leftovers. Occasionally, it's awesome. Usually, it's so-so. And sometimes, it's so bad we have to order pizza."

George said good-bye to Kelly and walked her bike up the cracked path along the house. "One-two-three—" Kelly called out from the basement window.

"ZOOT!" George yelled into the early evening air. She strapped on her helmet and began the familiar ride home. Houses passed by in a blur while Charlotte's words continued to roll through her mind.

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At home, Mom was staring at the open pantry cabinet, her long, dark-brown hair back in its usual ponytail. She wore a polo shirt and blue jeans—the same clothes she wore under her white lab coat at work every day. She preferred jeans to skirts and didn't wear makeup. She said it wasn't good for your skin, and, besides, women were beautiful enough the way they were. Indeed,

Mom was beautiful. She was tall, with a kind, genuine smile, and had the same bright-green eyes as George.

"Hey, Gee-gee," she said as she shut the pantry door.

When George was little and couldn't say her name properly, she used to call herself Gee-gee. Mom still called her that, even though Scott said that it sounded like a girl's name. George secretly thought the same thing.

"Have you seen your brother?" Mom asked as she rustled through the fridge for dinner options.

"He went to Randy's house."

"Hot dogs and beans it is!"

Scott hated baked beans, but both George and her mother loved them.

While Mom made dinner, George headed upstairs to take a bath. She took off her shirt while the tub filled, waiting until the last possible moment to take off her pants and underwear. She immersed her body in the warm water and tried not to think about what was between her legs, but there it was, bobbing in front of

her. She washed her hair with lots of shampoo so that the suds would cover the surface of the water. She scrubbed her body, stood with a splash, and dried off with her fuzzy blue towel. Then she wrapped the towel around her torso, up by her armpits the way girls do, and ran a small black comb through her hair. She brushed it forward and stared at her pale, freckled face in the mirror before combing it back into its regular part down the middle.

In her room, George changed into a pair of flannel pajamas covered in tiny penguins wearing red bow ties. Mom called that dinner was ready, and George went downstairs to eat.

Mom already sat at the kitchen table, getting ready to take a bite of her hot dog, which was covered in mustard and relish. She had toasted her bun but had left George's soft and cool, just the way she liked it.

"Thanks, Mom," said George. She squirted some ketchup onto her hot dog and took a steaming, juicy bite.

They ate in silence at first. Scott was usually the one who talked the most at dinner. But a question was burning in George's mind. Over and over it played.

"Mom?" she said after she swallowed the last bite of her hot dog. She barely realized she had spoken aloud.

"What's up, Gee-gee?"

George stopped. It was such a short, little question, but she couldn't make her mouth form the sounds.

Mom, what if I'm a girl?

George had seen an interview on television a few months ago with a beautiful woman named Tina. She had golden-brown skin, thick hair with blond highlights, and long, sparkling fingernails. The interviewer said that Tina had been born a boy, then asked her whether she'd had *the surgery*. The woman replied that she was a *transgender woman* and that what she had between her legs was nobody's business but hers and her boyfriend's.

So George knew it could be done. A boy could become a girl. She had since read on the Internet that you could take girl hormones that would change your body, and you could get a bunch of different surgeries if you wanted them and had the money. This was called *transitioning*. You could even start before you were eighteen with pills called androgen blockers that stopped the boy hormones already inside you from turning your body into a man's. But for that, you needed your parents' permission.

"George, whatever it is, you can tell me." Mom took George's hand in one of her own, and covered it with the other. "Whatever happens in your life, you can share it, and I will love you. You will always be my little boy, and that will never change. Even when you grow up to be an old man, I will still love you as my son."

George opened her lips, but there were no words in her mouth and only one thought in her brain: *No!*

George knew that Mom was trying to help. But George didn't have a normal problem. She wasn't scared of snakes. She hadn't failed a math test. She was a girl, and no one knew it.

"Mom, could I have some chocolate milk?"

"Oh, Gee-gee, of course." She went to the fridge.

In the weeks after Dad had left the house, Mom had given George a glass of chocolate milk every night before bed. Neither of them would say anything. Neither of them had anything to say. But these were some of George's favorite memories, just sitting there, being with Mom, knowing she would never leave.

George wouldn't finish her chocolate milk until she was ready for Mom to kiss her good night. Then Mom would take the nearly empty glass and turn it over above her mouth for one last drop. George always made sure to leave that last thick sip.

Now Mom came back to the table with a full glass of chocolate milk, frothy from a fresh stirring. The

sweetness filled George's mouth. She focused her eyes firmly on the creamy bubbles, now resting halfway down the glass.

She stared at the foam for a minute, and then downed the second half. She felt more than tasted it, coldness running down her throat. Then she handed the glass to Mom, who tipped it over her tongue for that final drop.

The sweetness of the chocolate milk had coated George's tongue, covering the words sitting on its tip. Someday, somehow, George would have to tell Mom that she was a girl. But this was not that day.

And as for how, she had no idea.

chapter IV

ANTICIPATION

The students of Room 205 tromped up the cold, dark stone stairs. Their footfalls echoed heavily off the tile walls. Two handrails ran along either side of the wall, one a foot above the other. They had been painted red years ago but had chipped over time, revealing layers of orange and green, and patches of bare steel underneath. The girls walked up with handrails on their right. The boys had handrails on their left, and they traveled the long way around the platform halfway up the flight.

Bulletin boards on the second floor were lined with construction-paper Wilburs and Charlottes that the younger grades had decorated. Principal Maldonado

stood at the far end of the hallway. She watched without a word or a smile, making sure the classes filed quietly into their rooms, where teachers sat with lesson plans on their cluttered desks and assignments on the whiteboards.

In Room 205, the morning journal assignment was written in neat script on the board. It read *If you could be a color, what color would you want to be? Explain why in no less than 5 lines.* The class settled into the rhythm of the morning, and scratches of pencils in notebooks replaced the metallic scrapes of chairs and coat zippers.

Once the line at the pencil sharpener had faded and most students were finished writing, Ms. Udell called on a few volunteers to read their journal entries. Janelle said she would be fuchsia because it was bright and dark at the same time. Chris wanted to be orange because it was the only color that was a food.

George wanted to be pink so that people would know she was a girl, but she hadn't written that down.

Instead, she'd said she wanted to be purple, like the sky at sunrise. She didn't raise her hand to read her journal aloud. She never did. Ms. Udell said that it was okay for journals to be private.

At the end of journal time, Ms. Udell addressed the class. "I know this is a big day that many of you have been waiting for—perhaps even *rehearsing* for." Murmurs filled the room, as well as a few giggles from the girls. George felt a warm wave pass over her as she remembered reading Charlotte's lines.

"I am happy to announce that I will be holding tryouts at one thirty," Ms. Udell continued. The class groaned. That was hours away. "Anyone who is caught looking at his or her lines instead of paying attention today, as well as anyone who asks me questions about the audition before one thirty this afternoon"—Ms. Udell paused for effect—"will be deemed unable to handle the *responsibility* of performing."

She nodded her head firmly, indicating that she had finished with the topic. The class waded through a morning of math, reading, and science, wishing impatiently for the afternoon to arrive.

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"Who eats green beans with spaghetti?" Kelly winced as she dropped her orange tray onto the long table. The school lunchroom was in the basement, and the grated windows near the tops of the tile walls let in little light. Most of the illumination in the large room came from long fluorescent bulbs that ran along the high ceiling.

George was already sitting down, poking at mushy strands of vegetable with her spork. She leaned down to sniff them, but couldn't smell anything other than the faint scent of spoiled milk that had seeped deep into the lunch table and couldn't be removed with all the bleach in the world.

"Who eats green beans with anything?" George asked, crinkling her nose.

"I happen to love green beans, you know. When my dad sautés them in garlic with just a touch of olive oil . . ." Kelly brought her fingers to her mouth and kissed them to the air. "*Mmm-wa! Bon appétit!* But this stuff?" She picked up a droopy bean between her thumb and forefinger. "It's limper than the spaghetti! Which is overdone too! It's not al dente, which is how you're supposed to cook pasta. *Al dente* is Italian for 'to the tooth' and it means it's still a little hard in the center, so you have to actually chew it." Kelly picked up a few strands of spaghetti on her spork and wiggled them in the air. "This stuff is not al dente. I can tell you that much."

George shrugged and spun her spork to gather up a mouthful of spaghetti. The lunchroom was already noisy, and getting louder as the rest of the third- through

fifth-grade classes filed through the lunch lines and filled the long tables.

"So do you want to practice?" Kelly asked.

"Not here." George nodded at the crowded table. She didn't want anyone else in the class to hear her reciting Charlotte's lines.

"You know they'll find out when you get the part," Kelly pointed out.

"That's different . . . *if* I get it." George wasn't sure exactly how it would be different, so she tried not to think about it.

"Whatever. We'll practice during recess."

Kelly snuck her camera out of her pocket to take pictures of the limp beans and spaghetti until Mrs. Fields, the lunchtime volunteer, scrunched her face in Kelly's direction and told her to put the camera away.

"Artists are never appreciated at lunchtime," Kelly mumbled as she stuffed her camera into her pocket.

Outside, the smell of pine trees wafted in from the yards of the houses that bordered the back of the school. The air was filled with the buzz of a hundred students at recess, punctuated by yells, laughter, and, occasionally, Mrs. Fields's piercing whistle. She was a short, wrinkly prune of a woman with poofy gray hair who disapproved of everything and walked with a hunched back that made her look even shorter and wrinklier than she already was.

Maddy, Emma, and several other girls were gathered in a circle, gossiping about their favorite television show, *Not-So-Plain Jane*, and whether their parents would let them go next month to see Jane Plane, star of the show, live in concert.

Jeff had a circle of kids around him too, hoping to get a turn to see his new phone. Mrs. Fields would confiscate it if she saw it, so the boys around him huddled

in close. Jeff didn't let any of them hold it, but he allowed a chosen few to touch the screen.

Kelly and George found a quiet spot at the far end of the fence to practice. Kelly pulled a copy of the script page out of her pocket. George knew her lines and didn't need to look at the sheet once as she spoke, but her heart thumped heavily and she spoke too quickly, swallowing the final words of each line. She glanced behind her whenever Kelly spoke, to make sure no one was watching, and missed half her cues.

Kelly frowned when they were done. "That wasn't your best performance."

"I know."

"Do you want to run through it again?"

"No!" A few nearby third graders turned their heads in the direction of George's shout. She lowered her voice. "I mean, no. It's too open. I'll be all right when I'm alone with Ms. Udell."

"I still don't see what the big deal is," Kelly said. "So

you want to play a girl onstage. It's not like you want to *be* a girl."

George's face paled. The air grew hot around her.

"What's wrong?" Kelly asked.

George opened her mouth, but there were no words, so she closed it again. She started to giggle nervously. George's charged laughter filled the air, and soon, Kelly was chuckling too, though she didn't know why. George's laughter grew frantic, and she felt light-headed. Her knees buckled and she dropped to the ground. Not wanting to feel left out, Kelly fell to the black pavement as well.

The kids in the yard ignored George and Kelly, but Mrs. Fields didn't.

"Off the ground!" she commanded. "You don't know what animals have urinated there!"

Kelly jumped up and extended a hand to George, who took it and let Kelly pull her to her feet.

"I hope an animal urinates on her head," Kelly whispered to George. Then she asked, "So . . . what were we laughing about?"

George stared at her best friend. "Are you serious?"

"Of course I'm serious," Kelly said, the bright sun shining on her earnest face. "I'm always serious. Except, you know, when I'm not serious. But right now I'm serious."

"But you *said* it!" George didn't know whether to be relieved or upset that Kelly didn't see that she was a girl. The high pitch in her voice revealed her anxiety.

"All I said was . . ." Kelly paused. "What *did* I say, George? I mean, I've always thought of myself as a funny person, but I didn't think I was such a good comedian that I could say something that funny without knowing it."

George opened her mouth, but as with Mom, she couldn't say the only words that blared through her

brain: *I'm a girl.* She wished the bell ending recess would ring.

"Are you nervous about the audition?" Kelly asked. "Don't be. My dad says that men performing in non-traditional gender roles is good for feminism. He says it's important, as an artist, to be in touch with his feminine side."

Last summer, George had seen that phrase in one of her own dad's magazines, an article called 10 WAYS TO GET IN TOUCH WITH YOUR FEMININE SIDE. George had been excited to read it, but the article had been disappointing. It talked about taking time to feel your emotions, which George did too much already. Worse, the article kept reminding the reader that finding your *feminine* side made you more of a man.

"Can we not talk about it anymore?" George asked. Somehow, it was worse that Kelly thought it was no big deal that George wanted to be Charlotte in the play

than if she had said it was a terrible idea. It was as if Kelly didn't see that anything was wrong at all.

"Criminy, you're like a safe, you are!"

"What?"

Kelly shrugged. "I don't know. My dad says it."

"Kelly." George took Kelly by the shoulders, ignored the tickle in her stomach, and spoke very seriously. "In case you hadn't noticed, your dad is still weird."

Deep inside, George worried that she was even weirder.

chapter V

AUDITIONS

After lunch, the class plodded through a spelling pretest, followed by a science work sheet on simple machines, but all George could think about was trying out for Charlotte. Maybe Kelly was right and Ms. Udell would be so proud of George for being herself that she would give her the part. The minute hand of the clock was a terribly slow lever, pushing the hour hand imperceptibly forward.

Finally, Mrs. Fields's wrinkled knuckles rapped on the heavy glass window of the classroom door. Ms. Udell welcomed her in. She would be watching the class while

Ms. Udell auditioned students in the hallway. Outside of the lunchroom, she smelled like Necco candy wafers.

"I congratulate you all for your patience." Ms. Udell looked directly at Kelly and winked. "The time has finally come to see how you fare as actors and actresses. Everyone who auditions will be given a part."

Ms. Udell would be auditioning students from both Room 205 and Mr. Jackson's fourth-grade class in Room 207. Half of the roles would go to students from each class. Ms. Udell pushed her clunky wooden chair toward the classroom door.

"Today, you are each reading Charlotte's or Wilbur's lines, but I am also casting for Fern, Templeton, and the other characters. If you do not audition today, you will not be cast in the play. If you'd rather not be onstage, don't worry. Mr. Jackson will need quality hands on the crew."

"I was really worried," Jeff muttered.

"Mrs. Fields." Ms. Udell turned her attention to the small woman, who had pulled over a spare chair and settled herself quite comfortably at Ms. Udell's desk. "Thank you again for staying late. I do appreciate it."

"Anything for the theater."

"Please do let me know if there's anyone you find is not *mature* enough to participate in our production. I'm sure I can find other accommodations for them."

"The kitchen staff can always use a young set of scrubbin' hands," Mrs. Fields declared.

Ms. Udell returned her attention to her class and waved a stack of colored index cards. "If you are interested in trying out, I will give you a card with a number on it. The number will dictate the order of your audition. Girls first, then boys. I do not expect you to have the lines memorized, but I do expect you to deliver them clearly and with enthusiasm. You will read only your part. I will read the lines of the other characters. While you wait, you may *silently* review your part. If you do

not wish to practice, you may begin your homework assignment."

Ms. Udell asked the boys who wished to audition to raise their hands. George joined them, lifting her hand just to the height of her head. Ms. Udell counted six blue index cards, shuffled them, and passed them out, along with six fresh copies of the practice part. George was number six. Last. The longest to possibly wait until her audition, with **WILBUR** staring up at her in bold, thick letters. George slumped in her chair and turned the page over.

Ms. Udell then distributed nine pink cards to girls who raised outstretched fingers and mouthed numbers to each other.

"Yes!" exclaimed Kelly, who waved two fingers in the air at George like a victory sign.

Janelle stood, waving a card with the number one on it. She held the door open for Ms. Udell, who pushed her chair into the hallway, where they both disappeared.

George listened closely, but she couldn't hear a sound from the hallway over the murmurs and rustling papers inside the classroom.

George tried to bury her mind in her homework. Monday night's homework always took forever, because the spelling words were also vocabulary words, and Ms. Udell insisted that each student write an official dictionary definition of each word before using it in a sentence. With Mrs. Fields's permission, George headed to the back of the room.

As she bent down to get a dictionary, someone in the room sniffled. George's stomach lurched when there was another sniffle and a snort, followed by the words, "Oh, Charlotte, I miss you so," and snickers. George bit her lower lip and walked the long way back to her seat, to stay as far from Jeff's and Rick's desks as possible.

By the time George was back in her chair, Janelle popped her head in through the doorway. Kelly bounced up and rushed out the door. Soon, she came beaming

back into the classroom and announced, with great flourish, "Number three, you're up!"

Kelly gave George a thumbs-up sign and hunched over in her seat. A few minutes later, on her way to pick up a dictionary from the back of the room, she dropped a note on George's desk. It was folded into a small square. When George opened it, the folds formed a grid across the page. The note read:

Charlotte,

You'll be R-A-D-I-A-N-T!!

Kelly

George couldn't help but grin. *Radiant* was one of the words Charlotte had woven into her web to save Wilbur, and it had been one of their vocabulary words last week. It meant "beaming and sparkling," and George couldn't think of a finer compliment. She took a break from her homework to recite her lines silently.

She remembered them all, and she knew just when to pause to give the words their best effect.

Maddy looked pale when she left the room, and even paler when she came back. Emma clutched her lines tightly. Maybe if the girls were terrible enough, Ms. Udell would be so relieved that George was good that she wouldn't care that George wasn't a girl. At least, not a regular girl.

There was a long wait after the last girl came back into the room, as Ms. Udell listened to the students from Mr. Jackson's class. Eventually, Ms. Udell came in to announce that it was time for the boys to take their turns. Robert was first and came back bragging, "Beat that, number two!" But George wasn't worried about the boys. Her competition was already back in their seats, writing definitions for words like *gesture* and *narrator*.

Finally, the fifth boy, Chris, went out into the hallway. He was a chubby white kid with a toothy grin. He

returned with a smile wider than ever, and danced victoriously back to his seat. Then it was George's turn.

In the hallway, Ms. Udell sat in the blocky wooden chair—the one that matched her blocky wooden desk. The chair looked awkward without its mate.

"You don't have your sheet, George," Ms. Udell said.

"Don't need it."

"Well, that's a good sign. It means you must have practiced." Ms. Udell gave a kind smile. "But do speak up."

Before Ms. Udell could say anything else, George closed her eyes and began. The first words rushed out of her mouth, but then she slowed into the cadence she had practiced. She felt herself as Charlotte and gave each word her full attention as it left her tongue. The words felt even more like hers than they had in Kelly's room. George reached the end of Charlotte's monologue and was ready for the dialogue with Wilbur that followed. But George didn't hear her cue. She opened her

eyes. Ms. Udell was frowning, and a thick crease had formed across her forehead.

"George, what was that?" she asked.

"I . . .," started George, but there were no words to finish the sentence. "I . . ."

"Was that supposed to be some kind of joke? Because it wasn't very funny."

"It wasn't a joke. I want to be Charlotte." George's voice sounded much smaller now that she was speaking her own words.

"You know I can't very well cast you as Charlotte. I have too many girls who want the part. Besides, imagine how confused people would be. Now, if you're interested in being Wilbur, that's a possibility. Or maybe Templeton—he's a funny guy."

"No, thanks. I just . . . I wanted . . ."

"Okay, then." Ms. Udell eyed George oddly. "For now, we need to get into the room to get ready to go. Would you hold the door for me?"

Ms. Udell pushed her chair back into the classroom, shaking her head. She announced that it was time to pack up, and sent George's row first to the coat closet.

George muttered to herself as she loaded her math book into her bag. *Stupid stupid stupid. Stupid. Stupid body. Stupid brain. Stupid boys and stupid girls. Stupid everything.* She kicked at the leg of her desk, knocking it into Emma's chair in front of her. Emma turned back to give George a dirty look.

George stared intently at the speckled tile floor and wished she were home in her bed. When Ms. Udell called her row, George hoisted her bag onto her back and shuffled over to the boys' line, still staring at the ground.

In the yard, Kelly bounded up to George, her ponytail flopping behind her. "So? How did it go? What did she think? Was she impressed or what? I bet she'll let you be Charlotte."

"I don't want to talk about it." George scraped her foot against the pavement.

"What happened?" Kelly cried, grabbing George by the shoulders. "Did you mess up?"

"Leave me alone." George jerked back and tried to head to her bus.

"Did she not like it?"

"No, Kelly. She didn't like it. She hated it."

"She said that?!" Kelly's eyes were wide.

"She thought it was a joke."

"Oh, well. At least you tried." Kelly shrugged. "That's what my dad says."

"AAAAAAHHHH!" George screamed in Kelly's face. "I don't want to hear what your dad says!"

Kelly's shoulders shrank. She opened and closed her mouth, then turned toward her bus line.

George took the steep steps onto her own bus and shuffled along the narrow corridor, her feet sticking to the rubbery floor. She picked an empty seat midway back and hoped that no one would take the spot next to her. Hugging her backpack tightly, she buried her head

in the dark space between the backpack and her chest and held back her tears.

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"So how were tryouts?" Mom asked later that evening. She had just gotten home from work a few minutes before and had started on dinner by dumping a brick of frozen peas into a glass bowl.

"I didn't audition," George mumbled. She sat at the kitchen table, tapping her pencil on her pinkie. Early evening light fell through the window onto her fractions homework.

"Why not? You practiced with Kelly for hours on Sunday."

"There was a lot to memorize."

"Gee-gee, you know every word to every commercial that comes on TV." She pulled a bag of frozen fish fillets from the packed freezer and arranged six on a baking sheet.

George shrugged. "That's different."

"I was just so excited to see my little guy onstage." Mom tousled George's hair. George brushed her aside with a shrug and buried her head deep in her homework. Neither of them said another word until Scott slammed the front door, announcing his arrival.

"Wash up," Mom told him. "Dinner's almost ready."

"Wash up? What makes you think I'm dirty?"

"Because I've met you. You're always dirty. Now go wash your hands. With soap!"

Over dinner, Mom asked Scott about his day at school.

"It was awesome!" Scott exclaimed.

"Oh, really?" Mom was skeptical. Scott rarely showed such enthusiasm about his education. "What happened?"

"So we were in PE, you know, and we had to go to the outside track and run a mile. And I have PE sixth period, right?" Scott waved his fork around as he spoke. "So

there was this kid. He's not even out of shape, really. But I think he has lunch fifth period. And I *know* he had macaroni, because he ralphed it up, all over the track. Mr. Phillips had to blow the whistle and let us stop early because he was afraid that someone would slip and fall in it."

Mom started rubbing her temples at the mention of *macaroni*, and by this point had her head fully in her hands. "Scott," she warned through tight lips.

Scott ignored her. "I was right behind him when it happened, so I got to see the vomit up close. Some of the macaroni pieces were still whole. I think it was mac 'n' cheese, because it was all yellow—"

"Scott!" Mom shouted. "Could you please tell a different story? Perhaps one less intimately related to the inner workings of the digestive system?"

"Sorry, Mom. I'll talk about boring things. I know, how about George? He's always good for being boring."

"Your brother is not boring," said Mom.

George had been staring directly at her food. She hated thinking about gym class, even someone else's gym class. Gym class meant boys yelling at her to run faster or throw the ball harder. She would hate to run a mile on a track with a bunch of them.

"What about that play you're gonna be in with your girlfriend?" asked Scott.

"She's not my girlfriend," George said into her plate.

"Your brother didn't try out," Mom explained.

"Why not?!" Scott cried. "You spent all weekend practicing for a play about a dumb spider, and then you didn't even audition?"

"Charlotte isn't dumb!" George threw her fork down. It ricocheted off the edge of her plate and twirled end over end in the air. All eyes were on the utensil, which spun as if in slow motion. It hit the ceiling and bounced on Scott's head before rattling to the floor.

"Ow!" Scott yelled. "Did you see what he did, Mom? He tried to kill me!"

"Scott, he couldn't have done that if he tried. It was an accident and I'm sure he's sorry. Aren't you, Gee-gee?"

George nodded, in a daze. She could still feel the weight of the fork in her hands.

"Then tell your brother so," Mom said before heading to the freezer for some ice.

"Sorry, Scott," George mumbled.

Scott rubbed his head and grinned. "Man, you've got some arm on you. If you ever got in a fight, I bet you could be pretty good."

Mom returned with a plastic bag filled with several pieces of ice. Scott held the bag on his head with one hand and resumed eating with the other.

"Well," Mom said, "at least the injury hasn't affected your appetite."

The flaky fish patties and soft peas required little chewing, and soon George's plate was empty. She asked to be excused, and dumped her dishes into the stainless

steel sink. She ran upstairs and closed the door to her room just as tears began to fall. She flopped onto her bed and cried into her pillow. She cried about Charlotte. She cried about being mad at Kelly. She cried about Ms. Udell thinking she was joking. But mostly, she cried about herself.

Then she pulled the denim bag from the bottom of her closet and brushed her fingers against the glossy magazines. She rubbed the cool pages against her cheeks, leaving behind tearstains that warped the covers. She told herself she didn't care whether she ruined them.

She should throw the magazines away, she thought to herself. She should get rid of them completely. But she couldn't just put them in the kitchen trash. Mom would see them and want to know where they came from. Even if George put them directly into the recycling can outside, someone might notice them. Besides,

she wasn't sure whether she could dump her magazine friends like that. And even if she could, she couldn't stop wanting to be like them.

So she hugged the magazines tightly to her chest, then packed them carefully away for next time.

chapter VI

TAKEN

Mom flicked on the light in George's bedroom the next morning. "Time to get moving. My alarm never went off. You already missed the bus. I'm driving you and your brother to school."

Mom left the door of George's room ajar and cursed her way downstairs to the kitchen. George lugged her body out of bed, shrugged on some clothing, and plodded downstairs.

"Where's your backpack?" Mom asked, brushing her hair with one hand as she guided her shoes onto her feet with the other.

"Upstairs," George answered groggily.

"Well, go get it."

"What about breakfast?"

"You'll eat in the car. And don't forget your shoes!"

George gathered her things into her backpack, wiggled her feet into her sneakers, and trod back downstairs.

Mom was already by the front door, rummaging in her purse for her keys.

"Where's your brother?"

"I dunno," said George. "Probably still in bed."

"Well, go upstairs and get him. Tell him he has *one* minute to get down here, or it's no phone for a week."

"Can I pull the covers off him?"

"Sure."

George bounded up the stairs once more, this time with proper motivation. Parent-condoned sibling cruelty was a rare gift, and not to be wasted. Mom had left the light on in Scott's room, but Scott was fully asleep, snoring away. George found the two bottom corners of

his thick green comforter and whisked the blanket off in one solid yank.

"Hey!" Scott grumbled.

"Mom said I could!" said George. "She also said no phone for a week if you're not downstairs in a minute."

"She just doesn't trust that I've got the situation under control," said Scott, already standing. He was wearing his favorite pair of jeans and a wrinkled black T-shirt. "I try to maximize my rest so that I can be at my best for my education, and what does she do? Complain, complain, complain." He ran his fingers through his curly hair a few times and slipped his feet into tall, unlaced boots. Then he slung his backpack over one shoulder and jogged down the stairs. George followed.

"You look like you slept in that!" Mom declared.

"I did." Scott grinned.

"And you haven't brushed your teeth, have you?"

"Nope." Scott's grin grew wider.

"You're disgusting," said Mom, resignation in her voice.

"I'm a teenage boy," said Scott. "What do you expect?"

Mom handed each of her children a granola bar, then motioned them toward the garage.

"I still don't see why I can't just take the next bus," said Scott as he buckled himself into the front passenger's seat. Scott took the city bus to high school, not a school bus like George did.

"Because the next bus isn't for forty-five minutes, and by that time you'll have missed first period." Mom backed the car out of the garage and down the driveway.

"It's only English. I already speak English real goodly."

"You're a laugh riot, Scotto." As Mom drove, she rambled on about how she needed a new alarm clock and how really her children were old enough to get

up on their own anyway, and hadn't she bought Scott an alarm clock last year for Christmas for that very reason?

George stared out the backseat window, counting telephone poles. When she was little, her grandfather had told her that if she counted a hundred telephone poles in a row, an electric fairy would grant her one wish. George didn't really believe in the electric fairy anymore, and sometimes she didn't even know what she was wishing for, but counting telephone poles had become a comforting habit.

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Room 205 buzzed as students filed in and hung their jackets and book bags in the coat closet. A group of girls gathered by the pencil sharpener around Maddy and Emma, who showed off the matching temporary pink streaks that Maddy's older sister had put into their hair the night before.

Ms. Udell subtly pointed at George and motioned with one finger for her to come up to the teacher's desk. The desk had probably been in the same room since the school was built; it might have been even older than Ms. Udell. The original shiny coating was worn away completely in some places and deeply scratched in the rest. If you dug your fingernail into the desk hard enough, you could leave a mark in the waxy varnish.

"You surprised me yesterday, George," Ms. Udell said, her reading glasses perched on her head. "I can't cast you as Charlotte, of course. I have too many girls who want the part."

"I know." George hoped that Ms. Udell would let her take her seat.

"But," Ms. Udell continued, "you did a good job. You have passion and dedication. Are you sure you don't want another part? You could be Wilbur."

Wilbur, the dirty pig. George shook her head. That would be worse than not being in the play at all.

"Or one of the other boys' parts. Templeton? Mr. Zuckerman? The gander?"

"No, thanks."

"Perhaps a narrator, then? The narrators have a really important role. They keep the audience informed."

George shook her head. She didn't want to be in the play, watching someone else be Charlotte.

"Well, okay." Ms. Udell eyed George warily. "I guess you can be in the crew."

The classroom door opened and Kelly bounded in. "Did I get a part? Did I?"

Ms. Udell's focus turned to the bubble of ebullience bouncing in front of her. "Kelly, you will find out about your part when everyone else does. At the end of the day."

Kelly gave an exaggerated sigh and headed off to the coat closet to join the group of girls huddled around Maddy and Emma. Ms. Udell turned back to where George had been, but George had already disappeared to her seat.

As promised, Ms. Udell didn't share the names of the students in the play until the final moments of the school day, at which point she distributed scripts to the actors and gave some advice on how to memorize their lines.

Kelly would be Charlotte. When she found out, she jumped nearly out of her seat and whooped with glee. Then she turned to smile at George, but George had turned her head to face the closet, shielding her eyes from view with her hand. It was bad enough that she wouldn't be Charlotte. Now she would have to listen to Kelly talk about it, and possibly nothing else, for the next three weeks.

Ms. Udell continued to read the cast list. Chris would play Templeton. He let out a deep "yeeeeah" and pumped his fist in the air. Maddy, Emma, and several other kids would play the barnyard animals, and most

of the rest of the kids who had tried out would be narrators. Kids from Mr. Jackson's class would be playing the parts of Wilbur and Fern. George's name wasn't said at all.

George knew she couldn't have possibly expected to hear Ms. Udell call her name. Still, her heart sank. She had genuinely started to believe that if people could see her onstage as Charlotte, maybe they would see that she was a girl offstage too.

When her row was called, George grabbed her book bag and got away from the other kids at the closet as quickly as she could. She packed her math workbook and her science reader.

Room 205 headed down to the yard for dismissal. George didn't pay attention when the class stopped to regroup. Several times, she bumped into the backpack in front of her.

The moment the class stepped onto the school yard, Kelly dashed out of the girls' line and over to George.

"How come you're not in the play?" she asked. "Ms. Udell said everyone who tried out would get a part. And I thought for sure Ms. Udell would make you Wilbur. You were so good this weekend. Rehearsals are going to be totally boring without you."

Another voice chimed in: "Yeah, George, how come you're not in the play?"

George cringed, recognizing Rick's voice behind him. Jeff almost never talked directly to George unless he had something really mean to say, but George wasn't surprised to see them both there when she turned around.

"Last week, you were all crying about the poor little spider," Rick continued. "And we saw you go out and audition. How bad did you have to be for Chris to get the part?"

"I'll bet he read the stupid spider's part by mistake!" Jeff smirked. "He's such a freaking girl anyway."

Jeff guffawed, and Rick laughed alongside him.

"Don't listen to them." Kelly tugged at the elbow of her best friend's shirt, but George stood, stuck in place. The hairs on her arms stood straight up, and the back of her neck tingled.

"Or maybe he just read it all backward," said Rick.

"*Knio! Knio!*" Jeff made a horrific sound, attempting to oink backward. Rick joined him, and they snorted across the playground toward the gate, where parents sat in cars in a line down the block.

She didn't exhale until Rick and Jeff passed through the gate. They didn't know her secret, or else they wouldn't have dropped it so quickly, but their guess had been so close that George's cheeks flushed with shame. She relaxed her hands, which had formed into fists, but her teeth were still clenched.

"They're jerks," said Kelly. "You're not a girl."

"What if I am?" George was startled by her own words.

Kelly drew back in surprise. "What? That's ridiculous. You're a boy. I mean"—she pointed vaguely downward at George—"you have a *you-know-what*, right?"

"Yeah, but . . ." George trailed off and looked at the ground. She kicked a small rock that skipped into a tuft of grass. She didn't feel like a boy.

They stood together in a heavy silence. Kelly's brow furrowed in thought. After a few moments, she spoke. "You know, I thought about whether I was a boy once. Back when I wanted to be a firefighter and I thought all firefighters were boys. Is it like that?"

"I don't think so, Kelly."

The lines in front of the buses had mostly disappeared and the drivers were only waiting for the final okay to start their routes. They had begun to turn over their engines, and the air filled with heavy rumbling and the fumes of diesel exhaust.

George had a sudden frightening thought and

grabbed Kelly's arm just above the elbow. "Don't tell anyone."

"I won't."

George's grip on Kelly's arm grew uncomfortable. "Not even your dad."

"Not even my dad."

They ran to their respective buses, the soles of their sneakers slapping on the blacktop, calling "One-two-three!" and "Zoot!" behind them.

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The school bus left George at the corner and drove off, its engine straining to pick up speed. George walked the half block to her house and turned up the driveway. She fumbled with the house key, balancing her book bag on one knee while she turned the key to the right, but the door was already unlocked, and pushed open easily. Mom sat on the couch.

"You're home!" said George.

"What's this about?" asked Mom. Her expression was flat. George's denim bag swung slowly in the air, hanging from one crooked finger. The zipper was open.

George's heart pounded, and for a moment, she thought she might burst on the spot. She took a deep gulp of air.

"I was feeling under the weather today, so I came back home to do some cleaning," said Mom. "Your closet was a mess . . . and I found these. Did you steal them?"

"No!" George's face was hot. "I . . . I collected them."

"Don't lie to me. Where did you get them?" Mom pulled out the copy of *Seventeen* from last October, the smiling twins on the cover unaware of Mom's tight grip.

"I found them in different places."

Mom eyed George, her eyebrows thick and heavy. She stood, with a deep sigh.

"George, I don't want to find you wearing my clothes. Or my shoes. That kind of thing was cute

when you were three. You're not three anymore. In fact, I don't want to see you in my room at all."

"But I didn't . . . ," George began, but Mom ignored her.

Mom disappeared to her bedroom with the denim bag in her hand. George remained by the front door, her mouth slightly open.

She couldn't believe her friends were gone.

chapter VII

TIME DRAGS WHEN YOU'RE MISERABLE

The days passed George by in a haze of unhappiness. She dragged herself through her daily routine. She dragged herself out of bed in the morning and to the bathroom. She dragged herself downstairs and dragged her spoon through her cereal and up to her mouth. She dragged herself to the bus stop, through the day, and back home again.

Kelly didn't call once that week, and George didn't call her. They didn't even eat lunch together. Kelly ate with the other lead actors and talked about the play. When Kelly did look George's way, she gave George an

awkward, forced smile. George ate lunch by herself that week.

On Thursday, she sat down without looking, and realized she was directly across from Jeff and Rick. She spent the entire lunch period staring at her lunch tray and listening to them snicker about Mrs. Fields, the kindergartners, and, of course, George.

At home, Mom didn't say anything about George's bag, or much of anything else, either. She went about her day with a stony face and rigid movements. George tried to avoid being in the same room with her. She ate her dinner as quickly as she could, skipped all but her favorite shows on TV, and spent as much time in her room as possible. And she couldn't stop thinking about her magazines.

Saturday morning, when there was a heavy *knock knock* on her bedroom door, George expected Mom. Instead, she was surprised to see her brother holding

up two video game driving wheels. "Wanna play *Mario Kart*?"

Scott hadn't asked George to play video games in months. They used to play almost every day. George would come home after school to find Scott on the couch, watching wrestling and ignoring his homework. They would play until Mom got home and yelled at them to turn off the TV and get their homework done. Now Scott usually came home just in time for dinner, if not later.

"Why?" George asked, still deep in her fog of misery.

"If Mom catches me on the couch playing video games, she'll make me do chores. But if I'm playing a game with my *kid brother*"—Scott ruffled George's already messy hair—"she'll call it fraternal bonding or something, and maybe let us play a few more rounds."

Scott's reason seemed selfish enough to be genuine, so George joined Scott in the living room and took a seat on the right side of the couch. They selected their cars and drivers. Scott drove as Bowser, the reptilian archvillain of the Nintendo game series. He loved being able to knock into the smaller characters and send them flying. George selected Toad. She liked the happy sounds the little mushroom made. When she was alone, she sometimes drove as the princess, but she didn't dare choose her in front of Scott.

A creature in the sky floated down with a checkered flag in its hands. After a brief countdown, the race was on. The pack of characters vied for the lead, throwing obstacles and running through one another while invincible. Scott and George made their way through the maze.

At the announcement of the final lap, they were in first and second place. The computer players were nearly half a lap behind. As they turned into the last long

straightaway, George shot a red shell into the void ahead of her. The shell whooped along until it slammed into Scott, sending him spiraling in the air. On-screen, Bowser pumped his fist in anger and slowly puttered back onto the road. He was a heavy beast, and took a long time to gain speed. Toad zipped past and into the lead. The finish line was just ahead, and George crossed it moments before Scott caught up.

Scott roared like a dinosaur and shook his wheel in the air. George giggled.

"You know," Scott said, "that's the first time I've heard you laugh in about a week."

"Yeah," George said.

"Girl problems?" Scott asked, his eyes focused on the television screen as the cloud creature announced the start of the next course.

"No," George said. She knew that wasn't true. Being a secret girl was a giant problem.

"What about Kelly?"

"I've told you," George said through gritted teeth, "she is *not* my girlfriend." She bit her lip as she veered around a sharp corner.

"I haven't seen you on the phone with her all week."

"Just forget it."

"Are you two having a fight?"

"NO!" The wheel felt moist in George's clammy palms.

Scott laughed before knocking a car into a pool of lava.

"What's so funny?"

"Sure sounds like you're having a fight."

"Shut up, Scott."

"Whatever. She's not *my* girlfriend."

"SHUT UP!!" George turned to her brother, turning the wheel along with her. Toad screamed his way down a ravine as the lower half of the screen fell into a deep, dark hole. "See what you made me do?"

Scott pulled into the lead for the final lap. George climbed into fifth place by the time she crossed the finish line, but it still put her third in the overall rankings.

They played the third round in deadly silence, racing through the final lap as competitively as if they were in the Indianapolis 500. They were battling for first and second place when Mario came through. He shimmered with invincibility and ran through both Scott's and George's cars, sending them flying into the air and falling back down to the track at a dead stop. They hobbled over the finish line, booed at the defeated music that played on the television, and vowed together to crush Mario in the fourth and final round of the match.

Scott bumped into Mario with his massive force, and George used her speed mushrooms to plow through him at top speed. They laughed their way across the

final line. They came in fourth and sixth places, delighted that Mario had ended dead last.

Scott and George played another game of *Mario Kart*, and another, until Scott insisted on switching to a shooter game. He promised George that it was fun and that she would enjoy it. She didn't, and after a few minutes, she left Scott to kill everything in sight.

chapter VIII

SOME JERK

The school yard filled with kids on Monday morning. Younger boys played kick the rock and ran about wildly, while older boys crowded around electronic gadgets that were hidden in the bottoms of backpacks during the school day. George leaned against the chain-link fence, watching some girls from her class jump rope. She knew the rhymes they sang, but no one would ask her to join. Boys didn't play jump rope.

"Hi," a small voice spoke behind George. It was Kelly. She wore a faded blue shirt with a smiling whale on it that read I'M HAVING A WHALE OF A TIME.

"I'm sorry I got the part of Charlotte." She twisted the toe of her sneaker into the blacktop pavement.

George shrugged.

"Are you mad at me?" Kelly asked.

"No."

"Good."

Kelly took a deep breath. "And I'm sorry I ignored you last week." She scratched her neck. "And you know what? If you think you're a girl . . ."

George braced for Kelly's next words.

"Then I think you're a girl too!" Kelly leaped onto her best friend and gave her a hug so big they both nearly toppled over. The openmouthed surprise and joy on George's face only made Kelly smile harder.

"So you're, like, transgender or something?" Kelly whispered as best she could in her excitement. "I was reading on the Internet, and there are lots of people like you. Did you know you can take hormones so that your body, you know, doesn't go all manlike?"

"Yeah, I know." George had been reading websites about transitioning since Scott had taught her how to clear the web browser history on Mom's computer. "But you need your parents' permission."

"Your mom's pretty cool," Kelly said, her eyebrows lifted. "Maybe she'd be okay with it."

George shook her head and looked down, staring at her shoelaces. Even without closing her eyes, she could see her denim bag hanging from Mom's long finger, swinging slightly. The words *It's not cute anymore* echoed in her mind. She told Kelly about her bag of girls' magazines, and about Mom taking it.

"But that's not fair!" Kelly was indignant. "You didn't steal them! What right does she have to take them from you?"

"Sometimes *transgender* people don't get rights." George had read on the Internet about transgender people being treated unfairly.

"That's awful."

"I know."

After an awkward silence, Kelly showed George some pictures she'd taken that weekend at the park. Many of them were close-ups of leaves, and some of them were quite striking. The ways the light hit different parts of the leaves made them look three-dimensional.

Kelly drew her camera out of her pocket. Then she started giving out directions as she circled around George, shooting away. "Smile more, like you just got a present. Now surprise, when you open the gift. And joy, like you just got what you always wanted."

George frowned. "Could you take pictures of the face I'm making, instead of telling me what face I should have?"

"I'm just trying to provide a little artistic direction. Never mind." She put her camera back in her pocket and joined a group of girls playing hopscotch. George leaned against the fence and looked up at the cloudy sky.

When the bell rang, the playground formed into girls' and boys' lines for each class. Once upstairs, George settled into her seat and began the assignment written on the board. It asked her to find as many words as possible that she could create from the letters of the word *PERFORMANCE*. George stared at the three words on her page: *PERFORM*, *MORE*, and *FOR*. She refused to write down *MAN*, even though it kept smacking her in the face, blocking her view of other words. George still had the same three words on her page when Ms. Udell began her morning announcements.

"As you are aware, our play is fast approaching. It's time for us to kick into high gear. We will be limiting our traditional academic endeavors to the forenoon hours." Ms. Udell ignored the blank stares she received from the class. "The time after you ingest your midday nourishment will be entirely devoted to theatrical pursuits."

"I think she means no work after lunch!" Chris called out.

"I most certainly do not!" Ms. Udell held a stern look for a moment before breaking into a grin. "But I do mean that we will be in the classroom only until lunchtime. The auditorium echoes, and I want the cast to get some experience projecting their voices properly. Plus, the crew needs to put together our set."

The class cheered—some for the play, but most because they would have less classwork. Kelly cheered loudest of all, but George remained silent. She didn't want to go into *high gear*. She didn't want to think about Charlotte anymore. She wanted the play to be over and done with. The only good part of Ms. Udell's plan was that it meant the class would skip afternoon gym.

Ms. Udell quieted the students and continued. "That does *not* mean that we won't be working hard in the mornings. In fact, we'll need to be twice as efficient. And I'm sure I don't need to remind you"—Ms. Udell

eyed Jeff, Rick, and then Kelly—"that students who cannot keep their attention on their studies in the morning will be sent to another classroom in the afternoon to complete them, as well as additional written assignments."

The morning passed in a drone of vocabulary, fractions, and reading. Not another word about the play was said until lunch, when the long lunchroom table burst into a flurry of excitement. Kelly said she knew all about voice projection, and she would be happy to help anyone who needed some coaching. No one took her up on it.

When the bell to end recess rang, Ms. Udell met her class in the playground instead of waiting for them upstairs as she usually did. Mr. Jackson stood beside her. Ms. Udell took the cast to the auditorium to practice onstage, leaving the remainder of the fourth grade in the school yard with Mr. Jackson to form the crew.

Mr. Jackson was a tall black man with a mostly bald head and a thick mustache. He called his crew to sit in a circle under the rusted basketball hoop. A half-dozen cans of paint, a bag of brushes, some buckets, a heap of cardboard, and several large tarps waited in a pile underneath the bent rim.

"Okay. We've hashed out costumes, props, and music," said Mr. Jackson. "Now it's time to create the backdrop for our actors, to bring literature to life! Remember, the lifeblood of a play is its crew. If the actors are like Wilbur, the star of the fair, then we are like Charlotte, the unseen heroes who got him there. Now let's help our stars put on *SOME PERFORMANCE.*"

Before the crew could begin painting, Mr. Jackson said they needed to develop a game plan. They argued about where to sketch hay bales, the pig trough, and Templeton's nest, and whether they needed to paint the Arables' kitchen at all. But everyone agreed that a dark corner at the top right would be perfect for Charlotte

and her webs. Mr. Jackson would provide a ladder to set up behind the backdrop for Charlotte to appear from above.

George kept quiet until it was time to choose members of the crew to help out onstage, but then her hand was up first. If she couldn't be Charlotte, she could at least deliver the large cards with the painted spiderweb words on them to Kelly. She would also hold the ladder steady while Kelly performed from the top. She would be Charlotte's Charlotte, deeply hidden in the shadows.

Two girls and a boy from Mr. Jackson's class would carry props onstage and off. Rick volunteered to raise the curtain. Jeff didn't sign up for a job. He said he'd rather eat a spider than come back to school in the evening. The stagehands were advised to wear all black on the day of the performances so they wouldn't stand out during the show.

Finally, it was time to get to work painting the main backdrop for the play. The crew laid heavy tarps over the

cracked blacktop yard. The tarps were covered in blobs and trails of yellow, blue, orange, and red. The canvas stuck to itself and crackled as the students unfolded it. Mr. Jackson handed out smocks made from large men's button-down shirts. Jeff refused to wear one, saying it looked too much like a dress. Four students unfolded a mass of white cloth to lay out over the tarp. It was made from two flat bedsheets sewn together, and would be their backdrop.

Each member of the crew was given an assignment. George's job was to paint the pig trough. She laid down a base of brown paint. Once the edges dried a bit, she would outline it and add some detail in black. While she was waiting, she dunked her brush into a plastic cup of mucky, murky water. She swished the paintbrush around, watching the brown sludge swirl, revealing wisps of green. As she was sweeping the paintbrush across a corner of canvas to dry out the brush, she heard Jeff and Rick chatting.

"What do you wanna pull the curtain for?" said Jeff, his voice filled with disdain.

"I don't know," said Rick. "I just, you know, thought it would be fun."

"I think it would be more fun to pull the curtain down right in the middle of the show!" Jeff laughed.

Rick gave a hollow chuckle. "Yeah, sure."

"Oh, come on, Rick! What's your deal? All of a sudden, it's like you care about this dumb play. Look at you, worried about how many strings there are on a thing of hay."

"They're called bales, and Mr. Jackson said that the string is called twine."

"Who cares?" said Jeff. "You're being a suck-up."

"I am not!" Rick yelled, and flicked his brush at Jeff. A stream of yellow sun streaked down the white cotton sheet. "Now look what you made me do." Rick searched for a rag and tried to wipe off the paint.

"Whatever." Even though George couldn't see him, she knew Jeff was rolling his eyes.

"What's the big deal anyway? She's just a stupid spider. Do you know what I'd do if I met a talking spider?" Jeff waited for Rick to respond, but Rick was focused on his brushstrokes. Jeff's wide brush sat in a pool of yellow on the tarp below a half-painted hay bale.

"I'd step on her. Crush her under my foot like the freak she is. Freaky spider. Stupid, freaky spider." Jeff began to sing an unformed tune. *"Stupid, freaky spider. I'm gonna step on you because it's what you deserve, you stupid, freaky spi-i-der. I'm glad you diiiiiiiieeed."*

George's face felt hot. Jeff had no right to talk about Charlotte like that. Jeff was always saying something mean. Charlotte wouldn't stand for it, and George wouldn't either.

She grabbed a blank piece of paper, a cup of black paint, and a thin brush. She laid out the paper and set to work. By the time she was done, she was quite pleased with her own creation. Charlotte wasn't the only one who could express herself through the well-crafted word.

George lifted the paper carefully and held it at her side between a finger and her thumb. She was so worried about whether the paint was already dry or whether the paper would smear against her leg that she barely thought about what she was doing or who she was doing it to. Meanwhile, her feet propelled her fast and hard toward her target.

Jeff was lying facedown on the pavement. He slathered a blue sky on the top of the canvas, leaving gobs of paint as he worked. Rick crouched nearby, painting a black line around the edge of a hay bale.

As George passed Jeff, she dropped the paper. It was a direct hit, landing perfectly on his back, right in the middle of his white T-shirt.

"Hey, what the heck?" Jeff's head whipped around.

"Sorry," said George. She whisked the paper off his back and grinned wildly.

"What a klutz," Jeff snorted, and returned to his blue sky. He had no idea that the words SOME JERK

glistened in black paint on his shirt, fashioned inside a simple spiderweb. Jeff was SOME JERK, and now everyone would know it.

George bit her tongue to keep from laughing out loud. It had worked! The *J* was backward, but the words were clear. George crumpled up the paper and threw it into the big black trash bag.

It wasn't until George sat back down that she froze. The color drained from her face, and her tongue seemed to swell. Jeff would realize what had happened soon, and he would know who had done it. She was dead. D-E-A-D. Dead.

George eyed Jeff nervously until Mr. Jackson announced it was time to pack up. Without cleaning a thing, Jeff lined up along the fence, and Rick followed. Suddenly, there was a gasp from Rick, and a scream from Jeff. Jeff whipped his T-shirt around.

"What the . . . ?" His voice trailed off as he met Mr. Jackson's glare, but his eyes gleamed with fury. He

rubbed his shirt as best he could, but it was too late; the paint was dry. Jeff gave up and turned it inside out, the tag pointing up and into his hair.

George could smell her own sweat. Her neck felt hot, then cold and wet, then hot again. Her body wanted to run. Then Jeff was right in front of her. Rick was behind her.

"Hey, Rick. It looks like someone's finally starting to grow some balls." Jeff thumped his right fist into his left palm.

George looked down at her feet and hoped that neither of the boys noticed the flush that filled her cheeks. There was nothing George dreaded more than when boys talked about what was in her underpants. Her cheeks grew so hot that she felt like metal. She wished she *were* made of metal, with laser eyes that could slice Jeff in two.

But she wasn't made of metal, and her eyes were as helpless as the rest of her. Jeff was a head taller, and he

was thick too. Jeff's pinkie was the size of George's index finger, and Jeff kept pounding his fist into his other hand. Rick stood behind George. He wasn't as tall as Jeff, but he was taller than George, and stronger.

Putting a hand on each of her shoulders, Rick easily held her in place. George felt a hard pit forming deep in her stomach. She looked over at Mr. Jackson, who was surrounded by students and art supplies.

"You think you're funny, don't you, freak? You think you can mess with me? You're such a freak. You're a freak. Freak. Freak." Jeff flicked his finger against George's forehead with each *freak*. His words crawled under her skin, settling deep into the crevices of her bones.

Without warning, Jeff pumped his arm back and launched his fist into George's stomach. She stumbled a few steps back into the chain fence, doubled over, and clutched at her waist, gasping for breath.

George's body spasmed. She retched once. She retched twice. She opened her mouth wide and vomit spewed forth in an arc that started at Jeff's shoes and splattered all the way up to his face. Then she slumped to the ground in a heap.

"Ew!" Jeff screamed, wiping his face and then looking at his hands in horror. "Ewwwww!!!"

Rick snickered.

"Shut up!" yelled Jeff, tearing off the shirt he was already wearing inside out because of the web declaring him SOME JERK. He wiped his face and spit furiously. He reeked of the acidic barf that dripped down his pants. Chunks of burger and corn soaked his shoes. He jumped away in horror, but couldn't get away from the stench.

Mr. Jackson ran over to the scene. "Now, what's going on here?" he asked. "George, are you okay?"

Jeff was a sputtering, shirtless mess. George was still

on the ground, holding her stomach, tears in her eyes. A crowd of students had gathered around.

"That kid punched that other kid," said a boy from Mr. Jackson's class, pointing at Jeff. "And then *that* kid"—his finger turned to George—"went BLECCCCCH and hurled and it flew and landed all over that kid." His finger pointed back at Jeff.

"Thank you very much for the play-by-play, Isaiah. Now if you would please get in line." Mr. Jackson addressed the fourth graders. "In fact, if you would all please get in line. Jeff, I want you at the very front with me. George, you too."

Mr. Jackson helped George up. George's stomach hurt, and her mouth felt raw. The word *freak* echoed between her ears. She followed Mr. Jackson and Jeff, who was still shirtless, into the school. The outside world felt distant, and she couldn't make out the whispers of the fourth graders behind her.

On the way, Mr. Jackson stopped at the main office to get a school T-shirt for Jeff. Ms. Davis, the school secretary, brought one out. She had a small face, an even smaller nose, and short dark hair that grayed at the temples.

"This vomit reeks," Jeff complained. "I gotta clean up first."

Ms. Davis sighed. "I'll take them, Mr. Jackson." She turned to Jeff and George. "But I'm coming in with you. No monkey business."

George, Jeff, and Ms. Davis went into the boys' bathroom together. George hovered by the trash can near the door.

"Don't you want to wash up too?" the secretary asked.

George shook her head. Her mouth still tasted of sick.

"Suit yourself."

Jeff put his head under the faucet to rinse it, and wadded up a bunch of paper towels to wipe down his upper body. He put his shirt in the sink and ran water on it, but Ms. Davis told him to hurry up. Jeff grumbled, wrung out his shirt, and put on the T-shirt she had given him.

Ms. Davis walked Jeff and George back to Room 205. Ms. Udell and Ms. Davis whispered at the door for a few moments. Then Ms. Davis stepped inside the classroom, and Ms. Udell came out into the hallway.

"Mr. Jackson spoke with me about the incident in the yard," she said in her iciest voice. "Jeffrey, can you please explain to me why you punched George in the stomach?"

"He ruined my shirt!" Jeff shouted.

"Mr. Forrester." Ms. Udell addressed Jeff by his last name. "I will thank you not to yell in the hallway. Further, there is no excuse for violence on school grounds, or anywhere else, for that matter. Much less for the sake

of a shirt. Mr. Jackson is writing up an incident report. When he is done, Ms. Davis will escort you both back down to the main office, where your parents have been called and will be picking you up."

George and Jeff waited in the hallway with Ms. Davis, Jeff shooting evil looks George's way the whole time. George stared at the ground. Once the incident report was done, the three of them headed down to the main office. George sat on the bench by the teachers' old-time clock, her feet dangling below her. Jeff sat in a folding chair next to Ms. Davis, facing the window, kicking the desk until Ms. Davis told him to quit it. He would stop for about a minute, and then resume kicking, softly at first, until Ms. Davis yelled at him again.

George's mom entered the office and rushed past George without even noticing her. Ms. Davis pointed her directly into Principal Maldonado's office and advised George to follow.

George had never been in the principal's office before and was surprised by how bright it was. Orange curtains framed windows that reached nearly to the ceiling, and piles of books were stacked around the room. Principal Maldonado sat at a large desk in the center of the room and invited Mom and George to sit across from her in two brown cushioned chairs. The principal had short gray hair and wore a turquoise necklace over a black turtleneck. She was a fat woman whose broad shoulders filled her chair with an easy self-confidence.

"Now, Mrs. Mitchell, George has defaced student property, and that is a serious offense. However, given the nature of the incident, as well as lack of a prior record on George's part, I would just as soon resolve this as simply as possible."

As the principal spoke, George's eyes scanned the wall behind her. List upon list of phone numbers and email addresses were taped up to the lower half, interspersed with handwritten notes held up with

thumbtacks pressed directly into the wall. Dozens of signs hung above, telling kids to eat right, not to take drugs, to do their homework, and not to be a bully. A sign in the far corner showed a large rainbow flag flying on a black background. Below the flag, the sign said SUPPORT SAFE SPACES FOR GAY, LESBIAN, BISEXUAL, AND TRANSGENDER YOUTH.

Reading the word *transgender* sent a shiver down George's spine. She wondered where she could find a safe space like that, and if there would be other girls like her there. Maybe they could talk about makeup together. Maybe they could even try some on.

George stared at the sign and thought about finding other girls like her while Mom and the principal chatted. Principal Maldonado asked about recent changes in home life—but there hadn't been any since Dad left three years ago. Finally, the principal said, "Why don't you take George home for the day to give him some time to cool down, and we'll leave it at that."

Mom thanked Principal Maldonado, who then turned her attention to George. "I wouldn't make a habit of bothering Jeff. Some kids like trouble, and they'll do whatever they can to find it. And if you land back in this office again, I can promise you I won't be so lenient."

George hoped she'd never find out what that meant.

chapter IX

DINNER AT ARNIE'S

Mom didn't say anything in the car about the fight. Instead, she turned on a radio station that promised *v-v-v-vintage modern rock* and sang along with the choruses. When they got home, Mom suggested George wash up.

In the bathroom, George combed her hair forward. If she squinted at the mirror, she almost looked like a girl. For now, anyway. Today her skin was smooth, but someday testosterone would grow a terrible beard all over her face. Scott had already started to sprout awkward tufts under his chin.

She brushed her hair back to its usual style and headed to her room to flop on her bed. A few minutes later, a quiet knock came on her bedroom door.

"Can I come in?" Mom asked.

"Yeah." George sat up and Mom took a seat at the foot of the bed.

"George, I'm going to be honest. I worry about you. There are a lot of kids like Jeff out there, and plenty who are worse." Mom blew a puff of air up at her bangs. "I mean, being gay is one thing. Kids are coming out much earlier than when I was young. It won't be easy, but we'll deal with it. But being *that* kind of gay?" Mom shook her head. "That's something else entirely."

"I'm not any kind of gay." At least, George didn't think she was gay. She didn't know who she liked, really, boys or girls.

"Then why did I find all those girls' magazines in your closet?" Mom raised an eyebrow, and a curved wrinkle formed across her forehead.

George drew in a deep breath, held it, and let it out. Then another.

"Because I'm a girl."

Mom's face relaxed and she gave a short laugh. "Is that what this is about? Oh, Gee, I was there when you were born. I changed your diapers, and I promise you, you are one hundred percent boy. Besides, you're only ten years old. You don't know how you'll feel in a few years."

George's heart sank. She couldn't wait years. She could hardly wait another minute.

"Tell you what," Mom said, patting George's knee. "How about we do something special tonight. Let's go to Arnie's." Arnie's All-You-Can-Eat Buffet was George's favorite restaurant. "You'll feel better once you're eating nachos and pizza and pie like a regular kid. For now, just chill for a bit. That's what I'm going to do."

George knew Mom was trying to make her feel better, but it didn't work. Nothing—certainly not a buffet dinner—could help the fact that Mom didn't see her.

Mom took her laptop into her bedroom and came out only to refill her seltzer glass. Once again, George wished she had her magazines to look at. Instead, she watched cartoons on the sofa until school was over at three. She knew it took Kelly about twenty minutes to get home on the bus—and sure enough, the house phone rang at 3:22. George picked up the cordless extension and headed to her room.

"What happened to you?" Kelly asked, not bothering to say hello. "Everyone's saying you picked a fight with Jeff. But I told them that was impossible because you've never been in a fight in your life, and that Jeff must have been the one to start it. I mean, really, who's gonna pick a fight—you or Jeff? What did he do to you? Are you okay? I mean, you're obviously not in the hospital or anything, but man, they said he got you good. And did you really throw up on him? Because seriously, that might be the funniest thing I've ever heard in my life."

Kelly was so loud that George could feel the phone vibrate. She held it a few inches from her ear and waited until Kelly was done.

"Are you there?" Kelly asked.

"Yeah."

"Yeah, what? Yeah, you're there? Yeah, you threw up on Jeff? Or yeah, you picked a fight?"

"All three."

"What the heck, George? What were you doing, picking a fight with the biggest bully in our class?"

"I dunno. He made fun of Charlotte, I guess." George's reasoning sounded foolish, even to her.

"Charlotte's not even real."

"Yeah, but—"

"If you're gonna be transgender and all, you're going to have to be a lot more careful. You won't be able to throw up on every bully you meet."

"I could try," said George. "Bleh! Bleh! Bleh!"

"You sound like a vomiting machine gun."

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"I could try," said George. "Bleh! Bleh! Bleh!"

"You sound like a vomiting machine gun."

"I could be a superhero!"

"You'd be Ralph the Ralpher. You could even have a motto: 'If you throw down, I'll throw up!'"

George and Kelly chuckled, but then a quiet fell over the conversation, and the only sound that came through the phone was the airy hum of the line itself.

"The play really means a lot to you, doesn't it?" asked Kelly, breaking the silence.

"It's just . . ." George sighed. "I just thought that . . . you know . . . if I were Charlotte in the play, my mom might . . ."

"See that you're a girl?"

"Yeah," said George. It felt funny to hear Kelly call her a girl—but in a good way, like a tickling in her stomach that reminded her she was real.

"Well, maybe it's not too late," said Kelly. "I mean, the play hasn't happened yet, has it?"

"But you got the part."

"There are two performances, silly. I could take one and you could have the other."

"You'd do that for me?"

"Of course I would. I thought about it the whole bus ride home. I can make sure my dad comes to the afternoon show. You could totally do it! In fact, you make a better Charlotte than I do."

It was true. George had listened to Charlotte's lines enough times that she knew every word, and she knew just how she would say them—mostly like Kelly did, but different in a few key places. Kelly emphasized some of the wrong words, and she still sometimes flubbed Charlotte's first line by saying "SalutaTAtions" instead of "Salutations."

"But how?"

"It's easier than easy! You'll already be dressed in black as a stagehand. All you have to do is put on the arm vest and you'll look perfect." As Charlotte, Kelly

wore a black leotard and tights, along with a vest with three stuffed arms sewn on either side.

"But Ms. Udell already said I couldn't have the part."

"You know what? Ms. Udell is wrong. You should be Charlotte. And by the time she realizes it's you, it'll be too late. You'll already be onstage and there won't be a thing she can do about it."

George could practically hear the devious grin on Kelly's face, and she could certainly feel the grin on hers. With Kelly's help, maybe she really could be Charlotte.

"But what about when the other kids notice?"

"Forget the other kids. Jeff won't be there, and no one else will care."

"What about my mom?"

"I thought showing your mom was part of the idea!" Kelly's shrieking voice hurtled through the phone.

"Yeah, but . . ." George's stomach flopped.

"Look, do you want your mom to know you're a girl?"

"Yes."

"Then be Charlotte." Kelly said it as if it was choosing strawberry ice cream instead of chocolate. "I gotta go. I still have one performance to rehearse for. And now, so do you! One-two-three—"

"ZOOT!" George hung up and twirled around the house, like Charlotte spinning a glorious spiderweb. She, George, was going to be Charlotte onstage! In front of Mom and everyone!

The butterflies in her stomach had butterflies in *their* stomachs.

● ● ●

Scott leaped out of Randy's house the moment Mom honked the horn, as though he had been waiting at the doorknob. He filled the car with a rant about his history teacher, followed by a tirade about his math teacher and a torrent about his biology teacher.

"The man wants us to dissect a worm!"

"I would think you would find that gruesomeness appealing," said Mom.

"Not if I have to diagram every last body part to scale. It's going to be a pain in the butt. If I'm going to diagram something, why can't it at least be a frog? That would be cool."

"If you think it's hard on you, just imagine how the worm feels."

George was glad that Scott was diverting Mom's attention. She didn't want to be asked why she was smiling after having been beaten up and sent home from school, but she was ecstatic about the idea of playing Charlotte onstage, and it was hard not to show it.

Mom turned in to Arnie's All-You-Can-Eat Buffet and rolled into a spot facing the building. Red awnings with thick green borders hung across the wide windows of the large, squat building. A long banner stretching across the front of the restaurant proclaimed OVER ONE HUNDRED ITEMS COOKED FRESH EVERY DAY.

Inside, happy eaters sat at booths and tables, their plates filled with food foraged from a dozen different cuisines in heaps of each person's favorites. No one waited on tables at Arnie's, and no one waited for their meals. Instead, endless buffet trays lined one long wall of the restaurant. People dressed all in white carried out full trays of food to the buffet and brought empty trays back into the kitchen. Tables filled with soda and lemonade glasses.

Mom paid at the door and unleashed her children on the buffet while she found a table. George filled her plate with fried chicken, mashed potatoes, corn fritters, pizza, a pile of nachos, and a cube of cherry Jell-O hidden under a taco, to eat while Mom was getting her own food. Even at Arnie's, Mom said you should have dinner before dessert. George went back to the table while Mom took her turn at the buffet. Scott sat down soon after.

"What's up with Mom?" he asked from behind

a plate piled high with ham, turkey, and chicken, topped with two slices of pizza. "She never takes us out to Arnie's on a weekday unless she's upset about something."

"Yeah, well." George looked over at Mom, who was still picking out lettuce for her salad. "I kind of got into a fight at school."

Scott's head shot up in surprise and his brow grew heavy. "When I got into a fight at school, I got grounded. How did you work Arnie's out of it?"

"I kind of also told her something."

"It must have been big. Mom's staring at the beets like a zombie."

"It was."

"Did you tell her you were gay?" Scott twisted his fork into a pile of mashed potatoes. "You know I'm okay with that, right? Before Dad left, he made me promise to take care of you. He said you were like that."

"I'm not gay," George said. Why did everyone think she was gay?

"Whatever. I don't care. My friend Matt is gay. It's no big deal."

But it was a big deal. "I told her I think I'm a girl."

"Oh." That was all Scott said at first. "Oh."

Scott chewed, swallowed, and took another bite of pizza. The background noise of the restaurant throbbed in George's ears. She wished Scott would say something, even if it was mean.

"Ohhh." Scott took a bite of turkey. "Ohhhhhhhhh." Scott began to nod slowly. He turned to George, whose stomach had jumped with each *oh* and was now nearly in her throat.

"That's more than just being gay. No wonder she's freaking out."

"I know."

Scott put down his fork. "So do you?"

"Do I what?"

"Think you're a girl?"

"Yes." George was surprised at how easy that question was to answer.

"Oh." Scott ripped a hunk off a roll with his teeth and chewed thoughtfully.

Mom returned with a green salad, topped with raw vegetables and vinaigrette dressing. She finished it quickly and dropped her plate off in a dish bin. Mom always started her meal at Arnie's with a salad. She said it was healthy, not to mention delicious, but she always ate it quickly and then returned with a plate just as decadent as George's and Scott's.

Scott had gnawed silently on a chicken wing while Mom ate her salad, but once she got up and approached the appetizer bar, he dropped the bone onto his plate.

"I know about your magazines," he said.

"Mom *told* you?"

"Naw, I found them this weekend. I knew Mom was upset about something, and then I saw the bag sitting on her bed. Dude, I thought you had porn or something in there, so I took a peek. You know, just to find out what kind of stuff my little bro was into. So I figured you were gay. But I didn't think you were *like that.*" Scott popped a corn fritter into his mouth. "So, like, do you want to"—he made a gesture with two fingers like a pair of scissors—"go all the way?"

George squeezed her legs together. "Maybe someday," she said.

"Weird. But it kinda makes sense. No offense, but you don't make a very good boy."

"I know."

Mom returned to the table, and the conversation was dropped. All three of them stuffed their faces until they dragged their very full stomachs to the car, groaning all the way, much like Templeton the rat after his night of indulgence at the fair.

All three of them crashed in front of the television when they got home, and watched a sitcom about a family with twelve kids. The jokes mostly focused on the empty fridge and full bathroom. George wondered what it would be like to live with so many people. Maybe each kid got noticed less. With Mom eyeing her from her chair, George wondered whether maybe that wasn't such a bad thing.

Scott snuck glances her way too, but where Mom's eyes were filled with concern and confusion, Scott looked at George as if his sibling made sense to him for the first time. George had never been gladder to have an older brother.

chapter X

TRANSFORMATIONS

George wasn't sure when Jeff would be back at school, and every morning, she kept nervous eyes out for the first sign of his spiky hair. When she finally spotted it, Jeff was already headed in her direction with a sneer across his face. He walked at a steady pace, his eyes steeled in the distance beyond George. He didn't break his stride for an instant but spit at her feet as he passed. Every time he passed her that week, he spit. Real spit that landed on the pavement if they were outside, pretend spit on the linoleum floors if they were inside the school.

The morning of the play, the students of Room 205 chatted and laughed, leaving their bags on their desks and ignoring the assignment on the board. Only Ms. Udell's threat to cancel the play quieted the class, and even then, she struggled to wrangle her students through a morning of reading, journals, math, and vocabulary. Kelly and George exchanged knowing glances throughout.

After recess, Ms. Udell and Mr. Jackson brought their classes to the auditorium. Kindergarten through third-grade students filed noisily into the old wooden seats for the afternoon performance. Parents and relatives sat in the first few rows. Isaiah, the boy from Mr. Jackson's class who was playing Wilbur, frolicked heartily, getting into character.

The cast and stagehands gathered with Ms. Udell backstage. The rest of the class went to sit in the audience with Mr. Jackson. It was dark behind the thick red cloth that draped the stage, and the air smelled musty,

but once the curtains were pulled, the light from the auditorium windows would fill the stage.

After the audience was seated, the overhead light flickered twice, signaling quiet. The curtain squeaked open and Jocelyn walked onstage. The girl from Mr. Jackson's class was playing Fern, and she carried a blanket in her arms, meant to represent the runt pig, Wilbur. For this scene, Wilbur didn't have anything to do or say but to be saved from Pa's ax, and Isaiah was too big for Jocelyn to hold him in her arms. The first narrator began to speak, and the play had begun.

When it was nearly time for Kelly's first lines, she stepped up the ladder, carefully holding her extra limbs in her hands. She gave her opening speech, which went perfectly. She even said *salutations* the right way. The audience was focused on her every move. She spotted her dad and winked at him. Then she climbed down to wait for her next scene.

"You were great!" George whispered when Kelly was back on the ground.

"You're gonna be even better!" Kelly whispered back.

George said nothing, but she pictured herself onstage, at the top of the ladder, sharing Charlotte's words with the audience.

The play was short, over before most of the younger students began to squirm in their seats. At the end, the actors took their bows and Ms. Udell thanked the members of the audience for their time.

Once the younger students had filed out, Ms. Udell spoke to the fourth graders and the family members in the audience. "Students who are performing this evening, please be back at five thirty. The play will begin at six sharp. Parents and family, I hope you'll stay for the PTA meeting that will follow." A few parents coughed in response. George knew that coughing was the adult equivalent of groaning.

Families congratulated the performers at the front of the stage. Kelly's dad had even brought a bouquet for her. He and other parents left with their children. Ms. Udell escorted the remainder of the class back to Room 205 for the final twenty minutes of the day, to write in their journals about *The Excitement of the Theatrical Experience*, which was what Ms. Udell wrote on the board in large letters.

George wrote a single sentence on her page: *It was exciting to help out with the play.* But what she really wanted to write was *I'm going to be Charlotte!!!!*

● ● ●

Mom arrived home right when it was time to head to school for the play. She didn't even bother to remove her shoes.

"Ready to go?" she asked.

Scott was at Randy's house for the evening,

supposedly working on a school project. George suspected that they were more likely watching gore flicks, but either way, she was glad Scott wasn't coming to the play. He had shown surprising tact until now, but if he said the wrong thing to Mom, he could really freak her out. George got up from the spot where she had been flopped on the couch for the last hour, barely noticing the talking dogs and superhero kids who flashed by on the television screen. She had bigger things on her mind. She put on her dress shoes, the only pair of black shoes she owned. When she was handing the spiderweb signs up to Kelly, her white sneakers hadn't mattered much, but if she was going to be Charlotte, she wanted to do it right.

As Mom pulled out of the driveway, George's stomach turned nervously. She counted telephone poles to relax.

"So how was the afternoon performance?" Mom asked.

"It was okay." George was used to counting while Mom talked. She held the tens on her fingers to keep track.

"That really sells it for me."

"Sorry, Mom. I was just thinking."

The ride to school wasn't long, so if George missed a pole, she might not have another chance to get up to one hundred. She supposed she didn't really need an imaginary electric fairy to go through with her and Kelly's plan, but it seemed safer that way.

"I'm excited to see you take a bow this evening, even as a stagehand. And Kelly will be great as Charlotte, I'm sure."

George didn't correct her. Mom would find out about the plan soon enough, and by then, it would be too late to stop it. George reached a hundred telephone poles with blocks to spare.

The tiny school parking lot was full, so Mom found a spot on the street a block away.

"Looks like it's going to be a big audience," Mom said.

"Guess so." George shrugged, trying to ignore the fear that coursed through her.

At the door of the auditorium, Mom kissed George on the cheek and searched for a seat. George could hear the students gathered backstage. The red curtain was heavy, and she fought her way through. The backstage lighting was dim, and George's eyes blinked to adjust. Most of the cast and crew were already assembled.

"There you are!" Kelly skipped over to George.

George grinned. They both wore all black. The only difference between their costumes was the vest of stuffed spider arms that Kelly wore. They shared secret smiles and giggles until it was nearly time for the show to begin. George shook with excitement.

"This is it, ladies and gents," said Mr. Jackson, gathering the cast and stagehands together. "Let's make

Mr. E. B. White proud one more time. Best performance and best behavior."

"Break a leg!" Ms. Udell said with a wink.

"Take your places and we'll get this show on the road!" Mr. Jackson twirled his index finger in the air.

Ms. Udell took the side steps off the stage and sat down in the first row of the audience. Mr. Jackson stayed backstage to oversee the performance.

The play began just as it had in the afternoon. The curtain rose on Fern Arable holding a blanket in her arms, cooing to a pretend piglet, and the audience applauded. The first narrator described the Arables' farm and told the audience about the baby pig who was moments from execution.

Backstage, Kelly took off the vest of spider arms and handed it to George, who checked to make sure that Mr. Jackson wasn't watching. Then she donned the vest. The fake arms were filled with cotton and didn't weigh much, but they were bulky. George had to bunch them

up in her real arms, as she had seen Kelly do, to make sure she didn't trip over them. She combed her hair forward with her fingers, as she had done countless times in the mirror, and waited. The opening scenes of the play had never been so slow.

George was bouncing on the balls of her feet with nervous excitement by the time the barnyard animals began to greet Wilbur. Charlotte's first lines were only moments away. George climbed up the ladder to appear above the backdrop, in full view of the audience.

"Salutations!" George called out. Her voice was loud and clear, but with a soft lilt that showed Charlotte's kindness. She looked down to see Kelly holding the ladder steady with one hand as she took pictures of George with the other.

George heard a gasp onstage below her, and then another, but she kept going. She explained to the animals what *salutations* were. She smiled and waved to Wilbur and to the audience, as if she were saying hello

to the world. The audience smiled back. A small kid even waved.

Ms. Udell sat in the middle of the front row, frowning, just as she had in the hallway after George's audition. George looked away. She looked for Mom, to see her reaction, but couldn't find her in the crowded auditorium.

The rest of the audience was watching her, waiting for Charlotte's next line, and George didn't disappoint. Every word sounded just as she had rehearsed it. She didn't make a single mistake. She felt like she was floating.

At the end of the scene, George climbed back down the ladder. Her body felt as light as air, and she wasn't completely sure her shoes were touching the ground. Kelly squeezed her from behind, grabbing the cotton arms along with George's waist.

"Wow, George, that was awesome!" she whispered. "Really."

"Thanks." George beamed a goofy, unfocused grin.

"You were totally like a girl." Kelly took George's hand, one of the real ones. "I mean, you totally *are* a girl." Kelly hugged her best friend tightly.

Jocelyn walked up to them, her fists in tight balls. "You can't just do that!" she whispered loudly.

"Why not?" Isaiah whispered back.

"Yeah." Chris crowded into the huddle backstage. "Why not? He was good. Better than Kelly, even. No offense, Kelly."

Kelly shrugged. "I wasn't that great."

"But it's disrupting to the other actors," said Emma.

Most of the narrators had joined the circle around George, as had a few of the barnyard animals, who were supposed to be clucking and mooing onstage. Rick remained by the curtain rope and said nothing.

"Hush." Mr. Jackson approached the group and herded it away from George and Kelly.

The side curtain moved, and Ms. Udell stepped backstage, her face in a scowl. She headed toward George, but Principal Maldonado appeared directly behind her and put her hand on Ms. Udell's shoulder. Then she whispered something into Ms. Udell's ear.

Ms. Udell looked at George, Kelly, and finally Principal Maldonado. She raised a finger and opened her mouth, but then stopped. She looked over at the play, still in progress, and the audience beyond. She gave a weak smile to Kelly, an even weaker smile to George, then stepped offstage.

Principal Maldonado gave George a subtle nod, more with her eyelids than her chin. Then she stepped offstage as well. By then, it was nearly time for Charlotte's next scene. George climbed carefully up the ladder and waited quietly for her cue.

The play passed by quickly, and yet it seemed to George as though she had been onstage since the

beginning of time, as if she were born there and had only now found herself where she had always been. Wilbur performed his silly antics; Templeton raced around to gather sesquipedalian words; the geese clucked around and were generally a nuisance. It was like a real barnyard onstage.

And at the center of it all, Charlotte provided her friendship and wisdom. George reveled in every moment, sharing her voice with the audience and watching them watch her as they waited for her next words.

It wasn't long at all before George gave Charlotte's final speech. Charlotte was dying. It was the way of things, and she could do nothing but accept her fate. The sadness in George's voice came from deep inside; she knew her moment onstage was nearly over.

"Good-bye, Wilbur," she said as her last words floated into the audience and out of reach. Before she could bear to step down from the ladder, George looked up. Sad faces filled the audience, and younger kids

wiped their eyes on their sleeves. Still, she didn't see Mom.

The moment George reached the ground, she cried too. She slumped against the backstage wall, hugging her knees, as she cried in sadness and joy. Charlotte was dead, but George was alive in a way she had never imagined. She watched the remainder of the show from the side of the stage, in a heady post-performance glow. Soon the audience began to clap.

Someone grabbed George's hand and brought her into the line of performers. Everyone bowed in unison. Then the human characters moved up for a second bow. The applause grew stronger as Chris, who had played Templeton, stepped forward. Isaiah hopped onto his hands and knees to oink like a pig once more, to laughter and even more applause.

George felt someone push her gently, and she let her feet guide her to the front of the stage. The auditorium was filled with hands clapping louder than ever. She

blinked a few times, and then saw Ms. Udell motioning for her to bow.

George looked out on the crowd and did the only thing that made any sense. She curtsied. She wore no skirt to hold daintily, but she didn't need it. She was graceful, and she held on to the moment as tightly as she could, even after the curtains were pulled shut.

The class clapped and hooted and howled. A few kids patted George on the back. "Way to go," they said, and, "You were awesome!"

"Congratulations to you all!" Mr. Jackson cried as he stepped out from backstage. "You were fantastic! Including our surprise star!" Mr. Jackson smiled at George. "Now, there are a lot of excited families here, eager to congratulate you. I suggest you get out there!"

George worked her way through the split in the curtain and surveyed the audience. Kids weaved around, finding their parents and saying good night to their friends. Chris re-created some of his favorite moments.

Kelly bounced around, taking photos. Nearby, her father gave George a giant thumbs-up sign. In the back, Rick slipped out the auditorium door. He had come alone. George wondered whether he would say anything to Jeff.

George heard her name coming from kids talking to their parents, as well as the word *boy*. Adults' heads turned her way. Most looked at her with open faces of surprise. A few smiled and waved. Others crinkled their faces in disgust. George stepped offstage and out of view of staring eyes.

Mom made her way up the main aisle. Her stern face stood out in the crowd. George felt as if she were frozen in place.

"Well, that was unexpected," Mom said. "I didn't even know it was you at first. I thought it was supposed to be Kelly, but then I realized I was seeing my son onstage, and nearly everyone in the audience thought he was a girl."

George's lips quivered, but her voice was clear. "I did too."

"Did what?"

A bit of Charlotte's confidence still coursed through her. "I already told you. I'm a girl."

Mom's face turned to stone and her mouth grew small. "Let's not talk about this right now."

George noticed Principal Maldonado heading toward them, a soft smile on her face.

"Congratulations! You were wonderful!" she said to George, then turned to Mom. "Your kid was great tonight. You just might have a famous actor on your hands someday."

"Thank you." Mom smiled politely. "He certainly is special."

"Well, you can't control who your children are, but you can certainly support them, am I right?" Principal Maldonado's earrings sparkled in the auditorium light.

"Excuse us," said Mom, searching awkwardly in her purse for some imaginary item. "But we've got to get home to dinner."

"Well, make sure the star gets extra dessert tonight!" Principal Maldonado put her arm around George. She smelled of vanilla.

"I certainly will," said Mom.

"That was beautiful, George. Really beautiful." Ms. Maldonado put her lips close to George's ear and whispered, "My door is always open," before she slipped away.

Mom took George by the hand and walked brusquely through the lingering crowd. Once they were out in the hallway, the murmurs from the auditorium were quieter, and their footsteps echoed. Outside, it was dark enough that the streetlamps had turned on, but the sky still held a bit of light. Mom jiggled her keys in her palm. Neither she nor George said a word.

At home, they watched a dancing competition on television as they ate a dinner of spaghetti. Scott was

still off at Randy's. George noticed that Mom kept looking over at George, but when George looked back, Mom had her eyes fixed on the television screen, even if it was showing commercials, which she usually hated.

Neither Mom nor George mentioned the play that evening, but once George was up in her room, she twirled around and around like a spider dancing on a web.

chapter XI

INVITATIONS

Kelly stood in a circle of girls in the school yard the next morning, telling an animated story, but she stopped when she spotted George. They pointed and called her over.

"And here's our hero!" said Kelly, smiling and holding her hands out as if she were a model presenting a new car on a game show.

"How did you know all the words?" Maddy asked.

"What was it like to play a girl onstage?" asked Ellie.

"I didn't even realize you were a boy at first," said Aliyah, a girl from Mr. Jackson's class who had been one of the barnyard animals.

"I heard you were really good," said Denise, who hadn't been there.

"I still don't think you should have done it," said Emma, who had been a narrator. "It could've messed everything up."

"Besides," said Jocelyn, "you're a boy. Why would you want to play a girl's part anyway?"

"I couldn't even imagine being a boy onstage, even if everyone knew I was really a girl. I just couldn't do it," said Maddy.

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"Yeah, it would be too embarrassing," said Denise.

Comments came flashing at George faster than she could respond, which was a relief, because she didn't know what to say. Instead, she shrugged and smiled weakly. She wished she could be Charlotte now. Then she could answer all their buzzing with sage words of advice, instead of drowning in questions.

George heard dreadful laughter behind her. It was a

familiar snicker that swelled into a snorting guffaw—Jeff's laugh. Before she could prepare, Jeff was in front of her, Rick at his side. Jeff pushed George's shoulders with the base of his hands. He didn't push hard, but George hadn't been ready, and she stumbled back. The crowd of girls dispersed, leaving Jeff and Rick facing George and Kelly.

Jeff snickered again. "I heard you were in our class play, *Charlotte*."

"He was, and he was great!" said Kelly.

"Oh, shut up. I'm talking to George here. He's more of a girl than you'll ever be."

"Leave her alone!" George yelled.

"Or else what?" asked Jeff.

"Just leave her alone." George stared at the ground.

"C'mon, Jeff. Let's go." Rick tugged at Jeff's elbow. "You promised if I told you what happened that you wouldn't mess with him."

"Whatever," said Jeff, flicking his finger on George's forehead. "This freak pukes. I like this shirt, and my mom still can't get his stink out of the last one."

Jeff cracked up and walked off with Rick.

"Forget them," said Kelly. "I've got a surprise. My uncle Bill's taking us to the zoo on Sunday!"

George crinkled her nose. Zoo air smelled like animal poop. Besides, she and Kelly had decided last year that the Smithfield petting zoo was for babies. They had more ducks than anything else, and their most exotic showing was a crusty old pony that had recently celebrated its fortieth birthday.

"Not the Smithfield Snoozefest, you dope." Kelly rolled her eyes. "He's gonna drive us down to the Bronx Zoo. They have over six hundred species. Tigers and gorillas and giraffes, not goats and sheep. They've even got panda bears! You're free on Sunday, right?"

"I guess," George said.

"Because I was thinking." Kelly lowered her voice. "The Bronx Zoo is super-far away, and we won't see anyone there we know. You've never met my uncle, have you?"

George shook her head.

Kelly grinned. "Don't you get it? We can go as *best girl friends*. We can dress up and everything!"

George's mouth hung open. George already knew Kelly was her best friend, but they had never been girls together before. George had never been a girl with anyone, if you didn't count being Charlotte.

"Did you hear me?"

"Like a skirt?" The hair on George's neck tingled just saying the word *skirt*.

"Sure. When *girls* dress up, they wear skirts. I have a lot to teach you about being a girl, Geor—Oh." Kelly stopped. "My uncle's going to figure out something's up the moment I call you George, isn't he?"

George thought about her private name. She had never said it out loud before, not even to her friends in the magazines. "You could always call me Melissa," she said now.

"Melissa," said Kelly, her eyes wide. "I like it. That's a great name for a girl." She said it again, drawing out each sound. "Me-lis-sa. That's perfect!"

George buried her chin in her shoulder and felt her cheeks grow warm.

"Are you okay?" Kelly asked.

"Yeah," said George. "It just sounds really good to hear."

"I can say it again. Melissa. Melissa Melissa Melissa!" Kelly began to twirl around George, stretching her arms out wide with each *Melissa*.

George clapped her hand over Kelly's mouth.

"Are you crazy? Jeff is right over there!" George jerked her head to the side.

"So? I've got a friend named Melissa. He doesn't know who I'm talking about. It's none of his business anyway."

Kelly danced around George, singing the name *Melissa* until George giggled and turned beet red. She had never heard her girl name out loud before, and now Kelly had made it into a song.

The morning bell rang and the mass of students in the school yard formed into a series of lines. As George walked up the stairs to Room 205, she listened to Kelly's tune still echoing in her mind.

Melissa Melissa Melissa . . .

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Mom was sitting on the couch when George got home, her laptop in front of her and a can of orange-flavored seltzer on the side table. A soap opera ran on the television with the sound turned low.

"Come over here, Gee." Mom patted the space on the couch next to her, closed the computer, and turned off the television. She took a few deep breaths before speaking.

"You were great in the play yesterday. I know I acted surprised at first, but I'm really proud of you for being yourself. What did the kids at school say?"

George shrugged. "Not much. Jeff was a jerk."

"What's new? You're one tough cookie. But the world isn't always good to people who are different. I just don't want you to make your road any harder than it has to be."

"Trying to be a boy is really hard."

Mom blinked a few times, and when she opened her eyes again, a teardrop fell down her cheek.

"I'm sorry, Gee. I'm so sorry." She pulled George toward her and hugged her tight. "You really do feel like a girl, don't you?"

"Yeah, I do. Remember that time I was little, when you found me wearing your skirt as a dress?"

"Yes."

"And remember how I wanted to be a ballerina and it drove Scott crazy because he said I couldn't because I was a boy?"

"I remember the temper tantrum you threw when I didn't get you a tutu."

"Are you upset with me?"

"Oh, baby, no." Mom stroked George's hair and sighed deeply. "But I do think you need someone to talk to. I probably could use someone too. Someone who knows about these things."

George knew that seeing a therapist was the first step secret girls like her took when they wanted everyone to see who they were. "And then maybe I could grow my hair out and be a girl?"

"One step at a time." Mom wiped away another tear that had drifted down to her cheek. She cleared her throat. "Now how's about that homework?"

George pulled out her vocabulary assignment and

began to work at the table while Mom went to the kitchen to start making dinner. Mom poured a box of corn bread mix into a bowl along with eggs and milk. George noticed that she mixed with quiet efficiency, holding her whisking arm tight to her body. She didn't hum or dance the way she often did when she cooked.

The house was quiet until Scott arrived home with the clatter of his bike hitting the pavement. He dashed through the house and up to the bathroom.

"Ahhhhhh," he said when he sauntered back down the stairs. "No wonder they call it relieving yourself. That was a good one!"

"Scott, go put your bike in the shed. And, Gee, set the table. It's almost dinnertime."

Mom portioned grilled chicken wings with barbecue sauce, corn bread, and steamed broccoli onto three plates, and set them out on the table. George filled three glasses with iced tea and brought out forks, knives, and napkins.

Over dinner, Scott complained about the unfairness of his latest social studies test, and told the story of Mike the Headless Chicken, a real chicken that had lived without a head for eighteen months in the 1940s. When Scott acted out the part of Mike, using the chicken wings on his plate, George laughed so hard she almost choked. Even Mom chuckled.

And that night, when George went to her bedroom, she found her denim bag on her bed, with all of her magazines still inside.

chapter XII

MELISSA GOES TO THE ZOO

George awoke before the sun and couldn't fall back asleep. She'd never been this excited for the zoo before, not even when she was little. When the dark cloudy sky revealed its first shades of purple, George slipped out of bed and settled down on the couch with some cereal and the remote control, but nothing on television caught her interest. It was too early for anything good to be on. She tried playing *Mario Kart* but kept losing focus and falling into deep lava pits.

The sky had begun to lighten, but there were still nearly two hours before she was supposed to leave for

Kelly's house. She went out to the backyard, where her sneakers squeaked on the dew-soaked spring grass.

In the far corner of the yard was an old oak tree, and tied to one of the lowest branches of the tree was an old-fashioned swing. George's dad had hung it after he and Mom separated, but before he left town. A plank of wood hung from two thick lengths of rope, with a stretch of bare dirt below, where years of feet had worn away the grass. The seat had once been bright red, but what was now left of the paint was dull and chipped, revealing the gray wood beneath. Once, Scott and George had fought for turns on the swing. Sometimes they even swung on it together. Scott hadn't used the swing in a long time, though, and even George hadn't been on it since last year.

George brushed the seat with the elbow of her jacket and sat down. She took small steps backward until she stood on tiptoe, the seat pressed against her behind.

Then she lifted her toes, leaned back in the seat, and glided into the morning air. She coasted for a bit and then began to pump her legs, rising higher and higher. Soon, she was able to see into the neighbor's yard with each lift into the sky.

The light in the east was still orange from the sunrise. The sun itself had lifted into the sky, and its rays were warm on George's face each time she emerged from the shade of the old oak tree. She swung for a long time, enjoying the rhythm and the breeze.

She wondered what kind of skirt she would wear, and whether she and Kelly would match. And she wondered what Kelly's uncle Bill would be like. If he was as clueless as Scott, he would never notice that George wasn't a regular girl. If he *did* notice, George wasn't sure whether he would be nice. Kelly said he was nice, but Kelly had been wrong before. He might laugh at George. He might even leave her at the zoo. Still, there was no way she was going to pass up this chance to be a girl with Kelly.

When George came inside, Mom was at the stove with a spatula, tending to a frying pan. She wore an apron that said MIND THE CHEF in large letters. The air smelled sweet, and George's stomach growled.

"You want pancakes?" Mom asked.

"Yes, please. With cinnamon."

George toyed with telling Mom about the plan, but she remembered Mom's words: *one step at a time.* She would tell Mom about her adventure when Mom was ready. Instead, they talked about the animals George would see, as if it were any other trip to the zoo.

After breakfast, George pulled out her bike and put on her helmet. She rode past the library and up the hill to the corner store where Mom sometimes sent her to pick up milk or a loaf of bread. She rode past the big purple house with a cactus garden for a front yard, and past the building where her old babysitter used to live. She rode alongside the cemetery twice—up the slow and steady incline, around the back, and

swoosh, down the trail on the far side, with its three bumps down.

When she couldn't bear waiting any longer, she headed toward Kelly's house. George pedaled as slowly as she could manage to stay upright, riding up and down side streets, but she still arrived fifteen minutes early. She waited around outside until she thought her head would pop.

When she finally knocked, the door opened instantly. Kelly pulled George into the main room of the basement apartment. She wore green pajamas and her hair was tied back in a puff of curls. "Finally, you're here! We can get dressed!"

"What if your dad wakes up and sees us?" whispered George, looking over at Kelly's father asleep on the daybed.

"Are you kidding me? He had a gig at the Masons' Lodge last night. He won't move until noon." Kelly

gestured her thumb at her snoring father. "If he does see anything, he'll think it's a dream."

Kelly led George into her room and shut the door behind her. The closet and most of her dresser drawers were open, displaying an array of girls' clothing, and Kelly had laid out an assortment of makeup on her desk. The air smelled of perfume, several bottles of which were lined in a neat row next to the makeup.

"Welcome to Kelly's Salon. Whaddaya think?"

George's heart thumped in her chest. It was as if all of the pages of all of her magazines had come to life in Kelly's bedroom.

"It's . . . wonderful."

"What do you want to try on first?"

"What *can* I try on?"

"Anything you want!"

George looked over the skirts that hung in Kelly's

closet. She had no idea how to choose. "What do you think would look good on me?"

"I have the perfect thing." Kelly sounded like a clerk at a high-end clothing boutique. She dashed to the closet and pulled out a flared skirt of purple swirls and rummaged through a drawer for a hot-pink tank top. She laid the clothing in George's hands. The top was soft, softer than any boys' shirt she had ever worn. And she had never held a skirt in her hands like this before. Together, they felt magical.

"I didn't even know you had any skirts," said George.

"I don't wear them to school. Boys are dirty and try to look up them."

"*I'd* never try to look up your skirt."

"Of course not. You're not a boy."

"Oh, right." George laughed. Even she was sometimes fooled by her body. Kelly laughed too, and no one passing by the basement apartment window would have

ever suspected that there weren't two girls in the room below, bonding over clothes, boys, and whatever else it was girls gossiped about.

"So," Kelly said, "don't you want to try them on?"

George nodded slowly. "Could you turn around?"

"Of course!" Kelly turned back to the closet and held shirts and skirts against each other, looking for the perfect match.

George eyed the tank top Kelly had given her. It looked a bit like an undershirt, but with thinner shoulder straps. She took off her T-shirt and slipped the girls' top over her head. The air felt cool on her exposed shoulders. Next, she took off her sweatpants and stepped into the skirt. She pulled it up to her waist and let the fabric settle into place.

She looked in the mirror and gasped. Melissa gasped back at her. For a long time, she stood there, just blinking. George smiled, and Melissa smiled too.

When her eyes started to sting, she twirled in a circle, and the skirt ballooned out below. Stopping with her legs crossed, she felt like a model.

Kelly squealed when she turned around. "Oh, that looks so cute on you . . . Melissa."

Melissa's heart fluttered, hearing her name.

"Can I take a picture?" Kelly snapped her camera before Melissa could answer.

"Now try these on." She handed Melissa a yellow skirt with shimmering fringe at the bottom and a black T-shirt with a yellow heart in the center.

Melissa fingered the fringe of the skirt. She didn't want to take off the clothes she was already wearing, but the fringe looked so lovely, and it would brush against her knees as she moved.

Kelly turned back to the closet, and Melissa changed shirts. She stepped into the yellow skirt and brought it up to her waist. Again, she gazed in the mirror, amazed to find herself there. She could have stared for a long

time, but Kelly wanted to know what Melissa thought of her ensemble.

"Don't I look elegant? New York City's really elegant, you know." Kelly wore a long black skirt, a black top, and black silk gloves.

Melissa frowned. "You look like you're going to a zoo funeral."

Kelly laughed. "Yeah, you're right," she said, pulling the gloves back off by their fingers.

Melissa tried on half a dozen outfits in a whirlwind. Before she could change out of one, Kelly had another ready, and took half a dozen pictures of Melissa in each. Melissa didn't know whether to laugh or cry as she modeled the girls' clothing, with Kelly oohing and aahing all the way. She held the fabrics delicately, as if they would break, and rubbed them softly between her thumb and forefinger.

For all the different outfits she tried on, though, Melissa couldn't keep her mind off the first.

"You said it was perfect," she said to Kelly. "And you were right!"

Kelly gave up and Melissa delightedly put the pink tank top and purple skirt back on. She twirled in the center of the room, giddy on freedom. Kelly settled on a pink T-shirt that said ANGEL in glittery yellow letters, which she paired with the yellow fringed skirt.

Kelly sat Melissa down in a chair in front of the mirror and began to brush Melissa's hair. She tried brushing it first to one side, and then the other, but decided finally to brush it forward so that the tips of it fell just above Melissa's eyebrows.

"What if your uncle figures out I'm not *really* a girl?" Melissa asked.

"Look at you. Why would he think you're anything else?"

Kelly was right. Melissa's frame was thin, and she was too young to be expected to have curves. She was

wearing girls' clothes and a girl's hairdo, even if it was short. She really did look like a girl.

Kelly gestured at her desk. "I've got all this makeup my aunt gave me for my birthday, but I don't really know how to put it on."

"I've never had any," said Melissa, "but I've read all about it."

Kelly handed her a small container of lip gloss. Melissa dipped her finger into the slippery, shiny substance and traced her lips. When she looked in the mirror, her lips sparkled.

Melissa and Kelly tried out every shade of gloss and blush in the kit. Melissa showed Kelly how to apply the blush high on the cheekbone and then blend downward, and how to choose colors to complement her light-brown skin. They amassed a great pile of tissues as they wiped off one color and replaced it with another. They smiled for the mirror and each other. Kelly took photo after photo.

"Oh, no!" Melissa cried suddenly. Her glee was replaced with dread as she looked down at her sock-covered feet. She pointed over to her ratty sneakers.

"You think I don't have that covered?" Kelly pulled a bucket of shoes from under her bed.

"You have so many shoes. Who knew you were such a girly girl?"

"Who knew *you* were?" Kelly grinned. She rummaged through the pile and handed Melissa a simple pair of white sandals. They were a little small on Melissa's feet, but since they were sandals, it didn't matter too much. Kelly found a pair of yellow canvas sneakers to match her own skirt.

They were ready, but Uncle Bill hadn't arrived yet, so Kelly turned cartwheels across the carpet. Half the time, her skirt would flip right over her belly, leaving her pink underwear showing. She would scamper down and smooth out her skirt, but that didn't stop her from trying again. Melissa was looking at her reflection from

every angle she could. She faced away from the big mirror and held a hand mirror so she could see her back.

"Kelly?" Melissa stopped her friend while she was upright. "There's just one more thing."

"Melissa, stop worrying. You look perfect."

"It's just . . . I'm wearing boys' underpants." Melissa felt the wide band of elastic around her waist that held up her white boys' briefs. No one would be able to see them, but she would know all day that they were there.

"Ew! Yuck! Pull them off!" Kelly was already at her dresser drawer. She handed Melissa a pair of light-pink underwear covered in tiny red hearts. They were small and light. "You can have them. Don't worry. They're clean."

"Are you sure?" Melissa asked.

"Of course. I have too many pairs anyway."

Melissa turned around and began to take off the purple skirt.

"You don't have to take it off. You can change under it. Skirts are awesome like that."

"Oh, right."

Melissa took off her own underwear, stepped into Kelly's, and pulled it up under her skirt. Other than the coolness of the fabric on her skin, she could barely tell she was wearing anything at all.

Kelly jumped up when she heard a knock on the front door. "Let's go!"

Kelly let her uncle into the small apartment. Bill Arden could have been his brother's twin, right down to the friendly twinkle in his deep-brown eyes. He was a painter; bright streaks of blue and red stained his sneakers.

"Well, you girls are dressed mighty fancy for the zoo," Uncle Bill remarked.

"It's not often a handsome man invites us out to New Yawwk City." Kelly pronounced the name of the metropolis as though she had been raised deep in the country.

"At least you're wearing practical shoes, which is more than I can say for most of the women I take out on the town. Although it's not often that I'm graced with the company of two fine young women at once. Kelly, who's your lovely friend?"

"This is Melissa. She's a bit shyer than I am."

Melissa was afraid to move, nervous that a single step could break the magic.

"Pleased to meet you, Melissa." Uncle Bill's hand was large and his handshake was firm, but not tight. "And as for you, my dear niece," he continued, hugging Kelly to his side, "I do believe a rampaging rhinoceros would be shyer than you are."

"I doubt that," said Kelly. "But there's only one way to find out. To the zoo!" Kelly grabbed two of her jackets, handed one to Melissa, and skipped down the cracked pavement to Uncle Bill's car.

The ride down to the zoo took nearly two hours, with Uncle Bill singing loudly and off-key to disco songs

on the radio. Kelly sang along when she knew the words. Melissa sat beside her in the backseat, admiring the swirls in her skirt. She fingered its hem, just a little heavier than the rest of the fine cloth. She brushed her palms down the tank top she wore, and combed her fingers through her hair. She reached out her hand and Kelly squeezed it in hers.

If Melissa held her body just right, she could see herself in the car's rearview mirror. It was hard to keep from giggling with delight. She looked out the window and counted a hundred telephone poles. Twice. Both times, she wished she could be like this forever.

Finally, Melissa saw a big green sign for the Bronx Zoo with a thick arrow pointing to the right. Uncle Bill drove off the highway, and soon they were paying a fee to enter a massive parking lot. Uncle Bill drove down a long line of cars and pulled into a spot at the end.

The air smelled mostly like grass and hay, with a hint of animal poop. Melissa knew the smell would

grow stronger, but she didn't care. She would be walking around all day dressed as a girl. Children and adults and even the animals would see her, and no one but she and Kelly would know a thing.

Around them, adults wrestled with babies and strollers, while older children stood around waiting. Kelly, Melissa, and Uncle Bill walked toward the entrance booth. There was a short line, but it moved quickly, and soon they were inside.

Melissa and Kelly laughed at the playing monkeys, shuddered past the slithering snakes, cooed at the baby grizzly bears, and stared at the tigers' teeth. Melissa surprised herself when she noticed her reflection in the glass in front of a display of exotic, glowing jellyfish. She was looking at a girl.

Melissa stopped at the tarantula exhibit. The furry crawlers were a much larger species of spider than Charlotte had been. Still, Melissa thanked each one quietly. She searched for webs, but didn't see any.

When they stepped out of the World of Insects, Kelly said she needed to use the bathroom. Melissa tensed. There was no way she could make it back home without going as well. She looked down at her skirt. She couldn't go into the boys' bathroom looking like this.

"Melissa and I will be right back," Kelly announced, grabbing her best friend by the hand before she could protest, dragging her right to a door with a sign with the word LADIES and a stick figure wearing a triangle skirt. Kelly pushed open the heavy metal bathroom door as if it were nothing and pulled Melissa in.

The air was cool, wet, and smelled of musk. The tiles were gray and green, not pink as Melissa had imagined. Most noticeably, there were no urinals, only a row of stalls on the left and a row of sinks, mirrors, and dispensers oozing pink soap on the right.

"You okay?" asked Kelly.

Melissa nodded but didn't say anything. She was

standing in the girls' room. Not even the eloquent Charlotte had a word for how she felt in that moment.

Melissa locked herself in a stall, delighted for the privacy. She lifted her skirt to see her underwear, covered in tiny red hearts. She pulled it down, sat, and peed, just like a girl. She didn't even tell Kelly afterward. That part of this magnificent day was her personal secret.

By early afternoon, Kelly, Melissa, and Bill were tired and hungry. Kelly found a meal station on the map just past Tiger Mountain. They smelled the food before they spotted a cluster of picnic benches set up around a bird-filled pond. Orange umbrellas advertising fruit smoothies shaded dozens of families. Some folks ate burgers and hot dogs and fries, while others munched on sandwiches and snacks pulled out of coolers from home. Strollers littered the walkways, with young children weaving between them and screaming with glee.

Uncle Bill took orders for lunch and stood in line while Kelly and Melissa waited for a table.

"So," Kelly said, "I call today a success. I'm already thinking about what to wear next time."

"You mean you'd do this again?"

"Melissa." Kelly rolled her eyes. "I'm surrounded by boys in my life. My father. My uncle. Seriously, until a few weeks ago, I thought you were a boy. It's nice to have some girl time."

"Well, you two look happy!" said Uncle Bill, setting down a tray laden with sodas, hot dogs, a container of ketchup, and a giant cup of fries.

"We are," said Kelly.

A wave of warmth filled Melissa from deep in her belly and out to her fingers and toes. She put her arm around Kelly. Kelly held her camera at arm's length and took a picture of the two girls' grinning faces.

Kelly took dozens more photos of Melissa that afternoon. And Kelly didn't ask Melissa to pose once. She didn't have to. Melissa already looked perfect in every one.

By the time they loaded into the car, Kelly, Uncle Bill, and Melissa were all exhausted, even though the sun was only just setting. Uncle Bill stopped off for coffee to stay awake and Kelly passed out as soon as they hit the highway. But Melissa didn't nod off for a moment. She couldn't. She was too busy remembering the best week of her life.

So far.

ACKNOWLEDGMENTS

I am inexpressibly indebted to so many people who have helped my baby grow over the last twelve years from "There should be a book about a trans kid!" to the story you hold in your hands. And yet, let me try.

Deepest and sincerest gratitude to Jean Marie Stine, without whom this book would still be a pile of chapters on a long-defunct hard drive. Infinite thanks to my aerobics instructor of an agent, Jennifer Laughran: "You're doing great! Just one more revision!" And with great appreciation for my editor, David Levithan, whose relentless enthusiasm for George is downright inspiring. Thanks to Ellen Duda for a cover that brought me tears of joy and to the copy editors who perfected every last dot and dash.

Powerful fondness and dearness for Beth Kelly, my oldest writing buddy, and Blake C. Aarens, my newest writing buddy. And so much love and thankfulness for the endless friends and family who read this story in its many stages: my parents, Cindy and Steve Gino, and my sister, Robin Gino Gridgeman. My dear partner in life, James McCormack. And Amy Benson, Lilia Schwartz, Matilda St. John, and Amithyst Fist.

And to the friends and family whose love and support allowed me to write and finish this book. Nana and Papa Gino, Aunt Sue, Uncle Paul, Nana and Rick Scott, Aunt Jerilynn, Wes, Anna, Kadyn, and Brinley. And Sondra Solovay, Joe Libin, Frankie Hill, Alicia Stephen, NOLOSE and all the radical fats, and so many more people—I would need another book to thank you all. I love you more than I know how to tell you.

AFTER WORDS™

ALEX GINO'S

George

CONTENTS

About the Author

Alex Gino loves glitter, ice cream, gardening, awe-ful puns, and stories that reflect the diversity and complexity of being alive. *George* is their first novel. For more about Alex, please visit www.alexgino.com.

FAQ (AOTAWTS)

Frequently Asked Questions (And Other Things Alex Wants to Say)

Q: *Why did you write* George*?*
A: I probably get asked this question more than any other, and as a writer, I think it's a funny one. Why do any of us tell the stories we tell? They are a combination of our lives and not our lives. They are the stories in our minds, shaped by the stories we know and the stories we seek. What I can say is that I didn't grow up with any positive representations of transgender people in books or other media. The first time I encountered the word *genderqueer* (meaning "neither a boy nor a girl"), I was nineteen, and I took that word and I consumed it—ate it and became it, because it was already me. I can only imagine how my life would be if I had seen someone more like me in a book or three when I was younger. As many of us do, I wrote the book I wanted to read as a kid.

Q: *How do I talk about the main character?*
A: Call her Melissa. That's the name she likes. If you slip up and call her George, no big deal. Correct yourself if you think of it, and move on. Same thing for her pronouns. She is always a she. Always.

Melissa is a transgender girl. If you are talking with someone who doesn't know what that means, you can say that she is a girl whom the world sees as a boy, or a girl who was assigned male at birth. You can also say that she is a girl, but

she's the only one who knows it. Notice that all of these say first that she is a girl.

Avoid the phrases *trapped in* or *stuck in* when talking about trans people. As Janet Mock said, "'Trapped in the wrong body' is a convenient, lazy explanation but it fails to describe #trans people and our bodies every time." I'm not stuck, as if in mud, and my body isn't wrong. It's just not what you thought it might be. Phrases like *feels like* or *identifies as* aren't so great either. They sound as though who trans people are is up for debate or discussion. It's better to say "is." Generally, if it sounds weird saying it about a cis-gender (nontrans) person, it's probably not good to say about a trans person. Do you "identify as" your gender? Or is it just who you are?

Please be aware that language for trans people is developing and changing as our community grows and matures, questions the ways that we have been talked about, and explores alternatives. And the same words don't work for everyone. For example, some trans people do consider themselves to be in the wrong body. Be open to developing and changing language.

Q: *How do I talk about you?*
A: Nicely, please.

Q: *Really? It's gonna be like that?*
A: Yup.

Q: *I mean, what are your pronouns?*

A: Oh! Well, why didn't you just ask? Yes, that is a totally appropriate question, even if someone's pronouns seem clear. In fact, if you are asking someone their pronouns because you're not sure, it's polite to extend the question to others around, even if you're pretty sure you know them, so that you're not putting one person on the spot. You can also check in on someone's pronouns if you're not sure you have them right, even if you've known the person a while. The person's pronouns may have changed.

I use the singular *they* and the honorific *Mx.* (pronounced "mix"). For example, you might write this about me: *When Mx. Gino finishes this FAQ, they will send it to their editor and get themself a piece of chocolate.* While some grammarians balk at the idea of the singular *they*, linguists tend to recognize its place in our language. And if there's someone reading this who thinks they haven't encountered the singular *they* before, they should know that they have—three times in this sentence alone. It's been used by writers like Geoffrey Chaucer and Jane Austen when the gender of the person being referred to is unknown, and it's a short jump from there to using the same word when the gender of the person is known but nonbinary (neither *he* nor *she* works). In fact, the American Dialect Association made the singular *they* used for known individuals its 2015 Word of the Year. And when it comes down to it, it's more important to be respectful than to follow a questionable grammatical rule.

While there are a number of gender-neutral pronouns by and for trans people (the most popular are *ze* and *hir*), I found it linguistically challenging to add new structure words to my

vocabulary. With the singular *they*? I adapted comfortably within weeks. If it feels weird at first, you can practice with animals. Your pet cat, hamster, or chinchilla won't mind!

Q: *Are you a lot like Melissa?*
A: I'm not that much like Melissa. Melissa is a binary trans girl, which means that she is a girl even though she was assigned male at birth, and she will grow up to be a woman. I'm genderqueer, or nonbinary, so I'm neither a girl nor a boy. Also, Melissa is growing up with access to the Internet and information about being transgender. When I was a kid, the only time I heard about anyone being transgender was when it was a joke or an insult. But both Melissa and I cried at the end of *Charlotte's Web*, and we both love playing Toad in Mario Kart.

Q: *Did you have a friend like Kelly growing up?*
A: Sort of. I had a best friend from elementary school through high school. Both of us were different in our own ways, and neither one of us was popular at school, so we were each other's support person. But since I didn't grow up knowing that I was transgender, I didn't have a best friend whom I could talk to about my identity. That would have been wonderful.

Q: *Who's your favorite character in the book?*
A: That's like asking me my favorite ice cream flavor. How could I choose?

Q: *What is your favorite ice cream flavor?*
A: Next question please.

Q: *Fine. Why did you name the book* George?
A: Here's the thing: I never meant for the book to be called the very name that Melissa never wants to hear again. Using the name a transgender person no longer uses (and that is probably connected with a gender that is not theirs) is called deadnaming, and it is extremely rude. When I was writing the book, I called it *Girl George* as a play on the musician popular in the '80s, Boy George. My editor suggested we call it *George*, especially because most kids today wouldn't get the Boy George reference. If I were naming it now, I would call it something different. Maybe something about Charlotte or maybe there wouldn't be a name in the title at all.

The good news is that Melissa isn't a real person, so we can't hurt her feelings. And if we feel uncomfortable talking about this book called *George* with a main character named Melissa, that discomfort offers some insight into a common trans experience.

Q: *How long did it take you to write* George?
A: A very, very, very long time. As in, I started writing in 2003. I wrote the first draft in about two years, and showed it to a few friends for feedback. I made some edits, and then a year later, I showed it to a good friend, fine hat wearer, and perceptive editor, Jean Marie Stine. After nearly suffocating under the amount of advice she gave me on the first five pages alone, I nursed my wounds and got back to work. For seven years, on and off, I expanded and polished and used all my senses to get the story out of my head and on the page. Once Jean Marie deemed it fit, I sent it out to the glitteriffic Jennifer Laughran.

Another year and four rounds of revisions later, I had a contracted agent who sent it out, and the splendiferous David Levithan of Scholastic picked it up. Guess what? More editing! I said good-bye to the final drafts at the end of 2014, and the book was released in August 2015. Basically, the book is older than Melissa herself.

Q: *Why do you say* trans *instead of* transgender?
A: Why do you say *teen* instead of *teenager*? Groups of people who talk about certain topics a lot develop shortcuts. And I happen to talk about trans people a lot. But you can use either—just note that *trans* and *transgender* are adjectives, not nouns. Oh, and it's never *transgendered*. For comparison, *yellowed* describes something happening to turn paper yellow, as opposed to paper that already is *yellow*. And you'd never call that sheet of paper *a yellow* either. It's yellow paper. And Melissa is a trans girl.

Q: *What's your goal for* George?
A: *George*'s success has already far surpassed anything I could have imagined. When I started writing Melissa's story, I hoped I might be able to convince a small, queer publisher to take it on. More likely, I thought that I would be distributing hand-stapled photocopies to local LGBTQ organizations. To think that my story is available in bookstores and, better yet, libraries throughout the country is astounding. To learn that children and whole classes are reading Melissa's story is astonishing. To know that it's being translated into eleven languages is mind-blowing.

My ultimate dream is that *George* becomes historical fiction. I want to live in a world where people read this book and wonder why Melissa's transness is such a big deal. I have a vivid image in my mind of a Saturday night, maybe twenty years from now. A drunk, macho guy lumbers down a dark alleyway. Ahead, he sees someone he identifies as trans. One of his first thoughts is of Melissa and her story, and he sees the humanity of the individual across the street from him, and nothing happens. They pass each other with a smile and a nod, and nothing happens.

Q: *I think I might be transgender (or gay, lesbian, bisexual, queer, etc.). What should I do?*
A: First of all, be proud that you're figuring out who you are. And remember that you don't need all the answers today, and the answers can change. If you can access the Internet, you can read up on as well as connect with other LGBTQ people. You might be able to find a youth group in your area, or an online community. Check the shelves of your local library. There might be some great books there, and if there are, you might talk more directly with your librarian. Librarians love to connect people with the right resources (it's literally their job!), and they often know about local groups.

You might want to tell important people in your life, or maybe everyone in your life, or maybe no one—at least not right now. All of these answers are valid. You are under no obligation to tell anyone anything. The choice is up to you, but remember to be safe. That can mean thinking carefully about who you tell and when as well as being ready to answer questions, including

some silly ones. At the same time, sometimes you'll be surprised. When faced with the choice between holding on to old beliefs and holding on to family and friends, many people choose the people they love. The path can be rocky though, and it can take way more time than you think it should. Make choices that are right for you.

If you aren't sure if there's someone in your life who you can talk to and you want or need to talk to someone, you can call The Trevor Lifeline anytime at 866-488-7386. Trained counselors are available 24/7 to support young people who are in crisis, who are feeling suicidal, or who are in need of a safe and judgment-free place to talk. Visit www.thetrevorproject.org for more information, as well as ways to contact them via text or chat. Hotlines aren't just for "other people"—they are there for you. Know that there's a community out here ready and waiting to love and cherish you.

Q: *I know someone transgender. How can I support them?*
A: Oh wow. I could write a whole book on this. In fact, I did. You're holding it! Seriously though, I'm glad you want to be supportive. There are so many small things you can do to support a trans person in your life—small things that add up to trans people feeling seen and real.

Probably the most important thing is using someone's name and pronouns. Try to get it right. No, really. Try hard. This is the least you can do for someone who has shared personal information with you. Practice. When you do make a mistake, apologize, correct yourself, and try not to make a big deal out of it. Please do not go on about how bad you feel.

The trans person doesn't need to take on your guilt, and it puts them in an awkward social position where the easiest way to end the conversation is to say, "Oh, don't worry about it" or "It's okay." It's not the trans person's job to make you feel better here. It's like bumping into someone: Say, "Excuse me," correct yourself, and move on.

On a related note, if you knew someone by another name, perhaps a name that does not match their gender, please keep this information private. Often, people try to tell me that they know someone trans by saying something like, "My good friend Mary, who used to be Bob . . ." Bob is quite likely a name she doesn't want to be called, and this old name is not something I need to know. It's fine to say, "My good friend Mary." You can add, "who is trans," if that information is important to the conversation, but remember that Mary is trusting you with her story and she might not want you to share it.

Q: *I'm so glad I understand transgender people now.*
A: Okay. This isn't a question, but I'm adding it here anyway. *George* is only one story. It is the story of a white, middle-class transgender girl growing up near New York City, written by a white, middle-class genderqueer person who grew up on Staten Island, New York. Every transgender story is different, just as we are all different. Race, money, disability, and other realities further impact these differences.

I will add that you don't need to understand someone to respect them, so while I'm glad you have a greater insight into Melissa's experience, I hope you also learned from Mom, Kelly, Scott, Jeff, Rick, Ms. Udell, and Ms. Maldonado about

how to respond when someone you know tells you that they're trans, as well as some insight into how the things you say and do might affect someone in your life who you don't yet know is trans.

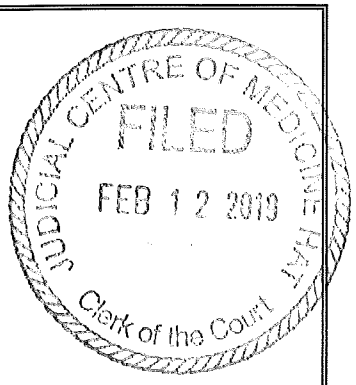
Some more things you can do:

- Read up on trans issues on your own, and when you have questions, seek out answers without asking a trans person in your life to be your information resource.
- Don't ask invasive questions about a trans person's body or surgery. They may choose to share, and if they do, thank them for trusting you with the information.
- Don't compliment people on how well they "pass" or give unrequested advice. Everyone's way of being trans is different, and saying someone "doesn't even look trans" doesn't usually feel like a compliment.
- Don't just say the "right things" around your trans friends. Raise issues even if—and especially when—it feels uncomfortable. Even and especially when everyone in the room is cis.
- A major and regular concern for trans people is safe, public restroom usage. Let your friend know that you're willing to go with them to make sure that they're safe.
- Know that it's not about being perfect or getting praise for having done the right thing.

And you don't need to know that you know someone transgender to be supportive. In fact, being supportive is a great way to let someone know that you're a good person to come out to. Have and mention books and media with good trans representation, and announce your space as a safe space, like Principal Maldonado. Watch the gendering of your language, and see if you notice patterns, like Ms. Udell's. Trust people at their word, like Scott. And show them how much you love them by supporting them in their goals, like Kelly.

Exhibit “B”

COURT OF APPEAL OF ALBERTA



COURT OF APPEAL FILE NUMBER	1801-0239AC
TRIAL COURT FILE NUMBER	8808-00144
REGISTRY OFFICE	CALGARY
APPLICANTS	P.T., D.T., F.R., K.R., P.H. AND OTHERS
RESPONDENT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA

DOCUMENT	Transcript of Oral Questioning of A.A. [redacted] on Affidavit sworn September 5, 2018
HELD AT	Amicus Reporting Group Calgary, Alberta
DATE	November 21, 2018

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403-266-1744

(Proceedings commenced at 3:26 p.m.)

[redacted], **sworn, questioned by Ms. McLeod:**

Q. So, [redacted], you just confirmed that you're going to tell the truth and answer my questions, right?

A. Yes.

Q. And I'm going to refer to you as [redacted]?

A. Yes.

Q. And can you tell me how old you are?

A. [redacted].

Q. And what grade are you in?

A. [redacted].

Q. What school do you go to?

A. [redacted]. I just had a brain fart.

Q. And you've been going to that school since September?

A. Yeah.

Q. And I understand that you went to [redacted] before that?
A. Yes.
Q. Did you go through grade [redacted] at [redacted]
A. Yes.
Q. And I understand you were at a different school prior to that; is that right?
A. Mmm hmm.
Q. An elementary school?
A. Yeah.
Q. Okay. And so I want to ask you some questions about the document in front of you. We call that an affidavit. Do you know what an affidavit is?
A. It's a document.
Q. Right. And do you recognize that document? You can look through it if you want.
A. Yeah. Am I able to keep it open?
Q. Yes, you are.
A. Okay.
Q. And did you write that document?
A. The document? Well, I said what happened is that my dad scribed for me and I -- and he asked me questions and then I said the answers and then he'd type it down. And because I'm not very good at sentences or putting -- knowing where to put the period down. And I read the whole thing.
Q. Okay. So you answered the questions to your dad and he

wrote things down and then you read it over afterwards; is that right?

A. Yep.

Q. And you agree with everything that is in it?

A. Everything.

Q. Good. Okay. If you look on your first page, so I'm looking at your paragraph 4.

A. Mmm hmm.

Q. So you state, (As Read)

> I believe that God creates people either male or female and this is also a biological reality.

A. Yeah.

Q. And from what I understand, that's in agreement with your religion; is that right?

A. Yeah. And I believe it.

Q. Good. And you also state that you know that you're a girl?

A. Yeah.

Q. Okay. And that you have a girl's body?

A. Yeah.

Q. And a girl's brain?

A. (NO AUDIBLE RESPONSE)

Q. And I understand that you know that you're able to breakdance and workout and build muscles all while being a girl; is that right?

A. Yeah.

Q. I understand that you are really into breakdancing?
A. Yeah.
Q. Yeah. You really like it?
A. Yeah.
Q. And do you still do a lot of weightlifting?
A. Yeah. I do it at school.
Q. There's a gym at school for you to use?
A. Yeah.
Q. So I'm going to ask you some questions about when you were at [redacted]?
A. Mmm hmm.
Q. And when you attended the Gay-Straight Alliance at [redacted]?
A. Yeah.
Q. Okay. Do you remember when you first started attending?
A. It was in I think September. Not September. I don't know.
Q. Do you remember what grade you were in?
A. [redacted].
Q. You don't remember what month you started attending?
A. No.
Q. No? If you look at the next page of your affidavit, actually page 3. So that's page 1, that's page 2. Now turn to page 3.
A. October. Okay. Yeah. I was thinking it was between September and November or something.

Q. Okay. And in paragraph 12 you state that on the first Monday in November of 2015 you attended a GSA?
A. Yeah.
Q. Okay. Did you remember that?
A. I remember attending GSA.
Q. Okay. And when you were answering your dad's questions about this affidavit, did you remember when you started going to the GSA?
A. Yeah. I must -- yeah. I remembered then.
Q. Are you a bit nervous right now? Is that why you're not remembering now?
A. (NO AUDIBLE ANSWER)
Q. Okay. Well, take a deep breath. It's not a test. I'm just interested in what you remember about that time. Okay?
A. Mmm hmm.
Q. Why did you go to the Gay-Straight Alliance at that time?
A. I had no friends. All the other -- all the clubs they had there were, like, for the grade 4s or kids younger than me or after school. I was originally wanting to join wrestling because that's really cool, but I couldn't go because I lived too far away. My mom didn't want to drive. So I was left with only one option. And I just didn't want to be alone.
Q. Okay. And how many kids were at the GSA when you first started attending?

A. A lot. Twenty.
Q. Was it a new club at the school at the time?
A. Mmm hmm.
Q. Yes? Sorry. I just have to ask you to say the answer just so that it's on the transcript.
A. Huh?
Q. I just have to ask you to say aloud the answer instead of nodding your head or shaking your head.
A. What was the question?
Q. Was it a new club at the school at that time?
A. Yes.
Q. Yes. Okay. And who was the teacher who was leading that club?
A. I know what she looks like but I don't remember her last name.
Q. Okay. And I take it then it wasn't one of your regular teachers or assistants?
A. Not in grade [redacted], no, but she was my [redacted] and [redacted] teacher in grade [redacted].
Q. Okay. And you think that there were a lot of kids at the GSA when you first started going there?
A. Yeah.
Q. Did you say 20? Somewhere around there?
A. Roughly.
Q. And do you know what grades they were in?
A. Most of them were older than me in grade [redacted] and [redacted].
Q. Were any others in grade [redacted] like you?

A. No. I don't know.
Q. Do you know if any of them were younger than you?
A. I don't know.
Q. When you went to that first meeting, what happened in the first meeting?
A. We made name tags.
Q. And what did you put on your name tag?
A. I put down [redacted] and female pronouns.
Q. Do you remember if any of the kids asked to be referred to a pronoun that was a different gender than their name?
A. Yeah. There was this girl and she went by they, them pronouns. And there was this other girl and she identified as a boy. She went by male pronouns and a different name.
Q. Okay. And what else happened at the first meeting?
A. They had pizza.
Q. That always makes for a good meeting.
A. I didn't eat any because I don't really like pizza that much.
Q. Was there anything else that you could eat?
A. No. I just had my own lunch.
Q. What else do you remember that happened at that first meeting?
A. The teacher said that Gay-Straight Alliance was all about a safe space for people to go. I remember, like, she just said, like, information stuff.

Q. And what did you understand that to mean, a safe space for people to go?
A. I was young, so to me safe space meant somewhere where there's nobody evil. I don't know. I wasn't really listening to her.
Q. Okay. It's three-forty.
A. Okay. Do you have a Kleenex? Thanks. I just have a runny nose.
Q. How would you describe the environment at the first GSA that you went to?
A. It was welcoming but with a hint of mischief.
Q. What do you mean by that?
A. There's something going on that you don't understand. You know there's something there that they're up to, something that's nothing good.
Q. And when you say that they're up to something, who do you mean? Everybody else at the GSA?
A. Their policies, what they believe.
Q. I meant who did you think was being up to no good?
A. I don't know. It's just a feeling you have. I get that feeling when there's something no good. I don't understand. I just feel something and I just feel like I just need to avoid it.
Q. Okay. So you had the feeling at the first GSA meeting that you attended that you didn't want to be there?
A. Well, I just had the feeling that I shouldn't be there at the back of my mind.

Q. Did you leave?
A. No. I wanted friends.
Q. And so is that why you stayed just because you wanted friends?
A. Yeah.
Q. Okay. And did you make any friends at the GSA?
A. Yeah.
Q. And who did you make friends with?
A. A lot of people. They didn't ignore me. They actually listened to me when I talked to them. They actually said hello to me. Other kids pretend I'm not there.
Q. That must be hard?
A. Yeah. I was desperate.
Q. And when they listened to you, what were you saying?
A. We -- sometimes we talked about cooking. One time this girl said, I should make cupcakes sometime for next meeting or, like, sometimes -- I remember one time they talked about dogs. But most of the time we talked about -- they talked about their gay transgender problems, and, like, what they wanted to do with their future and stuff.
Q. And what kinds of problems did they have about being gay or being transgender?
A. What I remember them saying -- it's a long time ago. Just give me a second. Okay. I have one memory that the girl who felt like a boy, she said, My parents don't really care. And then she said that she was

going to get a binder. That's something I remember.
Q. Do you remember what any of the kids who said that they were gay talked about in terms of their problems in being gay?
A. I don't know.
Q. [redacted], you said that you went back to the GSA because you made friends there?
A. Yeah.
Q. And that people listened to you and that they said hello to you and didn't ignore you. Did other kids say at the GSA meetings that they sometimes felt that way too, that people ignored them?
A. No.
Q. Did anyone express any concerns about being bullied because they were gay or transgender?
A. No.
Q. No? Any other problems that you remember them talking about with being gay and transgender?
A. Didn't talk about problems. They talked more about solutions, like packers and stuff.
Q. You said that they also talked to you about what they want to do in their future or with their lives?
A. Yeah.
Q. Do you want to explain to me about that?
A. Yeah. They talked about surgery. Well, top surgery.
Q. And was that the girl who identified as a boy who was talking about that?

A. Yeah.
Q. Did you become friends with her?
A. Yeah.
Q. Did everyone call her by her female pronoun or her male pronoun?
A. Male.
Q. How many GSA meetings do you think you went to?
A. Probably about 17 or 18.
Q. Was there ever a [redacted] who was the teacher who was in charge of the GSA meetings?
A. No.
Q. Did you talk about what transgenderism is to people at the GSA?
A. Huh?
Q. Did you talk about transgenderism at the GSA meetings?
A. I? In what ways?
Q. Well, did you talk about what transgenderism is and what it means?
A. Yep.
MR. CAMERON: When she says you, I think what you're asking is are people talking about that, right? Not just you specifically. Were they talking about that at the GSA? I think that's what she's asking.
A. Yeah.
Q. MS. MCLEOD: Did people discuss about different sexual orientations at the GSA meetings?
A. Yes.

Q. And did they discuss any problems that they had if they had a different sexual orientation than heterosexual?
I missed it. It's three fifty-two.
A. I don't know.
Q. Okay. You don't remember?
A. (NO AUDIBLE RESPONSE)
Q. Okay. Were there any activities at the GSA meetings? Like, did you work on any kind of projects together?
A. We made genderbread men.
Q. You made gingerbread men?
A. Genderbread men.
Q. Genderbread men. What were those?
A. Gingerbread but they called them genderbread.
Q. Did you do that once or more than once?
A. Just once.
Q. Did you do anything else like that? Any other cooking projects?
A. After that nothing much happened. People stopped going.
Q. When was it that people stopped going?
A. Gradually.
Q. Did anyone ever tell you why they stopped going?
A. No.
Q. When did you stop going?
A. I stopped going -- I stopped going in February when I was in grade [redacted]. I just got bored of it. Like, before as well. Because I found these other people to hang

out with. We traded Pokémon cards.
Q. And I'm going to ask you about when you went by a name other than [redacted] at school?
A. Yeah.
Q. When did that first happen?
A. September when I -- September of grade [redacted].
Q. And what did you ask to be called?
A. [redacted].
Q. And why did you ask to be called [redacted]?
A. I just think it's a nice name.
Q. I agree. And when you wanted to be called [redacted], who did you ask to call you [redacted]?
A. Well, what happened is that the teachers -- is it okay if I say their names?
Q. Sure.
A. [redacted] and [redacted], they had me -- they're, like -- so they said, Hello. The principal wants to meet with you. So then we walked into the office, and then the principal is, like, so is there any alternative name you want to go by? And I was, like, [redacted], and so that's what happened.
Q. So I take it then that you didn't go by [redacted] at all when you were in grade [redacted]?
A. I didn't.
Q. You didn't? Did you ask to be called male pronouns in grade [redacted], him and his?
A. I did ask, but [redacted] and [redacted] said it wasn't

legal yet.
Q. You asked them if you could go by male pronouns and your teacher and your assistant said that you couldn't yet?
A. Yeah.
Q. Okay. And then did they tell you that that changed at any time?
A. Well, [redacted] said she would practice using male pronouns on me over the summer, and then they started in September.
Q. Did you want them to do that at that time?
A. Huh?
Q. Did you want them to do that at that time?
A. Do what?
Q. To use male pronouns with respect to you?
A. I did.
Q. And when you say over the summer, do you mean the summer between grade [redacted] and grade [redacted]?
A. Yes.
Q. And did you see [redacted] and [redacted] over that summer?
A. No. I have to use the washroom.
Q. Okay. Let's take a break. Good timing. It's just about 4 o'clock.
(ADJOURNMENT)
Q. MS. MCLEOD: It's four-oh-five.
A. Okay.

Q. We were just talking on the break about working out. When did you start doing weight training?
A. I started when I was [redacted] in January.
Q. So that was when you were in grade [redacted]?
A. Yeah.
Q. And when did you start breakdancing?
A. Also in January when I was [redacted]. They were New Years resolutions.
Q. And you've kept them?
A. Yeah.
Q. It's impressive. And when did you -- your dad told me that you liked arm wrestling too. When was that?
A. I started arm wrestling after I started weightlifting because I wanted to improve my strength.
Q. So was that also while you were in grade [redacted]?
A. Yeah.
Q. Is that one of the reasons why you were hoping to get into wrestling when you were in junior high?
A. Yeah. And also because me and my [redacted] wrestled when we were younger, and [redacted] would always beat me and when I got strong I got [redacted] down pinned to the ground. And now [redacted] doesn't want to wrestle me again.
Q. I'm sure that's a common experience between siblings when the younger one gets stronger. And so do you still arm wrestle?
A. Yeah. I like to arm wrestle guys.
Q. And you still breakdance?

A. Mmm hmm.
Q. And I understand that you are also interested in your nutrition to make sure that you can stay strong and get stronger?
A. Yeah.
Q. And have you ever wanted to do anything else to get stronger? Like, take drugs to get stronger?
A. Yes.
Q. When did you first want to do that?
A. Oh, I was asking my dad why -- why boys are stronger, and he said that they have testosterone. And I said, Oh, like, that's cool. But then he said, But if you take testosterone, you'll get hairy and you'll look like a man. That was the only issue.
Q. And were you discussing that with your dad when you were first getting into weight training and arm wrestling?
A. Well, we were talking about it.
Q. At that time?
A. He just told me the other effects of testosterone and muscles. He was telling me why I shouldn't take it.
Q. Do I understand it right that you were having those talks with him when you were in grade [redacted] and starting out in weight training and arm wrestling?
A. Yeah. We were talking about all kinds of things, anything really.
Q. When I asked you earlier about whether you talked to

the GSA about transgender people, I don't think I asked you, what do you understand transgender to mean?

It's four-ten.

What do you understand transgender to mean, the word?

A. Transgender? It means -- so what it means is that you feel like your opposite gender and you want the genitals of your opposite gender.

Q. The girl in your GSA that went by a boy's name, what was her name or their name?

A. Which name?

Q. What did you call that person?

A. [redacted].

Q. [redacted]. Did [redacted] tell you that they identified as transgender?

A. Yes.

Q. Did you think that you were transgender at any point?

A. Yes.

Q. And when did you think that?

A. Well -- well, I learnt of it from the media, like buzz feed. I'm like, mmm, what is this? I was really curious.

Q. And so when you first learned of it from buzz feed, is that when you thought you might be transgender?

A. I was thinking a little. Just, like, mmm.

Q. And when was that when you first started having curiosity about that and looking through the media?

A. It happened a slight bit in the summer in August. Just a really slight bit though. But I wasn't thinking much. I was just thinking, mmm. I was just curious. I always heard these terms, like, what does it mean? And then I got more into watching the media after I was going to GSA.

Q. Okay. So when you said the summer in August, was that before you started grade [redacted] that summer?

A. Yeah. But it was, like, really rare though. Sometimes I'd just, like, mmm, what's this?

Q. Okay.

A. I didn't really get any --

Q. Sorry?

A. Sorry. I shouldn't be talking.

Q. No. That's okay. So at some point you told your friends in the GSA that you were transgender; is that right?

A. After I told [redacted].

Q. So was [redacted] the first person that you told that you thought you were transgendered?

A. Yes.

Q. And then after that you told people in the GSA?

A. Yeah.

Q. And what grade were you in at that time?

A. [redacted].

Q. Do you remember when it was?

A. Late in the year.

Q. And who else did you tell?
A. My psychologist.
Q. Who was your psychologist at that time?
A. [redacted].
Q. [redacted]?
A. Yeah.
Q. Where did you go to see [redacted]?
A. [redacted] -- I think it's called [redacted] or something.
Q. And how did [redacted] respond when you told him that?
A. Huh?
Q. How did [redacted] respond when you told him that you thought you were transgender?
A. [redacted] was a woman.
Q. Oh.
A. She said I have a client -- or not a client -- or I don't know these work terms. I have -- there's somebody else at my work, no skirt, no dress, but -- but she's still a woman.
Q. Did she say anything else about it?
A. If I told her stuff she'd just repeat it back to me. So, you want to be a boy. So you want to do this.
Q. So you told her that you wanted to be a boy and she repeated that back to you?
A. Yeah. She just repeated everything I said. She's like a voice recorder.
Q. And what did you tell her that you wanted to do?

A. Told her that I wanted to get a flat chest.
Q. And why did you want to get a flat chest?
A. Well, because I just don't like the feeling of having boobs. They're just uncomfortable, and, like, it got in the way of my breakdancing, and bras are uncomfortable.
Q. I'm not going to argue with you about that. Do you still feel that way?
A. Yeah.
Q. Do they still get in the way of the breakdancing?
A. Not really anymore because I have a lot of muscle on my chest so it keeps them so they stay still.
Q. Do you still see [redacted]?
A. No.
Q. Do you have any psychologist at the moment?
A. No.
Q. Was [redacted] the last psychologist that you saw or did you see anyone else?
A. I did see this one psychologist once or twice. She was called [redacted], but she made me uncomfortable because she talked really loud and high pitched. It scared me off.
Q. And I understand that you saw some psychiatrists for a little while?
A. Yeah.
Q. Who did you see who was a psychiatrist?
A. [redacted]. I had two. Well, I also had -- well,

first I had [redacted] and then [redacted] and then [redacted].

Q. And were they all psychiatrists?

A. Yes.

Q. Did you discuss with [redacted] your feelings about wanting to be a boy?

A. Yeah. Then he asked me if I wanted a penis and I said no.

Q. And did you keep going to [redacted] after he asked you that?

A. Huh? What?

Q. Did you keep seeing [redacted] after he asked you that?

A. He -- well, after he moved. I think he's in Vancouver. I'm not sure.

Q. And do you remember when it was that he moved and you stopped seeing him?

A. No.

Q. Did you talk to [redacted] about wanting to be a boy?

A. Yes.

Q. And did he recommend any treatment for you with respect to being a boy?

A. Yeah. He recommended the Sexual Health Clinic to get me on hormones and surgery.

Q. Did you go to the Sexual Health Clinic?

A. No.

Q. Did you ask to go to the Sexual Health Clinic?

A. Yes.

Q. And so why didn't you go?

I missed the time again. I'm sorry. It's four twenty-five.

So do you remember why you didn't go to the Sexual Health Clinic? I'm sorry if this question is upsetting you.

A. It's a hard question.

Q. Do you want to not answer that question?

A. Is that fine?

Q. Pardon me?

A. Is that okay?

Q. Yeah.

A. Yeah.

Q. Okay. Did you talk with [redacted] about how you wanted to be a boy?

A. I did.

Q. Okay. And did he recommend any treatment for you about those feelings?

A. Yeah, he did. I wasn't really fond of getting a penis or anything. All I wanted was a flat chest and muscles. And was, like, Yeah. You can get a penis and all that. And deep down it's, like, I don't really want a penis that much. So he was, like, enforcing it.

Q. Did he ever recommend that treatment for you?

A. Yes.

Q. Okay. I take it you didn't get that treatment?

A. Huh?

Q. You didn't get that treatment?
A. No.
Q. No. You haven't taken any hormones or hormone blockers?
A. No.
Q. Did you ever want to?
A. I did before.
Q. And so now you don't I take it?
A. I don't want to take it.
Q. And I understand that you were seeing [redacted] until January of this year; is that right?
A. Yes.
Q. So was it after you stopped seeing [redacted] that you decided that you didn't want to take the treatment about your feelings about wanting to be a boy?
A. It didn't happen automatically. It slowly gradually --
Q. When you say that it slowly happened, are you saying it's happened over the course of this year or did it start earlier than that?
A. I slowly changed my mind about the transition during winter holidays.
Q. When did you take winter holidays? Do you mean the Christmastime holidays?
A. Yeah. Christmas holidays. I wasn't at school. I was only around -- and I was hanging out with my friends, seeing them at practice and stuff. And then -- so I wasn't at school or anybody using male pronouns on me

or anything so -- and I didn't really care.
Q. What didn't you really care about?
A. If I was a boy or girl.
Q. It's four-thirty.
So you decided over winter holidays, Christmastime, 2017 to 2018, that you didn't want to transition anymore; is that right?
A. Slowly it was in the back of my head.
Q. Okay. And does that also mean that you weren't feeling like you were a boy?
A. It was going away.
Q. And did you tell [redacted] that?
A. No. I didn't feel comfortable telling him.
Q. And why didn't you feel comfortable telling him?
A. Because I didn't feel comfortable and realized it myself.
Q. And when did you tell people at school that you wanted to be called a girl's name and female pronouns again?
A. In the spring.
Q. Spring of what year?
A. 2018.
Q. And who did you tell?
A. I told [redacted] and she started crying. And she said I was pushing everyone away that was trying to support me, and I said that I didn't need the support.
Q. Do you know who she meant by everyone?
A. [redacted], and I stopped seeing him. And -- yeah.

Q. Did you understand who she meant by anyone else besides [redacted]?
A. Huh? Like, I don't feel comfortable. So, like, push away anybody else? Oh, yeah. Like, I didn't feel comfortable talking to [redacted].
Q. And had you told [redacted] that, that you didn't want to talk to [redacted]?
A. Yes.
Q. And why didn't you want to talk to [redacted]?
A. She treated everyone like dogs.
Q. What do you mean?
A. She used a high pitched voice. Like, her voice was originally deep, but she would higher it.
Q. Do you mean, like, the pitch of it or do you mean the volume of it?
A. Both. So she'd be, like, Okay. I'm calling the office on you. Hello. So [redacted] is being bad. That kind of thing.
Q. And do you recall what she was calling the office about when she was claiming that you were being bad?
A. I wasn't focusing on math. I don't like math.
Q. Was there anyone else that you didn't want to be talking to at that time in the spring of 2018 that you had talked with earlier?
A. After I told -- came out as normal to [redacted], I didn't talk to her again. She didn't accept me as normal. She said she would accept me no matter what,

but she was crying. And when I came out as a boy to her, she was all happy. And they were all, like, trying to get me to change my mind and go back to being trans again.

Q. [redacted] was trying to get you to change your mind?

A. And [redacted].

Q. And was anyone else trying to get you to change your mind?

A. No.

Q. And so after that you stopped speaking to both of them?

A. Yeah.

Q. Did you speak to any other teachers?

A. Speak to the teachers about it? No. I spoke to my friends from practice about it.

Q. And by practice, do you mean breakdancing practice?

A. Yeah. I told them about my problems at school. They helped me a lot to help -- they helped me a lot to get back to normal.

Q. And I take it breakdancing practice is away from school; is that right?

A. It is.

Q. It's four-forty.

I want to ask you about when you first decided that you wanted to go by a different name than [redacted]?

A. Yeah.

Q. When did that first happen?

A. Well, I thought it over during the summer when I was going into grade [redacted]. Actually I came up with a list of different boy names I like.

Q. But [redacted] was at the top I take it?

A. Yeah.

Q. And when you were at practice, did you go by [redacted]?

A. No. I didn't really need to come out to them. I was comfortable in my own skin there. I didn't care about gender at practice.

Q. When you were going by the name [redacted] at school, you weren't going by the name [redacted] at home, right?

A. No.

Q. And why not?

A. My parents didn't want to because it's not my name.

Q. And how did you feel about that at the time?

A. Disappointed.

Q. Your friend [redacted], did [redacted] go by [redacted] at home; do you know?

A. I don't know.

Q. You said earlier that [redacted] said that their parents didn't care. What did you understand that to mean? Care about what?

A. They don't really mind or care about how she feels.

Q. Did she ever tell you how that made her feel?

A. No.

MS. MCLEOD: [redacted], I'm going to take a quick break, and then I think I'm almost finished my

questions for you. Okay?

(ADJOURNMENT)

Q. MS. MCLEOD: Going back to when there was a lot of kids going to the GSA at [redacted], did any of the kids ever discuss about whether they had come out as LGBTQ to their families?

A. I don't know.

Q. You don't know if it was ever discussed?

A. What? I don't know or remember.

Q. Do you remember if any of the kids at the GSA discussed whether they felt like they belonged in the rest of the school?

A. Belonged? What do you mean?

Q. Like, whether they felt comfortable?

A. They didn't feel comfortable in gym class because they separated the boys and the girls. And they didn't feel comfortable using the washroom either.

Q. Did you have any of those feelings about gym class or using the washroom?

A. I did.

Q. And what did you do about those feelings of discomfort?

A. Starting in grade [redacted] I started using the gender neutral washroom and I went with the boys in gym.

Q. And how did you feel when you made those changes?

A. Different. It's like -- it was luxurious to have a bathroom to myself. I could just go in. Sometimes I would go there when I'm sad and there was nobody to

hang out with. Say if it wasn't GSA that day, I could hide there.

And for gym when they separated the boys and the girls, being with the boys were a lot different because they played. All the girls did was they just sat down on the side and they gossiped.

Q. So you were happier when you were playing with the boys?

A. I wouldn't say that.

Q. No?

A. It was so-so. It was just different.

Q. And were there other kids from the GSA that were also doing that?

A. I don't know.

Q. I understand that you stopped seeing [redacted] in January, right?

A. Yes.

Q. And that you were seeing [redacted]?

A. Yes.

Q. And is he a pediatrician?

A. Yes.

Q. And do you get any counselling from [redacted]?

A. I don't.

Q. He gives you medications for attention deficit and anxiety?

A. Yeah.

Q. And have there been any changes in your medication in

the last year?

A. I don't know.

Q. How often do you see [redacted]?

A. Not that often.

Q. How many times do you remember having seen him or her?

A. I've been seeing him for a long time, so I can't really count those.

Q. Do you remember how many times you would have seen him in the past year?

A. No.

Q. When were you first asked to put together this document?

MR. CAMERON: Objection. Are you talking about her affidavit?

MS. MCLEOD: Mmm hmm.

MR. CAMERON: Objection.

MS. MCLEOD: On what basis?

MR. CAMERON: Solicitor-client privilege.

MS. MCLEOD: In terms of when?

MR. CAMERON: Any discussions between counsel and the client are privileged. I'm objecting to the question. I mean, she swore it when she swore it. It's on there.

OBJECTION TAKEN to answering the question: When were you first asked to put together this document?

Q. MS. MCLEOD: When did you first start talking to your dad about the information that was going into

the affidavit?

A. The summer.

Q. This past summer?

A. Yeah.

Q. And do you understand what the litigation is about?

A. What does litigation mean?

Q. Court cases.

A. What the court case is about?

Q. Yeah.

MR. CAMERON: I'm going to object to that question. It's not relevant. Her experience is relevant. You can ask questions about that, but her understanding about this litigation is not relevant. It is what it is.

OBJECTION TAKEN to answering the question: What does litigation mean?

MS. MCLEOD: Have you seen any other documents related to this court case?

A. I don't know.

Q. It is 5 o'clock.

When you were in the GSA at [redacted], did you ever talk about the need to respect people who were different from others?

A. Yes.

Q. And did you ever talk about bullying or trying to stop bullying?

A. In the first day.

Q. And I know you've had some troubles with feeling suicidal at times in your past?
A. Yes.
Q. How are you feeling in that respect now?
A. I'm feeling fine.
Q. Good. When was the last time you recall feeling suicidal?
A. In December in grade [redacted].
Q. And that was when your teachers called your parents?
A. No. It was before that. I felt suicidal because, like, everything was just stressful. It was living a double life. Boy at school, girl at home. And there was that voice in my head I called [redacted], and he would tell me things, like, kill yourself. You're useless. Nobody likes you. And it just got to me. And then I told [redacted]. And then I was just --
Q. And then it was right after that that you stayed home for a couple of months, right?
A. Yes.
Q. And did [redacted] stop talking to you during that time?
A. No. It did lay off a little.
Q. When did [redacted] stop talking to you?
A. I told him to shut up.
Q. When did you tell him that?
A. Well, my dad told me that I need to stop letting this [redacted] thing get to me and just get rid of it.
Q. And when did that happen?

A. It was right after -- when I came home from school when -- [redacted] called my dad.
Q. So that was in December of grade [redacted]?
A. Yeah.
Q. And did [redacted] listen? Did he shut up?
A. Yeah.
Q. Following that time when you went back to school in February?
A. Yes.
Q. You were still going by your boy's name at that time, right?
A. No, I wasn't.
Q. You weren't?
A. I went by [redacted].
Q. And did you go by girl pronouns then too?
A. Yes.
Q. So when you went back to school in grade [redacted], you went back to being called [redacted] and getting called girl pronouns. How were you feeling at that time? Did you feel more like a boy or more like a girl?
A. I still felt like a boy.
Q. And did you tell anyone that?
A. Yes.
Q. Who did you tell?
A. I didn't tell. I just didn't correct them when they used male pronouns.
Q. You didn't correct them when they used your girl

pronouns?

A. No. When they used male pronouns.

Q. Okay. So I guess I'm a little bit confused. People at school were still using male pronouns for you when you went --

A. Yeah.

Q. -- into grade [redacted]?

A. Because they got so used to it and I still felt like a boy.

Q. Okay. And were they still using [redacted] as your name?

A. Well, it got really confusing then and really weird. People would call me [redacted] and then some people were, like, what? What's your name then? Huh?

Q. And that was throughout the end of grade [redacted]?

A. Yeah.

Q. And what did you tell them to call you?

A. I only told them to call me [redacted] if they asked.

Q. And then when you started grade [redacted], were you still feeling more like a boy or more like a girl?

A. Well, throughout the summer I was hanging out with my friends from practice and I was feeling less insecure about being a girl, but I still did have boy feelings.

Q. And did you still have those boy feelings when you started grade [redacted]?

A. Yeah. In grade [redacted], yes.

Q. So you told me I think that you started to feel like a girl at Christmas or winter break last year, right?

A. Yes.
Q. So not quite a year ago. And how have you been -- how have you been feeling about that?
A. What do you mean?
Q. Have you been feeling good about that?
A. I don't feel anything. I just don't -- I don't know really. Like, what do you mean feeling good about what?
Q. About the fact that you're identifying as a girl?
A. Yeah, it's good.
Q. And is it good at school as well?
A. Yeah.
Q. Do you know anyone at your current school who is transgender?
A. Yes. There's this -- there's this girl who dresses as a boy, wears boy's clothes, but I just confirmed that she was trans yesterday. I saw her walking by and she was wearing a shirt with a transgender flag on it.
Q. What's the transgender flag?
A. It's pink and blue.
Q. And do you know her or do you just see her at school?
A. I just see her around walking in the halls.
Q. And do you know anyone at your current school who identifies as gay or lesbian or bisexual?
A. Yeah.
Q. Have they talked to you about that?
A. Yes.

Q. Are these kids that you knew from [redacted]?
A. No. Because I went to a completely different [redacted] school because I don't want to see those kids from [redacted] again because they were jerks. It's just this one girl I know that's gay.
Q. And did she tell you that?
A. Yeah.
Q. But I take it that that's not in a GSA that she's telling you that?
A. It's not in a GSA.
Q. She's just a friend that you met at school?
A. Yeah.
Q. And you said that you weight lift now at school?
A. Yeah.
Q. Are you in any other kinds of activities at school?
A. I'm in a dance club. Well, Acro-Cheer Club, and I made friends there. I hang out with them.
Q. And is the girl that you know who's gay, is she also in the Acro Club?
A. No.
Q. And have you told her about how you identify?
MR. CAMERON: Objection.
MS. MCLEOD: Why?
MR. CAMERON: Because that's private. She doesn't have to answer that question. I've been very patient with this examination. You've had a lot of leeway, but that's a private matter and my client

doesn't have to tell you that.

OBJECTION TAKEN to answering the question: And have you told her about how you identify?

Q. MS. MCLEOD: Have you told anyone at your new school about how you identify?

MR. CAMERON: Objection.

OBJECTION TAKEN to answering the question: Have you told anyone at your new school about how you identify?

Q. MS. MCLEOD: Do you know if there is a GSA club at your new school?

A. Yes.

Q. Do you know of anyone who attends it?

A. I have this one friend from church.

Q. And has the friend told you about any activities that they do at that GSA club?

A. No.

MS. MCLEOD: [redacted], it's five-twenty, and I think those are my questions for you.

MR. CAMERON: I have a couple of follow-up questions. Do you need a break?

A. No.

MR. CAMERON: I'll be fast.

Mr. Cameron questions the witness:

Q. You told Ms. McLeod -- this is Ms. McLeod here. You told Ms. McLeod that [redacted] and [redacted] said that it wasn't legal yet to be called male pronouns, called by male pronouns or addressed by male pronouns.

Do you remember that?
A. Yes.
Q. When they said it's not legal yet, what did you understand that to mean?
A. It's not allowed by law.
Q. Did you take that to mean that the law was going to change or what did you understand when they said yet? What did that mean?
A. I took it as it's going to change.
Q. Okay. Ms. McLeod asked you about [redacted], [redacted] and [redacted].
A. Huh?
Q. Ms. McLeod asked you about [redacted] and that he recommended hormones and surgery and puberty blockers. Now, did [redacted] tell you anything else about puberty blockers that you recall?
A. No.
Q. Did he talk about side effects of puberty blockers?
A. No.
Q. He didn't tell you that there might be consequences for taking them?
A. No.
Q. Did [redacted] and [redacted] or [redacted] ever tell you that if you went through puberty naturally probably --
MS. MCLEOD: Objection. Don't lead her, please.

OBJECTION TAKEN to answering the question: Did Dr. Pinzon and Dr. Richie or Dr. Cohen ever tell you that if you went through puberty naturally probably --

MR. CAMERON: Do you know what dysphoria is?

A. Yes.

Q. Gender dysphoria? And you understand that the treatment that the doctors were recommending was to help with dysphoria?

A. Yes.

Q. Did they ever tell you that dysphoria would --

MS. MCLEOD: I'm going to object again. The last one was leading as well and now you're asking another leading question.

OBJECTION TAKEN to answering the question: Did they ever tell you that dysphoria would --

Q. MR. CAMERON: Were you ever aware or advised by any of these doctors that puberty would affect dysphoria and make it go away? Did anybody tell you that?

A. Yes.

Q. Who told you that?

A. To make it go away?

Q. As opposed to surgery and hormones?

A. Huh? Like, it's better than -- what?

Q. Did anybody -- you were in these meetings with the doctors?

A. Mmm hmm.

Q. Did anybody ever tell you that puberty would fix your dysphoria, would make it go away? That puberty would do it, not hormones and puberty blockers?
A. No, they didn't say.
Q. That it would happen naturally? That it would probably happen naturally? Nobody said that to you?
A. They didn't say that puberty would help.
Q. You've gone through puberty now?
A. Yeah. And I don't have those changes I was dreading.
Q. What changes are you talking about?
A. I was dreading the upstairs area, and, like --
Q. You mean having breasts?
A. Yeah. Big ones, and having big hips.
Q. And how do you feel about your body today?
A. It's good because I don't have any of that.
MR. CAMERON: Those are my questions.
MS. MCLEOD: Thanks a lot. I hope you make it on time to practice.

(Proceedings ended at 5:26 p.m.)

Certificate of Transcript

I, the undersigned, hereby certify that the foregoing pages 1 to 42 are a complete and accurate transcript of the proceedings taken down by me in shorthand and transcribed from my shorthand notes to the best of my skill and ability.

Dated at the City of Calgary, Province of Alberta, this 22nd day of November, A.D. 2018.

_____

Gayle Ikert, CSR(A)

Official Court Reporter

- I N D E X -

[redacted]

November 21, 2018

The following is a listing of exhibits, undertakings and objections as interpreted by the Court Reporter. The transcript is the official record, and the index is provided as a courtesy only. It is recommended that the reader refer to the appropriate transcript pages to ensure completeness and accuracy.

EXHIBITS

NONE ENTERED

UNDERTAKINGS REQUESTED

NONE REQUESTED

OBJECTIONS

OBJECTION TAKEN to answering the question: Have you told anyone at your new school about how you identify? 38

OBJECTION TAKEN to answering the question: Did [redacted] and [redacted] or [redacted] ever tell you that if you went through puberty naturally probably -- 40

OBJECTION TAKEN to answering the question: Did they ever tell you that dysphoria would -- 40

This is **Exhibit "F"** referred to in the Affidavit of **Darren Leung** sworn before me this 20th day of March, 2024.

Barrister & Solicitor

Court File No.: FM-76-2023

IN THE COURT OF KING'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF FREDERICTON

IN THE MATTER of an application for judicial review and declaratory relief pursuant to Rule 69 and Rule 38 of the New Brunswick *Rules of Court*

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Applicant (Respondent on motion)

-and-

THE PROVINCE OF NEW BRUNSWICK, as represented by the MINISTER OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Respondent (Respondent on motion)

-and-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Proposed Intervenors (Moving Parties)

AFFIDAVIT OF [redacted]

COUR DU BANC DU ROI DU NOUVEAU-BRUNSWICK

DIVISION DE PREMIÈRE INSTANCE

CIRCONSCRIPTION JUDICIAIRE DE FREDERICTON

DANS L'AFFAIRE d'une requête en revision judiciare et de jugement déclaratoire en vertu de la règle 69 et la règle 38 des *Règles de procedure* du Nouveau-Brunswick

B E T W E E N :

THE CANADIAN CIVIL LIBERTIES ASSOCIATION

Requérant (intimé â la requête)

-et-

LA PROVINCE DU NOUVEAU BRUNSWICK, représentée par le MINISTRE DE L'ÉDUCATION ET DU DÉVELOPPEMENT DE LA PETITE ENFANCE

Intimée (intimé â la requête)

-et-

GENDER DYSPHORIA ALLIANCE and OUR DUTY CANADA

Intervenants eventuelles (parties requérantes)

AFFIDAVIT OF [redacted]

AFFIDAVIT OF [redacted]
(Hereinafter, "P.T.")

I, [redacted], of the [redacted] in the Province of Alberta **MAKE OATH AND SAY AS FOLLOWS:**

Introduction

1. I am the father of A.A., a biological female, and another affiant in these proceedings. I have personal knowledge of the facts hereinafter deposed except where stated to be based on information, in which case, I believe the same to be true.

2. On April 4, 2018, I swore an Affidavit in (then) Court of Queen's Bench Action No. 1808-00144 (the **"Alberta Court Proceedings").** A copy of that Affidavit (excluding exhibits) is attached hereto and marked as **Exhibit "1" ("My First Affidavit").** My First Affidavit remains true and correct today.

3. I am aware that A.A. swore an Affidavit in the Alberta Court Proceedings and am familiar with its contents **("A.A.'s First Affidavit").**

4. I am in a unique position to provide evidence in these proceedings as I have direct experience with: (a) being a parent of a neurodivergent/disabled child - A.A. who was diagnosed with Autism when she was about 5 years old[1]; (b) parenting a child (A.A.) who experienced gender dysphoria and who socially transitioned[2] from being female to male at school without my knowledge as described in My First Affidavit; (c) the betrayal of and broken trust with the school because it failed to inform my wife and I of our minor, disabled daughter's social transition at school even though we were advised that A.A. was "very sad overall"[3]; (d) the

[1] When A.A. was 7-11 years old, she also experienced body dysmorphia and suffered with anorexia nervosa, an eating disorder.
[2] By that term or its derivatives, throughout this Affidavit, I mean that my daughter used male pronouns, used a masculine name, and sometimes used washroom facilities for gender neutral individuals.
[3] We sought the school's input and support for A.A, but were not told that A.A. was regularly attending the Gay Straight Alliance ("GSA") program (or even what the GSA was), self-identifying as a male at school and thought of herself as bisexual and transgender. When A.A. was suicidal, we were naturally looking for possible explanations and information so we could help her, as described in My First Affidavit.

pressure and influence of the psychologist and medical health providers who encouraged and suggested that my minor daughter continue to transition by potentially using hormones and potentially undergoing surgical intervention, as described in A.A.'s First Affidavit; and (e) being a parent who, together with my wife, has loved and supported A.A. during her many struggles and challenges, including in connection with her exposure to transgenderism at a school GSA club, particulars of which exposure are detailed in A.A.'s First Affidavit.

Schools and Authorities

5. My wife, D.T., and I entrusted the public school system, its teachers and administrators, in Alberta to safeguard my Autistic minor daughter while she was in their care. Under the supervision of the public-school teachers and publicly funded health care providers, my disabled minor daughter was encouraged and supported into socially transitioning her gender causing her harm. The school kept her social transition from us as described in A.A.'s First Affidavit and My First Affidavit.

6. We believed that the school had A.A.'s best interest in mind. We believed then and still believe now that some authorities genuinely thought they had A.A.'s best interests in mind. However, in the end, what we saw in relation to A.A. were some authorities who seemed more concerned with pushing a transgender ideology or agenda in secret, and how we understand they became upset when A.A. decided to de-transition as A.A. explains in A.A.'s First Affidavit.

7. In my situation, the school encouraged my daughter to keep secrets from my wife and me. I can imagine that other parents have similar concerns about the school's responsibility to inform parents about the activities of the child at school. It is dangerous for teachers not to tell parents what is going on in their child's life. My concern is that A.A.'s situation could be repeated in New Brunswick for other children if the schools encourage children to transition and then it is kept secret from their parents, or they encourage children to keep a social transition secret from their parents.

8. The teachers at A.A.'s school did not take into account the mental issues that A.A. suffered from: Autism, and her tendency to focus radically on some things and completely block out

other things, but also her past issues of body dysmorphia and anorexia where I guided her away from starving herself and encouraged her to build muscles and become a strong woman. The teachers saw her interest in building muscle and going to the gym to lift weights and wrongfully manipulated that fact, turning it into an issue of gender identity. Everyone at her break-dancing group saw A.A. as a girl. It was only the teachers who treated her as a boy and were trying to convince her to transition.

9. The teachers (incorrectly) saw transgenderism as a solution to A.A.'s Autism and resulting social deficiencies.

10. As part of our Christian faith, we believe that gender is a premortal characteristic that exists before we are born that makes us special and unique. It was highly offensive and disrespectful to my wife and I that the school would teach A.A. ideas that were contrary to our religious beliefs and would actively recruit her to depart from the religious values that were taught to her in our family home.

Secrecy's Effect on A.A., the Family, and Our Relationships

11. It was devastating for my wife and I to have found out that my daughter had been living a double life without our knowledge. My wife and I originally naturally focussed on how we could help A.A. We only wish we had known sooner so we could have offered her guidance and support to ensure she was taking the right path for her. Having a wedge driven between A.A. and my wife and I, was not in A.A.'s best interests including because she was isolated from those who love and want to support her most. This is especially the case given A.A.'s complex psychological and medical history, including her Autism. Being blocked by school and other authorities from knowing what was going on left A.A. vulnerable to people who do not know and care for her like my wife and I do; having conceived, raised, cared for, and loved her with all of our hearts from the beginning of her life. Encouraging A.A. to lie or mislead or condoning that behaviour in relation to her parents (or anyone) sends her the wrong moral messages which also goes against our Christian faith which encourages truth and not deceit in dealings with others.

12. A.A. is doing well and my wife and I mostly trust her now. The fact that A.A. kept secrets from us when she was younger damaged our relationship with her. Re-building trust is an ongoing process and takes time so that things can be fully restored. Schools and professionals should not have wedged themselves between us and our daughter. Until A.A. was [redacted], it was our responsibility to care for her in every respect therefore I believe we have the concomitant right to know from school authorities - who stand in the place of the parents when they do their jobs - what was happening to and with her.

13. From my own personal experience, in my view, parents cannot provide and are prevented from providing the necessary and proper care for their children if they have not been given access to all information about their child. The school does not know enough about the specific child or about medical or psychological issues to make any determinative decisions for a child and certainly cannot make unilateral decisions that affect children without obtaining the parent's consent. There are a lot of life events that happen at school for a child but that does not mean the duty to care for the child is transferred to the teachers. I believe that parents have the right to know what goes on in their child's life so that they can make informed decisions about the level of care for their child.

Connection with these Proceedings

14. I am able to provide a voice for New Brunswick and other parents who remain silent but are going through similar experience as l have. I believe that the Court needs to know what it was like for me, a father, being left out of the conversation with the school while my daughter was going through a major change and upheaval in her life, including to the point of attempting suicide.

15. I understand that some parents in New Brunswick may not want to step forward in these proceedings to tell their stories. From my own experience, I did not want to initially join the litigation in Alberta because this topic is highly politicized and I was concerned about my daughter and my family's health and safety. Once I knew that A.A. and my identities would be properly protected by the Court throughout the litigation, I was willing to participate and support the participation by A.A. in the Alberta Court Proceedings as well. This is because I

felt that it was important for her experiences and perspectives and mine to be utilized for the benefit of society as lawyers use these to advance their legal analysis and arguments.

Partial Publication Ban

16. My disabled daughter and my family have suffered tremendously over the last few years dealing with the breach of trust with the school, A.A.'s mental health concerns and suicide attempt, A.A. socially transitioning and de-transitioning, and the Alberta Court Proceedings. Our lives have just regained some sense of stability again after many years of turbulence. These New Brunswick Court proceedings are becoming nationally known, and the topic is highly politicized. If my name, my wife's name, or my daughter's identity was revealed as part of these proceedings, it could potentially cause my entire family tremendous harm. I could be verbally attacked, verbally bullied, and even physically harmed by people who disagree with me. The same could happen to my family.

17. As a permanently disabled person, A.A. receives government funding through Alberta Income for the Severely Handicapped **("AISH")** on which she is financially dependent. It is imperative for A.A. and my family that A.A. do not say or do anything in public that could compromise her AISH funding. Her and I speaking in these proceedings without the Court protecting our anonymity could possibly (albeit not properly) result in that, for example.

19. The bottom line is that I do not want my involvement in this matter and name and any identifying information like the name of A.A., exposed to the public. If that happened, I would be very worried about my safety and wellbeing and that of my family.

20. I was able to sign my First Affidavit using my initials. Identifying information was redacted. I am writing this Affidavit requesting that this Court permit me that same protection now in respect of this Affidavit as I had then in terms of a limited publication ban. Because I could be identified by my daughter's (A.A.'s) Affidavit if her name were public, I would need her name and any information she provides in these proceedings that could identify me to be similarly protected through a Court order granting an acceptable publication ban.

21. I swear this Affidavit for no improper purpose.

SWORN BEFORE ME AT THE [redacted], IN THE PROVINCE OF ALBERTA, THIS _____ DAY OF APRIL, 2024	)	
_____	)	_____
A Commissioner for Oaths in and for Alberta	)	[redacted]

THIS IS **EXHIBIT "1"** REFERRED TO IN THE AFFIDAVIT OF [redacted] SWORN THIS ____DAY OF APRIL, 2024

A Commissioner for Oaths in and for the Province of Alberta

Exhibit “1”

COURT FILE NUMBER	1808-00144
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	MEDICNE HAT
APPLICANTS	P.T., D.T., F.R., K.R., P.H., M.T., J.V., A.S., R.M., UNIVERSAL EDUCATION INSTITUTE OF CANADA, HEADWAY SCHOOL SOCIETY OF ALBERTA, THE CANADIAN REFORMED SCHOOL SOCIETY OF CALGARY, GOBIND MARG CHARITABLE TRUST FOUNDATION, CONGREGATION HOUSE OF JACOB - MIKVEH ISRAEL, KHALSA SCHOOL CALGARY EDUCATION FOUNDATION, CENTRAL ALBERTA CHRISTIAN HIGH SCHOOL SOCIETY, SADDLE LAKE INDIAN FULL GOSPEL MISSION, ST. MATTHEW EVANGELICAL LUTHERAN CHURCH OF STONY PLAIN, ALBERTA, CALVIN CHRISTIAN SCHOOL SOCIETY, CANADIAN REFORMED SCHOOL SOCIETY OF EDMONTON, COALDALE CANADIAN REFORMED SCHOOL SOCIETY, AIRDRIE KOINONIA CHRISTIAN SCHOOL SOCIETY, DESTINY CHRISTIAN SCHOOL SOCIETY, KOINONIA CHRISTIAN SCHOOL - RED DEER SOCIETY, COVENANT CANADIAN REFORMED SCHOOL SOCIETY, LACOMBE CHRISTIAN SCHOOL SOCIETY, PROVIDENCE CHRISTIAN SCHOOL SOCIETY, LIVING WATERS CHRISTIAN ACADEMY, NEWELL CHRISTIAN SCHOOL SOCIETY, SLAVE LAKE KOINONIA CHRISTIAN SCHOOL, PONOKA CHRISTIAN SCHOOL SOCIETY, YELLOWHEAD KOINONIA CHRISTIAN SCHOOL SOCIETY, THE RIMBEY CHRISTIAN SCHOOL SOCIETY, LIVING TRUTH CHRISTIAN SCHOOL SOCIETY, LIGHTHOUSE CHRISTIAN SCHOOL SOCIETY, PARENTS FOR CHOICE IN EDUCATION, and ASSOCIATION OF CHRISTIAN SCHOOLS INTERNATIONAL - WESTERN CANADA,
RESPONDENT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT** of P.T.

Clerk's Stamp

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	**Justice Centre for Constitutional Freedoms** #253, 7620 Elbow Drive SW Calgary, AB, T2V 1K2 Attention: J. CAMERON and M. MOORE Telephone: 403-909-3404 Facsimile: 587-747-5310

AFFIDAVIT OF P.T.

Sworn on April 4 **, 2018**

I, P.T., of the Town of [redacted] in the Province of Alberta, SWEAR AND SAY THAT:

1. I am a [redacted] Consultant and have a Bachelor of Science in [redacted]. I am a married father of [redacted] children, [redacted] of whom suffer from a form of Autism Spectrum Disorder (ASD). My wife, D.T., and I have enrolled each of our children in [redacted] Board of Education ("[redacted]") public schools. I have personal knowledge of the facts herein deposed except where based on information and belief, in which case I verily believe same to be true.

2. Use of the terms such as "we", "us" and "our" references my wife D.T. and myself.

3. Use of the term "our daughter" references our [redacted] child.

4. As of the date of this affidavit, our daughter is [redacted] years of age. We love and cherish our daughter. Raising her has been challenging as she has struggled with various mental health problems, and with her social skills. She is very vulnerable because she tends to be naïve, credulous, and will do almost anything to be liked by others, even if it is detrimental to herself.

5. Our daughter entered [redacted] at a new school, at the age of [redacted], in September of 2015. She was happy to start at a new school and excited to make new friends.

6. A year later, by December 2016, our daughter had become severely depressed and suicidal. We were forced to remove her from school and keep her home for two months to ensure her safety and address her condition. We only discovered afterwards, once our daughter was able to explain to us what had happened, that our daughter's participation in the Gay-Straight Alliance ("GSA") at her school was the primary catalyst for her downward spiral.

7. We were never fully or properly informed by our daughter's school, prior to December 2016, about the nature of the GSA our daughter attended, the degree to which our daughter participated in it, or the nature and severity of her struggles with the suggestions of her peers and teachers regarding sexuality, gender, and identity.

8. Our daughter could have lost her life because her school chose to withhold information from us as parents. The *School Act* now requires information about our vulnerable daughter to be withheld from us in regard to GSA meetings or GSA-related activities, which re-endangers our daughter's mental stability and emotional wellbeing. If she begins to again participate a GSA, we will not know. If within the confines of such a club, she is encouraged to experiment, sexually or psychologically, it will be illegal to inform us. This threatens our daughter's safety, and it prevents us from helping her in whatever new peril she may find herself in.

Background

9. Our daughter was diagnosed with Autism Spectrum Disorder: Pervasive Developmental Delay Not Otherwise Specified ("ASD") at the age of five, and with Attention Deficit Hyperactivity Disorder ("ADHD") at the age of eight. Attached to this Affidavit as **Exhibit "A"** is a psychological assessment that discusses these diagnoses. As noted in the assessment, our daughter had "very poor social judgment" at the time of the assessment. Improvement in this regard has been minimal. Our daughter continues to struggle emotionally and socially; she strongly desires friends and to be liked by her peers, but rarely achieves this goal due to her lack of social skills.

10. D.T. and I both take an active role in supporting our children in their education and development. We regularly assist them doing homework, frequently discuss their school day with them, attend parent teacher interviews and maintain frequent communication with their teachers.

11. D.T. and I believe that God creates people either male or female, and this is also biological reality. As parents, D.T. and I have sought to raise our children to embrace their God-given identity and potential, and to understand and accept the scientific reality that sex and gender are determined by biology. Our intention has always been to protect our children from activities that would undermine our ability to raise our children in accordance with our religious beliefs regarding God's design and intention for human sexuality. We also believe and teach our

children that engaging in sexual activity outside the context of a marriage between one man and one woman is morally wrong.

12. Having children with disabilities, D.T. and I recognize the importance of understanding the unique differences, including strengths and weaknesses, each of our children have, and providing care and support to each of them in light of their unique traits and struggles.

13. A consequence of her ASD is a deficiency in emotional regulation which has caused her to have socialization problems. Attached to this Affidavit as **Exhibit "B"** is a 2013 academic article titled "The Role of Emotion Regulation in Autism Spectrum Disorder RH: Emotion Regulation in ASD" which discusses this issue.

14. Our daughter is often isolated and with few friends. We have been informed that people with ASD sometimes have a difficult time making close friends, and that it is common for girls with ASD to be somewhat "tomboy-ish" regarding their activities and to socially relate better to males. Attached to this Affidavit as **Exhibit "C"** is a 2011 report titled, "Brief Report: Female-To-Male Transsexual People and Autistic Traits". My wife and I supported our daughter in her interests. We have not tried to pressure or to conform her interests, activities, or social life to things stereotypically associated with females.

Fall 2015

15. In September 2015, our daughter began attending a [redacted]public school (herein after referred to as "our daughter's school", "her school" and "the school") that offered an ASD "cluster" program for students with learning disabilities such as ASD (the "ASD Program").

16. We communicated regularly with the primary ASD Program teacher (the "ASD Program Teacher") as she oversaw many aspects of our daughter's education.

17. Our daughter began the 2015 school year described as "mostly happy" and "confident" by the ASD Program Teacher (see September 1, 2015 email attached to this Affidavit as **Exhibit "D"**). Despite experiencing some anxiety, our daughter initially did well in the ASD Program. She made progress in her studies and made friends with another girl, also in the ASD Program.

18. On October 28, 2015 we had a regular parent-teacher meeting with the ASD Program Teacher. The ASD Program Teacher mentioned at this meeting that there was a new "club" starting at the school that she was excited about and thought it would be good for our daughter to attend. The ASD Program Teacher said she could not share any details about the "club" to us, but that our daughter was likely to make many new friends. Unfortunately, we did not press for further details regarding the "club". We mistakenly assumed it was some type of socializing club where our daughter could improve her social skills and make friends, which is something we wanted for her and knew would be good for her.

19. In December 2015, we started to notice that our daughter was growing more emotional and anxious. The friend our daughter had made no longer wished to be her friend. We arranged for our daughter to meet with her psychologist. We now know that our daughter, who was [redacted] years of age at the time, had been attending the school's GSA since sometime in early November 2015. The GSA was new to the school in the fall of that year. We later learned that our daughter became aware of the GSA, which met during the lunch break, because her ASD Program Teacher and our daughter's primary Educational Assistant (the "Educational Assistant") promoted it directly to the students in the ASD Program, including our daughter, and encouraged our daughter to attend.

Introduction and Experience at the GSA

20. Our daughter's behaviour and demeanor began to change dramatically in November 2015, with the commencement of her attendance at her school's GSA.

21. In November 2015, our daughter typically played the Pokémon card game with her peers, an activity she enjoyed. On the date of the first GSA meeting, our daughter informed us she was getting ready to play Pokémon with her peers when the ASD Program Teacher and the Educational Assistant both implored her to join them in attending the GSA. Although preferring to play Pokémon, she decided to attend the GSA meeting.

22. The meeting started with each person stating their name and their "preferred pronoun". Our daughter stated her full female first name and said that she went by

"she". Next was a PowerPoint presentation regarding the "Gender Spectrum", followed by each student declaring their "identity". These "identities" included "bisexual", "lesbian", and "gay". Our daughter, being only [redacted] years of age and rather innocent and curious, asked what "bisexual" meant. Upon being told that "bisexual" referred to people who are physically or sexually attracted to both sexes, our daughter immediately declared that she was a "bisexual", too. There were about half a dozen students in attendance at the first GSA meeting.

23. We now know that shortly thereafter, at a subsequent GSA meeting, our daughter asked what "transgender" meant. She was told that "transgender" describes the situation when a person's gender does not match what was "assigned" at birth. By the end of that particular GSA meeting, our daughter decided that she was also "transgender". Before she left that GSA meeting, she was given a booklet by someone at the GSA entitled "I think I Might Be Transgender, Now What Do I Do?" (the "Booklet"). We were not aware at the time that she had been given the Booklet. We have since reviewed the content of the Booklet, a copy of which is attached to this Affidavit as **Exhibit "E"**).

24. The Booklet states that "transgender people feel that the gender to which they were born, or assigned at birth, does not fit them". When our daughter was given this booklet she was a credulous, [redacted] year-old autistic girl. She completely lacked the maturity, discretion, and understanding to make informed, responsible decisions regarding her gender. The Booklet also states that "there is no obligation to tell anyone about your identity".

25. The Booklet cites the experiences of adults, not children. It reads like a sales pamphlet, with no negative testimonials and statistics, and ignoring the experience of people who are profoundly disillusioned with their "transition". The Booklet also states, "Others feel (when they come out) as if they are thrown into a lion's den, with challenges from parents, friends, and family". My wife and I are profoundly saddened and upset that the school was willing to promote and distribute material that informs children they will feel like "they are being thrown into a lion's den" when sharing honestly with parents and family. This is irresponsible, and a breach of the trust that we placed in the school, to tell our

daughter, a vulnerable intellectually-disabled girl, that essentially everyone was likely to be against her. Putting children, especially vulnerable children with autism, through this harmful and anxious situation is cruel and dangerous.

26. My daughter has informed us that she read the entirety of the Booklet upon receiving it, and that it convinced her at the time that she was "transgender".

27. Our daughter continued to attend the GSA meetings. In one of the GSA meetings prior to the 2015 Christmas break, she was taught about "packers". "Packing", I am informed, is the act of wearing something between one's legs to give the appearance of the presence of a penis and testicles. Attached to this Affidavit as **Exhibit "F"** is an article published by the BC Provincial Health Services Authority's Transgender Health Information Program that discusses "packers". At [redacted] years of age, our daughter was being taught about how to wear a fake penis to make others think she was a male. Neither her school nor her teachers informed us that our daughter was being taught these things.

28. We have since learned that shortly after attending the first GSA meeting, our daughter began to pretend to be a boy at school. She has since told us she liked pretending to be a boy, partly because she was very much a "tomboy" in personality and interests, but more so because she enjoyed the special attention she received, and the new friends she believed she had made. She found that pretending to be a boy at school made her very popular.

29. Over time, the distinction between reality and fantasy was blurred, and our daughter increasingly started to "self-identify" as a boy at school, instead of just pretending. This caused her to live a "double-life": living as the female she was at home, while "self-identifying" as a male while at school.

Events of January – June 2016

30. Our daughter, unbeknownst to us at the time, continued to attend the GSA from January to June 2016.

31. Matters worsened regarding our daughter's emotional and psychological condition in February 2016. The ASD Program Teacher informed us on February 24, 2016

(email attached to this Affidavit as **Exhibit "G"**) that our daughter was acting strangely and speaking unkindly to the ASD Program Teacher. Our daughter has since told us that the ASD Program Teacher made her feel very uncomfortable, but that she felt like we trusted her, and that if her parents trusted the ASD Program Teacher that meant the ASD Program Teacher was trustworthy. She also has told us that when she first started attending the school she believed that all adults were right, and that she should trust the people we entrusted her to.

32. On March 8, 2016, the ASD Program Teacher told us via email (attached to this Affidavit as **Exhibit "H"**) that our daughter had become "very sad overall" and had "closed herself off".

33. Unaware of what could be causing our daughter's depressed emotional state and strange behaviour, we responded by arranging for our daughter to meet more often with her psychologist, and to meet with a psychiatrist. In an email sent to the ASD Program Teacher on March 9, 2016 (attached to this Affidavit at **Exhibit "I"**), we candidly speculated about the various factors that could be contributing to our daughter's struggles with anxiety and depression. Unfortunately, the ASD Program Teacher withheld from us that our daughter was regularly attending a GSA, and that she was "self-identifying" as a boy at school, and that she now thought of herself as "bisexual" and "transgender".

34. Meanwhile, sometime in March 2016, in response to suggestions from a fellow GSA-attending student, our daughter began using male pronouns to refer to herself and adopted a male first name. She requested that her teachers use her male name and pronouns, and they did so. This dramatic change was also not communicated to us.

35. In a March 15, 2016 email (attached to this Affidavit as **Exhibit "J"**), the ASD Program Teacher told us our daughter had stated she was "very stressed-out by everything". My wife and I had several lengthy conversations about this, confused as to the source of our daughter's anxiety. Little did we know!

36. The ASD Program Teacher also stated in this email that our daughter had formed a close bond with her Educational Assistant. At the time, we had no cause for

alarm regarding this state of affairs and, in fact, considered it a positive development. However, we now know that this same Educational Assistant, in addition to imploring our daughter to attend the first GSA meeting, accompanied our daughter to the first five GSA meetings. As mentioned above, at one of these early GSA meetings, our daughter impulsively declared herself to be "bisexual" even though she had only just learned about the term and the concept. The Educational Assistant, who was in attendance at this GSA meeting, immediately responded "that is totally fine!". Instead of conducting herself as a reasonable adult, responsible for the care of our [redacted] year-old intellectually-disabled daughter, by helping her to think through such things, she enabled and encouraged our daughter to "self-identify" with labels she did not, and could not have, properly understood.

37. Our daughter has since informed us that once she started attending the GSA meetings in the fall of 2015, her Educational Assistant continually encouraged our daughter to "self-identify" as "transgender", as a boy, and to "transition". This type of behaviour on the part of an adult in a position of trust and authority over our daughter is unacceptable. We are shocked to hear that our daughter's Educational Assistant was influencing our daughter in this manner, and thereby contributing to her confusion and anxiety regarding her gender.

38. On April 7, 2016, we received an email from the ASD Program Teacher (attached to this Affidavit, as **Exhibit "K"**), in which the ASD Program Teacher stated, rather oddly and cryptically, that our daughter had been "deeply reflecting on her self-identity at this time." Unsure of what the ASD Program Teacher was referring to by "self-identify", we nonetheless were not overly concerned as we generally trusted the ASD Program Teacher to have our daughter's best interests in mind and to be candid with us if there was anything we should know regarding our daughter.

39. Then, at a parent-teacher meeting on April 21, 2016, we were informed, for the first time and nearly six months after the fact, that our daughter had been attending a GSA at her school. My wife and I were surprised. But, not knowing anything about GSAs, except, as we were told, that they were intended to reduce bullying,

we were not concerned. We thought it would be a good opportunity for her to show kindness and be empathetic towards those experiencing bullying for being gay, or for any other reason. At that time, we thought our daughter was attending the GSA because she supported anti-bullying efforts and wanted to show her support. We thought this, in part, because we believed that if our daughter was attending the GSA for reasons relating to her own struggles with gender or sexuality, that the school would inform us.

40. On May 4, 2016, we visited our daughter's psychologist and psychiatrist (the "May 4 Meeting"). They opined that she had developed Gender Dysphoria. We were surprised that the Gender Dysphoria label was so readily applied to our daughter, but, of course, we were as yet unaware that she had been "self-identifying" as a boy at school and that the school had been encouraging this and hiding their activities from us. We well understood that our daughter was a "tomboy" and saw no need for concern in that regard.

41. Upon telling us at the May 4 Meeting that our daughter had Gender Dysphoria, the psychologist and psychiatrist immediately proposed puberty blocking drugs and potentially surgery as a treatment response. We were shocked at the drastic and invasive treatment recommended.

42. At the same meeting, with both my wife and our daughter present in the room, the psychiatrist directly asked our daughter if she wanted a penis. She emphatically answered "no!".

43. A few days later, the ASD Program Teacher sent us an email on May 9, 2016 (attached to this Affidavit as **Exhibit "L"**), in which she informed us, for the first time, that she was aware our daughter had been struggling with her sexuality and gender. We were advised by the ASD Program Teacher that the school had told our daughter about a "local transgender clinic". The ASD Program Teacher suggested we consider sending our daughter to the clinic. Attached to the email was a 2014 document published by the Canadian Psychological Association titled ""Psychological Works" Fact Sheet: Gender Dysphoria in Children"(the "2014 CPA Gender Dysphoria Fact Sheet", attached to this Affidavit as **Exhibit "M"**).

48. Our knowledge in May 2016 was still limited. We were not yet aware that our daughter was "self-identifying" as a boy at school, and were not informed of this by the school until September 2016). Neither the school, nor the psychologist who considered her to be Gender Dysphoric, informed us of this. At the time, our understanding was that she was experiencing a "tomboy" phase as she struggled with puberty and the onset of menstruation.

49. We were also still unaware of the true nature of the GSA, although we began to suspect that the group was more than merely an anti-bullying socializing club. Based on the name "gay-straight alliance, we wrongly assumed the club was limited to matters regarding sexual orientation. We were concerned that the GSA may have a negative impact on our daughter's understanding of her sexual orientation. We did not yet realize that the impact of the GSA upon our daughter was different and much worse.

50. I expressed in the May 9 Email to the ASD Program Teacher that I did not want our daughter to continue attending the GSA at the school. I ended the email by stating, regarding our daughter's participation in the GSA, that "I will be lovingly steering her away from it." I now realize that my direction to the ASD Program Teacher was not considered explicit enough and not followed. I wrongfully assumed that my direction that our daughter not attend the GSA would be honoured.

51. Again on May 9, the ASD Program Teacher emailed us in response (attached to this Affidavit as **Exhibit "P"**), stating, in part:

> Thank you so much for your very thoughtfully written reply. I know [our daughter] has a very loving family and everything you said supports and proves this completely! I absolutely agree that [our daughter] is attracted to opposite sex individuals and I have no doubt she is not questioning this. I agree with you that her big concern is her hitting puberty and being adverse to having to dress in "girl clothes".

52. I mistakenly assumed the ASD Program Teacher would work with us, and respect our wish that our daughter not attend the GSA. If the ASD Program Teacher had been forthright regarding her objection to my direction, or her unwillingness to follow it, I could have guided my daughter more effectively.

53. There was no pertinent communication between ourselves and the ASD Program Teacher following the email exchange on May 9, 2016. We assumed that our wishes would be respected, and that if further issues developed we would be apprised. We regret that we trusted the school as much as we did, and that we did not take a more active hand.

Summer 2016

54. Once the 2015-2016 school year ended, we noticed that our daughter was much less anxious and depressed. She enjoyed the summer of 2016 and she socialized well with other girls from her church during a young women's summer camp. She described it as one of the best experiences of her life. As a family, we enjoyed many trips and hikes that summer. She appeared much happier than she had been during the previous school year.

Events of September to December 2016

55. Our daughter started the 2016-2017 school year "mostly happy" as described in a September 14, 2016 email from the ASD Program Teacher (attached to this Affidavit as **"Exhibit "Q"**).

56. However, unbeknownst to us, our daughter had in fact been pretending, at the behest and suggestion of her peers and teachers, to be a boy at school, and a girl when she came home to us. We were not informed at that time by the school that in September 2016, when she returned, that she recommenced this practice despite having abandoned it during the summer holidays.

57. On September 14, 2016 we finally discovered that our daughter had been self-identifying as a boy, including using a different, male name to refer to herself. We were very troubled by this behaviour, and that the school had again failed to inform us about important and concerning developments regarding our daughter. This behaviour had gone on for four months during the previous school year (from March through to June 2016) without our knowledge.

58. We emailed the ASD Program Teacher on September 15, 2016 (attached to this Affidavit as **Exhibit "R"**) to again express our disapproval of our daughter

attending the school's GSA (which we had concluded was the source of at least some of the issues of the previous school year) without our knowledge or consent.

59. My wife and I discussed with our daughter her behaviour, her feelings, and why she was referring to herself with a male's name. After a full discussion, we and our daughter agreed she would use and be referred to by her own first name or a shortened version of it. Further, our daughter said she would tell her school principal and teachers that she wished to be referred to by her given, female name, or a shortened version of it. I followed up with our daughter on several occasions during the fall of 2016, inquiring whether she was being referred to by her given first name and not the male name. She said she was, and that she corrected all who referred to her as the male name. Unfortunately, our daughter was lying to us.

60. On October 25, 2016, the ASD Program Teacher informed us via email (attached to this Affidavit as **Exhibit "S"**) that our daughter had, that morning, been "very emotional and anxious" and had expressed "dark thoughts and feelings... about herself".

61. In an October 27, 2016 email to the ASD Program Teacher (attached to this Affidavit as **Exhibit "T"**), we again explained, in an attempt to help the ASD Program Teacher to better understand our intellectually-disabled daughter's struggles, that she is a vulnerable girl, and that she had had body image issues in the past. The purpose of this email was to help the ASD Program Teacher understand why it was important to be careful with the influences our daughter was exposed to.

62. On November 7, 2016 we received a concerning email from the ASD Program Teacher (attached to this Affidavit as **Exhibit "U"**) in which she stated, in part:

> ...[our daughter] shared that she has a voice in her head that talks to her and says very mean things. The voice is called '[redacted]', and he often says things like, "You are dead, You are no good. You are better off not existing, You may as well be dead." [our daughter] says she often fights with this voice because it tells her she is worthless and is better off not being alive. Further to this, a different person mentioned to me that [our daughter] was talking to herself in Math Class and was saying, "No [redacted], Stop it [redacted]', out loud.

63. It was clear to us that our daughter was deeply disturbed and suffering from severe mental health problems. We were doing everything we could to help her, but we were still unaware of the extent to which her extreme gender and identity struggles were contributing to her problems.

64. Our daughter has informed us that, by the fall of 2016, most of the students who initially attended the GSA meetings had stopped attending. At one point, there were only two students, including our daughter, attending the meetings. Our daughter felt pressured by the teachers facilitating the GSA meetings to recruit new members, which, our daughter has informed us, added to the anxiety and stress she was experiencing at the time.

65. Circumstances deteriorated further in December of 2016. In a series of three emails sent on December 6, 7 and 8 (attached to this Affidavit as **Exhibit "V"**), the ASD Program Teacher informed us that our daughter was "becoming more and more depressed", was "having suicidal thoughts", and was possibly "struggling with [redacted] the voice in her head, who is telling her to end it."

66. These developments concerned us greatly. In response, we kept our daughter home from school on December 9 and for the rest of December 2016. Her emotional state gradually improved and we began to talk about the things she was experiencing.

67. On December 8 and 9, I spent a number of hours with my daughter so as to discuss the serious problems she was facing. We discussed how serious it was to contemplate suicide. I was very concerned and worried about her. I took time to determine the thoughts, feelings, and circumstances she was experiencing that had lead her to be in such a dark place. We discussed at length her feelings and thoughts regarding gender and her body and how those thoughts and feelings were contributing to her depression and anxiety.

68. We kept our daughter out of school until the week of February 13-17, 2017. During that time, her emotional and psychological state continued to improve. Slowly, over the course of several weeks, she explained to us what had been happening at school: how she had continued to "self-identify" as a boy at the encouragement of staff and peers, how the school had continued to refer to her by male pronouns and

a male first name, how she had been permitted to join the boys team during sex-segregated activities in Phys Ed class and how she had continued to attend the GSA meetings.

69. Once out of school, our daughter stabilized emotionally and psychologically. We patiently loved her and counseled her. She became happier as she re-accepted being a biological girl, that was also a "tomboy".

70. We felt betrayed by the ASD Program Teacher and our daughter's school. The ASD Program Teacher and the Educational Assistant claimed to care about our daughter's well-being, yet they were enabling and encouraging the very behaviours and thought-processes that were contributing to our daughter's serious depression and anxiety and withholding the existence of those behaviours and thoughts from us, her parents.

Return to School in 2017

71. Our daughter eventually became well enough to return to school. Naturally, we were uneasy about sending her back to school, but, as our daughter suffers from an intellectual disability, she struggles to learn and requires the specialized resources and learning environment provided by the ASD Program.

72. We contacted to the principal of our daughter's school in an effort to establish parameters for our daughter that would enable her to attend school, without falling back into the pattern of "self-identifying" as a different sex, anxiety, and depression.

73. We made a verbal agreement with the school that the teachers would refer to her with female pronouns and at least use a shortened form of her female name. The school principal acknowledged our daughter's unique needs, including her need to have informed support and care from us as her parents. The principal agreed to ensure that he and school staff would keep us informed as to the experiences and challenges our daughter has in school, including questioning her gender.

74. Our daughter resumed attending school in February 2017, but no longer attended the GSA.

2017-2018 School Year

75. Thankfully the 2017-2018 school year has been largely uneventful. Our daughter has not been attending the GSA. She has grown and improved over the course of the school year, emotionally, socially, and academically. She has become much more comfortable with the fact that is a girl and looks like a girl. She has slowly begun to dress in a more feminine manner.

76. Unfortunately, and despite our daughter having now embraced her female gender, the aforementioned Educational Assistant has persisted in attempting to secretly influence our daughter. Our daughter informed us that in February 2018 our daughter's Educational Assistant promoted a book to our daughter titled "GEORGE" (a description of which is attached to this Affidavit as **Exhibit "W"**). This book is a fictional story about a "transgender" boy. The Educational Assistant even told our daughter that she could keep the book at school so that we, her parents would not find out.

77. This recent development has reminded us of the dangers of permitting and mandating secrecy in regard to our daughter. It was in the context of an environment of secrecy that our daughter became depressed and suicidal in late 2016. We found out just in time. If the amendments to the *School Act* remain in place, and we are prevented from knowing what is going on in our daughter's life, what happened to our daughter once is even more likely to happen again, and, if it does, we may not find out until it is too late.

Conclusion

78. My wife and I carefully supervise our children because we love them. We realize the world is a bad place and that there are people who would harm our children if we do not protect them. We would not entrust our children to the care of a daycare, athletic club, extracurricular activity, or any individual who wanted to create a place or time of secrecy where parents were excluded and precluded from knowing what transpired with their children.

79. We have no doubt, after the events that we have lived through, that it is of the utmost importance for us to be aware of our daughter's experience at school,

including and especially the clubs and activities that she is involved in. We could have lost our daughter permanently when she was scared and confused and depressed, and contemplating taking her own life. We cannot find words to describe such a tragedy. Preventing us as parents from knowing about her activities at school, as now required by the *School Act,* threatens our child's safety and prevents us from being able to counsel and assist her. Keeping us in the dark about our own child threatens her safety and her future, and creates the risk of a tragedy that would be an inestimable loss to us as parents.

80. I swear this Affidavit bona fide in support of the accompanying Application, and for no improper purpose.

SWORN BEFORE ME at [redacted], Alberta,)
this 4 day of April, 2018.)
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James Kitchen)
Barrister and Solicitor
A Commissioner for Oaths in and for
the Province of Alberta

[redacted]

P.T.