



Conversion Therapy Bans for Gender Identity: The Harmful Consequences for Women and Girls in Canada

**A brief submitted to the Standing Committee on Justice and Human Rights
Regarding Bill C-6, An Act to amend the Criminal Code (conversion therapy)**

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Presented by Canadian Women's Sex-Based Rights

Canadian Women's Sex-Based Rights – caWsbar – is a cross-Canada, non-partisan coalition of women and male allies working together to preserve the sex-based rights and protections of women and girls, as enshrined in the Canadian Charter of Rights and Freedoms (Section 15).

Introduction

The federal Liberal Party has introduced Bill C-6 which proposes to ban conversion therapy for sexual orientation and gender identity in both children and adults. Conversion therapy is defined in the Bill as “a practice, treatment or service designed to change a person’s sexual orientation to heterosexual or gender identity to cisgender, or to repress or reduce non-heterosexual attraction or sexual behaviour.”

“Conversion therapy” as it’s widely understood today is coercive and damaging. It may include such inhumane practices as aversion therapy or shaming of homosexual persons. These therapies are abhorrent indeed, and we welcome legislation to ban such practices. However, the notion that neglecting to immediately affirm, or questioning, one’s gender identity is a form of conversion therapy is a falsehood that, if legislated, runs the risk of causing harm to Canadians. This brief addresses the potential harms to women and girls.

Gender Identity Is Not Fixed

According to most definitions, including the World Health Organization’s, gender is a social construct which involves identifying with social roles influenced by one’s culture.¹ There is no evidence to suggest that gender identity is free from social influence, or that it is fixed and innate. In fact, research in multiple countries, including Canada, reveals that about 80% of trans-identifying children desist (stop seeing themselves as the opposite sex) after experiencing a natural puberty.²

The presumption of a fixed “gender identity”, therefore, is a falsehood. Bill C-6 fails to account for the fact that not all transgender-identifying persons continue to see themselves as trans throughout their lives. Indeed, there is a growing global community of persons who have de-transitioned and once again identify with their biological sex.

Conflation of Sexual Orientation with Gender Identity

In recent years activists have begun to conflate gender identity with sexual orientation as it concerns conversion therapy, suggesting homosexual and transgender persons are the same. Further, activists imply that research demonstrating the harms of conversion therapy for sexual orientation can and should be applied to gender identity. This is simply not true. To date, all studies examining conversion therapy have focussed exclusively on sexual orientation.

This activist-initiated sex/gender conflation has resulted in a gender medicine model that insists providers must immediately affirm the patient’s chosen gender identity, without question. Thus, the “Affirmation Model” often involves setting children on a pathway to puberty blockers, cross-sex

¹ World Health Organization. <https://www.who.int/health-topics/gender>. Accessed 31 Oct. 2020.

² Cantor, James, 2016. Do trans- kids stay trans- when they grow up? *Sexology Today!* 11 Jan. 2016. http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html. Accessed 31 Oct. 2020.

hormones, and multiple surgeries that may start soon after the typical onset of puberty.³ Many of these medical interventions are irreversible, and may potentially cause serious side effects such as permanent infertility, inability to breastfeed and sexual dysfunction in adulthood.

Interference in the Doctor-Patient Relationship

In its current iteration, through the very inclusion of “gender identity”, the Bill, if passed, may result in harmful interference in the doctor-patient relationship. Rather than risk a serious criminal charge, doctors and mental health professionals will likely be inclined to affirm their patients and clients, placing them on a path to irreversible medical treatments -- even if their professional opinion is that underlying mental health issues or family dynamics may be causing the patient to adopt a transgender identity.

Trans-Identifying Females Are Distinct from Trans-Identifying Males

Adolescent natal females who question their gender identity often do so for very different reasons than do natal males. These distinct reasons typically involve trauma, undiagnosed autism, and/or homophobia, both internalized and parental. Once these issues are addressed, girls and women may find they no longer identify as transgender.

As it is presently drafted, Bill C-6 will likely prevent girls and women who are struggling with gender identity from receiving adequate therapeutic support to address a wide variety of female-specific issues including sexual abuse, eating disorders, lesbophobia, and internalized misogyny.

We, therefore, stress that a thorough *sex-based* analysis of Bill C-6 must be undertaken in order to understand the differences between the female and male paths to transgender identity.

Recent Increase on Adolescent Natal Females Identifying as Transgender

We are deeply concerned about the rapidly increasing numbers of adolescent natal girls who are presenting to gender clinics in Canada.⁴

Prior to 2013 adolescent girls rarely began identifying as transgender in their teens. Alarming, at present, they comprise approximately 75% of patients seeking transgender care, as stated by Dr. Margaret Lawson, endocrinologist at Children’s Hospital of Eastern Ontario.⁵ Although this phenomenon is occurring simultaneously around the world, several prominent gender clinicians have stated that the root cause of the increase in girls identifying as trans is still not understood.

³ Provincial Health Services Authority, BC, 2020; *Medical Affirmation & Transition*.; <http://www.phsa.ca/transcarebc/child-youth/affirmation-transition/medical-affirmation-transition>. Accessed 31 Oct. 2020.

⁴ Aitken, Madison et al. Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*. 2015 March; 12(3):756-63. doi: 10.1111/jsm.12817.Epub2015 Jan 22.

⁵ Beard, J. Spike in Demand for Treatment of Transgender Teens. *CBC News*. <https://www.cbc.ca/news/canada/ottawa/trans-teens-ottawa-cheo-demand-1.5026034>. Published 4 Mar. 2019.

Mental health professionals working with this demographic have noted that many of these adolescent females have comorbid mental health conditions, such as eating disorders, depression and anxiety. A large percentage of them are either on the autism spectrum, have been bullied, or are same-sex attracted. Some are distressed by the thought of going through puberty and developing an adult female body. This distress may have developed as a result of early exposure to pornography, trauma, or having become the object of unwanted male sexual attention.⁶

Safety Considerations

It should be noted here that consent forms at gender clinics almost ubiquitously state that there is no long-term research on the safety of cross-sex hormones or gender reassignment surgery.⁷ In other words, in the absence of evidence, gender medicine is currently largely experimental.

We assert that medical treatments for transgender persons should be subject to the same scientific rigour as any other treatments provided by our public healthcare system. Namely, that:

- all care must include a thorough diagnostic process;
- therapies must be evidence-based and proven effective;
- treatments and surgeries must be ethically sound;
- and patients must be able to provide fully informed consent.

Healthcare treatments and protocols should be informed and determined by scientific evidence rather than the well-meaning but unproven claims of activists.

In direct opposition to the previously accepted “watchful waiting” approach, the newer Affirmation Model for treating gender identity charts a clear path -- it starts with social transition and progresses to major medical interventions including administration of life-long cross-sex hormones and amputation of healthy body parts. It is, therefore, crucial to establish that the patient’s gender identity is stable from early adolescence into adulthood before proceeding with medical interventions, to ensure unnecessary, irreversible treatments are not performed on minors and young adults who may come to regret their medical decisions.

Sex Bias in WPATH Transgender Guidelines

The guidelines most commonly used in Canada for transgender care were developed by the World Professional Association for Transgender Health (WPATH)⁸. The current edition, *Standards of Care, Version 7*, was published in 2012 -- at a time when approximately 75% of the patient demographic, namely, adolescent natal females, was virtually non-existent. The primary group considered in the

⁶ Kaltaila-Heino, R et al. Two Years of Gender Identity Service for Minors: Over-representation of Natal Females with Severe Problems in Adolescent Development. *Child Adolesc Psychiatry Ment Health*. 9 (2015).

⁷ "Appendix K: Consent Form for Feminizing Hormone Therapy."

https://bmc1.utm.utoronto.ca/~kelly/transprimarycare/pdf/SHC_AppendixK.pdf. Accessed 31 Oct. 2020.

⁸ World Professional Association of Transgender Health. *Standards of Care: Version 7*. 2012.

WPATH Standards is natal males. However, the Institute of Medicine, in 2011, cautioned that clinical practice guidelines should not be assumed to apply from one patient group to another.

It should also be noted that WPATH ignored two other accepted standards when formulating their transgender care guidelines: 1) they did not perform a systematic literature review, and 2) they did not avoid conflicts of interest. Consequently, no WPATH transgender treatment guidelines have passed any review or are listed by any third-party guideline clearinghouse or database.⁹

In the past, people with gender dysphoria underwent extensive assessments and counseling, in order to determine if their underlying mental health could be improved, and to determine if a medicalized pathway could be averted. Non-medicalized treatment was attempted first, due to the significant risks associated with puberty blockers, cross-sex hormones and surgeries. These include sterility, loss of sexual function, cardiovascular disease, infections, cancers, and brain and bone development issues.¹⁰ The same risks for women who undergo early hysterectomies also apply to young females who identify as transgender and undergo hysterectomies, such as pelvic floor prolapse and cardiovascular problems.¹¹

As one would expect, there were some adult transgender people for whom talk therapy was unhelpful. They report that they found the counseling to be demeaning, and have characterized this approach as a form of conversion therapy. While some assessment and therapy methods in the past may have indeed been stigmatizing and unethical, this does not mean that all assessments or counseling methods are stigmatizing or unethical.

The patients for whom counseling and non-invasive methods *were* helpful in alleviating gender dysphoria are dismissed by activists as never having been transgender. Therefore, the very vocal community for whom counseling alone was ineffective has declared that talk therapy does not work for anyone at all.

Thus, with the current widespread adoption of the Affirmative Model and a move away from watchful waiting, the pendulum has swung in the opposite direction and the declaration of a transgender identity is never to be questioned or challenged. Assessments for gender dysphoria have been discouraged and largely discontinued in Canada.

A perfect storm for significant medical harm is occurring: at the same time thorough assessments and counseling are being discouraged for gender dysphoria, a new patient group -- adolescent natal females -- has emerged for which these talk therapy approaches may be most beneficial. This is the age-old fallacy of the male bias in medicine.

With this new demographic of gender dysphoric adolescent girls, we cannot assume an immediate medicalized pathway to transition will be effective for them. A systematic analysis of counseling methods for gender dysphoria has never been undertaken. It is, therefore, reckless to deny one group

⁹ MacRichards, L. Bias, Not Evidence Dominates WPATH Transgender Standard of Care. *Canadian Gender Report*. 2019. <https://genderreport.ca/bias-not-evidence-dominate-transgender-standard-of-care/>. Accessed 31 Oct. 2020.

¹⁰ Heneghan, C. Gender-Affirming Hormone in Children and Adolescents. *BMJ*. 25 Feb. 2019.

¹¹ Zachary, R. et al. Barriers to Evidence-Based Transgender Care: Knowledge Gaps in Gender-Affirming Hysterectomy and Oophorectomy. *Obstetrics and Gynecology*. 2019 Oct; 134(4): 714017.

(females) access to non-invasive treatments because they did not work for another group (males). We should not attempt irreversible medical treatments without trying non-invasive treatments first. It is possible to perform ethical and sensitive counseling to explore issues that may be underlying a patient's distress.

Sex Bias in Rationale for Conversion Therapy Laws

The evidence cited for establishing the need for conversion therapy bans usually involves research in the male homosexual community. However, very little discussion has taken place on how immediately affirming a transgender identity in females, without exploring the context for this identity, may cause physical, emotional and mental harm.

This male bias is illustrated in a brief submitted in 2019 to the Standing Committee on Health entitled "Protecting Canadian Sexual and Gender Minorities from Harmful Sexual Orientation and Gender Identity Change Efforts"¹². In it, Travis Salway, PhD called for developing a bill against conversion therapy in Canada. Of note, none of the signatories of this document were mental health professionals or gender clinicians. In this document, women's and girls' experiences of sexuality and gender are rarely considered. The assumption is made that natal females' experiences of gender identity are equivalent to natal males' experiences with sexual orientation. Only one article in the reference section refers to women, and most of the references refer to sexual orientation only. There are no references given to justify adding gender identity to conversion therapy bans, or any evidence that any non-medical treatment model for gender dysphoria has been studied. Stories in the Canadian media about conversion therapy bans have been almost exclusively about males.

The current government has promised to apply a GBA+ analysis to all government initiatives, and we urge the Canadian government to consider the impacts of Bill C-6 on women and girls.

Female Detransitioners Emerge As a Distinct Patient Group

There is already evidence that this new trans-identifying patient group (adolescent females) requires a different treatment approach than natal males: the increasing numbers of natal female detransitioners.

These detransitioners are primarily females in their twenties who identified as trans boys in their teens, but discovered that transitioning did not alleviate their gender dysphoria. They are now transitioning back to identifying with their birth sex -- and grieving the harm done to their healthy bodies.¹³

Many detransitioners say they developed a transgender identity as a "way out" of trauma, and they now wish they'd had a mental health professional thoroughly assess their condition and sensitively help them

¹² Salway, T et. al. Protecting Canadian Sexual and Gender Minorities From Harmful Sexual Orientation and Gender Identity Change Efforts. *A brief submitted to the Standing Committee on Health for the committee's study of LGBTQ2 Health in Canada.* <https://www.ourcommons.ca/Content/Committee/421/HESA/Brief/BR10447600/br-external/SalwayTravis-2-e.pdf>. Accessed 31 Oct. 2020.

¹³ The Detransition Advocacy Network: Home. <https://www.detransadv.com/>. Accessed 31 Oct. 2020.

explore their thoughts and feelings.¹⁴ They feel let down by the medical community, who unquestioningly gave them testosterone, mastectomies, and even hysterectomies as teenagers, simply because they asked for them. Some of the young women report that they self-diagnosed through information found online, in chat rooms, at school or through friends.¹⁵ Cosmetic surgery clinics in Canada are even enthusiastically marketing their surgeries to young women, as can be seen on the McLean Clinic's YouTube¹⁶ and Instagram¹⁷ accounts. Many of the positive comments on the Mississauga-based clinic's social media channels appear to be posted by minors.

If Bill C-6 is passed in its current form, a chill will be cast on the mental health profession. This is because the Bill proposes a ban on helping one be "cisgender," even if they've discovered it is who they really are. In essence, the Bill legally prohibits doctors and therapists from helping patients accept their naturally sexed bodies. If this were to happen, detransitioners would have nowhere to turn to help them deal with their ongoing dysphoria. This would be a great tragedy for the many vulnerable young women who have already been betrayed by a medical system that has utterly failed them.

Conclusion

The distress that many adolescent girls experience at puberty is outlined extensively in the literature. Eating disorders, psychosomatic illnesses, and social contagions are common in this group.¹⁸ And, although the paths to a transgender identity appear to be very different for females as opposed to males, the subject remains largely unstudied.

In recent years, the concepts of gender identity and gender expression have been introduced into Canadian school curricula, and have been the subject of many enthusiastic media stories and online forums. While this increase in visibility in the popular culture may benefit some groups, the impact on vulnerable girls who do not feel at home in their bodies while going through puberty -- and are being bullied, experiencing same-sex attraction, or struggling socially (such as those on the autism spectrum) -- has not been considered.

Mental health and medical professionals must not be prevented from encouraging these troubled girls to explore their reasons for struggling with gender identity. Therapists must be fully permitted to provide treatment in a responsible, competent and sensitive manner by exploring all of the issues that may contribute to a feeling of gender dysphoria or discomfort with the naturally sexed body. Female

¹⁴Marchiano, L. The Ranks of Gender Detransitioners Are Growing. We Need To Understand Why. *Quillette*. 2 Jan. 2020.

¹⁵Littman, L. Parent Reports of Adolescents and Young Adults Perceived to Show Signs of Rapid Onset Gender Dysphoria. *Plos One*. 16 Aug. 2018; <https://doi.org/10.1371/journal.pone.0202330>.

¹⁶"McLeanClinic - YouTube." <https://www.youtube.com/channel/UCHYOKgcXLczjwNVIBV9AVg>. Accessed 31 Oct. 2020.

¹⁷"McLean Clinic in Mississauga (@topsurgery) • Instagram" <https://www.instagram.com/topsurgery/>. Accessed 31 Oct. 2020.

¹⁸Sweeting, H et al. Explanations for Female Excess Psychosomatic Symptoms in Adolescence: Evidence from a School-Based Cohort in the West of Scotland. *BMC Public*. 22 Oct. 2007. doi: [10.1186/1471-2458-7-298h](https://doi.org/10.1186/1471-2458-7-298h).

detransitioners have much to contribute to this discussion and must be consulted in order to obtain a full understanding of the issue.

Our recommendations are as follows:

1. Clearly define conversion therapy, and exclude from the definition all ethical, sensitive counseling and thorough assessments to diagnose and treat gender dysphoria. Clearly allow counsellors to be able to challenge their client's views on gender identity, if they feel other factors rather than an innate gender-body misalignment may be involved. In fact, thorough assessment and counseling should be encouraged as it is even recommended in the WPATH Standards of Care.
2. Consult with women and girls regarding the effects Bill C-6 may have on them; particularly listen to the experiences of those who have detransitioned or desisted from a transgender identity.
3. Undertake and make available to the public a sex-based analysis of Bill C-6. Do not refer to research and experiences of only those born male.
4. Encourage a full exploration of comorbid conditions underlying the patient's gender dysphoria before initiating any invasive medical treatment, in an ethical and sensitive manner.
5. Provide funding for research into natal females with gender dysphoria, and particularly detransitioners, to develop and assess non-medicalized approaches to patient distress rather than allowing only a medicalized, irreversible pathway that the patient may later regret.
6. Strengthen informed consent procedures and regulations; assess whether children and adolescents are able to consent to puberty blockers, cross-sex hormones and surgeries, taking into account cognitive and social development, and the fact they are making irreversible decisions while in a state of distress. Note that if children and adolescents are able to consent, then they are also able to consent to non-medical treatments offered them such as counseling (imprudently labelled as "conversion therapy" by some activists).
7. Institute stronger advertising regulations for Canadian medical professionals selling adolescents transgender surgeries and drugs¹⁹.

¹⁹ Kay, Barbara - Young Canadians are being sold 'gender-affirming' top surgery on Instagram
<https://thepostmillennial.com/young-canadians-are-being-sold-gender-affirming-top-surgery-on-instagram>