Canadian Gender Report

Submission to the Standing Committee on Justice and Human Rights respecting Bill C-6 *An Act to Amend the Criminal Code Conversion Therapy)*

October 24, 2020

Canadian Gender Report is an organization of parents and professionals concerned about the medical treatment of gender distressed children and adolescents.

The provisions of Bill C6 dealing with conversion therapy for gender identity need to be significantly redrafted. In Canada and throughout the world, rising numbers of children and adolescents, especially natal girls, are experiencing distress over their gender identity. Many of these young people are on the autism spectrum and have other complex mental health conditions.

Clinicians throughout the world are struggling with the best way to help these young people. There is growing concern that the affirming model of care, which is currently dominant, is starting many children and youth on a path to irreversible medical transition without a proper mental health assessment.

The current language of Bill C6 will have the effect of entrenching the affirming model of care at a time when it is still experimental and there is growing concern that it is neither safe nor effective.

Our concern with the Bill is primarily over the issue of gender identity. The Bill fails to recognize that sexual orientation and gender identity are two different issues.

Gender identity and the growing trend to treat gender-related distress with medical interventions creates the potential for exponential growth in the number of individuals who are medically harmed. Invasive treatments, such as hormone therapy and surgery, have life long medical consequences.

It is our position that it is essential to ensure the availability of a broad range of non-coercive, ethical psychotherapies for individuals experiencing distress they believe is related to a mis-match between their gender identity and their body. Given the potential of agenda-free psychotherapy to help young people resolve distress, restricting the availability of this type of healthcare, while promoting "affirmation" approaches that pave the way to medical transition people may later regret, is not ethical.

Criminal Scenarios?

The outcome of agenda-free psychotherapy for the following situations may result in young people re-identifying with their birth sex - changing to "cis-gender". The definition of conversion therapy in the Bill would make accessing psychological treatments almost impossible in Canada, while invasive medical treatments are readily accessible.

1) Help a 13 year old girl who started to identify as a boy soon after she was sexually assaulted to resolve the trauma she experienced.
2) Help an adolescent girl who is often the victim of bullying and harrassment at school resolve feelings of shame and confusion because she is same-sex attracted and has started to identify as a boy at age 15.

3) Help a 12 year old pre-pubescent boy who has become convinced that he is really a "demi-girl" after a school presentation on being transgender when in fact, he is a late developer and experiencing social isolation and anxiety.
4) Help a 14 year old girl who has decided she is non-binary and is demanding testosterone and a double mastectomy when she has undiagnosed autism and is experiencing puberty as a medical condition that needs to be treated. Autism screening is not provided as a standard of care - her parents need to seek this out independently without being "caught out" that they are not "affirming enough" of their daughter's new transgender identity.
5) Help a 16 year old adolescent resolve her eating disorder and dependence upon social media for validation when taking "T" (the street name for testosterone) gives her a feeling of control over her body and makes her fat simply melt away.

The above examples are based on real-world accounts from detransitioners and concerned parents.

Gender Dysphoria and its Treatment

In order to explain the harmful effects of the Bill, it is first necessary to review what therapists who treat gender related distress do.

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*) of the American Psychiatric Association includes a condition of "gender dysphoria" which may be loosely defined as distress a person feels because of a mismatch between their natal sex and their internally felt sense of gender identity.

There are currently three basic approaches for treating gender dysphoria in children.

The first is watchful waiting which, as the name suggests, means observing the child's development. If gender dysphoria worsens in later puberty, hormone therapy may be started.

The second is the affirmative model, which starts from the premise that a child should be encouraged to explore his or her sense of gender identity and supported with various interventions to transition to the opposite sex. These may begin with a puberty blocking drug as the child approaches puberty followed by cross sex hormones. Clinics in Canada do not generally perform gender re-assignment surgery on minors but there are doctors in the United States who will do double mastectomies on patients as young as thirteen.[1]

The final approach is to avoid immediate affirmation of gender identity and to try to treat a child's distress through psychotherapy. Children with gender dysphoria often have other mental health issues and a therapist will attempt to treat these issues before addressing the gender issues. The therapist may also explore the causes of the child's gender dysphoria and look for ways to make the child comfortable in his or her own body. A therapist may ultimately recommend medical transition, but the primary goal is to resolve the child's distress without the need for physical intervention.

Therapists who practice this third approach describe it as a holistic or developmental model. Those who oppose it describe it as conversion therapy.

There is an ongoing debate between supporters or the affirming and developmental models of care in medical journals and conferences. However, at a political level, advocates of the affirmative approach have the upper hand. There are members of the transgender community who are passionately committed to the affirming approach and they have been successful in making it the only acceptable approach in gender clinics.

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[1] Johanna Olson-Kennedy et al., "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults," *JAMA Pediatrics* 172, no. 5 (May 2018): 431–36, https://doi.org/10.1001/jamapediatrics.2017.5440.

The Impact of the Bill on Therapy

The basic problem with the Bill is that it is not clear what it prohibits and what it permits. Section 320.101 defines conversion therapy as a treatment or service designed to change a person's gender identity to cisgender. This raises the question of what exactly a "cisgender" identity is. There are many new gender identities being created such as non-binary, gender-queer, gender-fluid or pangender. The bill purports to create an exception for therapy to facilitate exploration of gender identity and its development, but it is not clear where exploration leaves off and attempting change begins.

However, the general language of the bill suggests that exploration can be in one direction only. Any therapist who attempts to make a child comfortable with his or her body before proceeding to social or medical transition risks being accused of conversion therapy.[2]

The vagueness of the bill will make it difficult to enforce. It may be so vague that it could be challenged as unconstitutional. However, this does not mean the bill is harmless. A five year prison term is a terrifying threat to have hanging over a therapist who says the wrong thing to a patient. Even an unsuccessful criminal charge could ruin a health professional.

Parents or gender dysphoric children and young adults who have detransitioned know from experience that conversion therapy bans in provincial legislation or professional policies make it difficult to find a therapist who will do anything other than recommend transition, even where there is evidence of other serious mental health problems. A criminal law with more severe penalties will make this situation much worse.

Does Gender Identity Change: Desistance and Detransition

One of the premises of the affirming model of care is that gender identity is innate and cannot be changed through therapy. This view is incorporated in the preamble of the bill which states that the belief that gender identity can or ought to be changed is a myth.

In fact, there is substantial evidence that gender identity does change. Past studies have shown that between 60 and 90 percent of children who were seen at a gender clinic ceased to show signs of gender dsyphoria and accepted their natal sex during puberty.[3] In the most recent study, by a Dutch clinic, 47 of 128 patients persisted in their gender dysphoria, 52 desisted and 28 were untraceable. Since there was only one gender clinic in the Netherlands, it is reasonable to assume that the 28 who did not return to the clinic did not proceed with medical transition.[4]

Today, desistance is less likely because clinicians are more likely to recommend affirming cross gender identity and many parents begin social transition of their child before attending a gender clinic.[5]

Desisters themselves seldom speak up in this debate. They simply go on with their lives and have no reason to speak out on gender issues. Their interests are represented by concerned parents and

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2 James Cantor, "Bill C-6," *Sexology Today* (blog), October 13, 2020, http://www.sexologytoday.org/2020/10/bill-c-6.html.

3 James Cantor, "Do Trans- Kids Stay Trans- When They Grow Up?," *Sexology Today* (blog), January 11, 2016, http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html.

4 Thomas D. Steensma et al., "Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study," *Journal of the American Academy of Child & Adolescent Psychiatry* 52, no. 6 (June 1, 2013): 582–90, https://doi.org/10.1016/j.jaac.2013.03.016.

5 Kenneth J. Zucker, "The Myth of Persistence: Response to 'A Critical Commentary on Follow-up Studies and "Desistance" Theories about Transgender and Gender Non-Conforming Children' by Temple Newhook et al. (2018)," *International Journal of Transgenderism* 19, no. 2 (April 3, 2018): 231–45, https://doi.org/10.1080/15532739.2018.1468293.

clinicians who advocate a cautious approach to gender transition. The issue of desistance and persistence is complex. We need unbiased research and nuanced discussion, not criminal laws.[6]

Detransitioners are people who have begun the process of transitioning to the opposite sex who regret their decision and take active steps to resume their birth sex. Some may have only started social transition while others have gone through gender reassignment surgery. (There are also people who regret their decision to transition but nevertheless decide to continue in their new identity.)

The number of detransitioners is hard to determine. Gender clinics say that very few of their patients detransition. However, de-transitioners respond that they no longer trust the gender affirming medical community. As a result, they do not go back to gender clinics or respond to surveys run by transgender organizations.[7] Detransitioners have their own stories and concerns but one common theme is that gender clinics were too quick to recommend transition and that they would have been helped by the kind of extended psychological assessment that is being stigmatized as conversion therapy.[8]

Detransitioners are becoming increasingly vocal on social media and are starting to organize their own advocacy groups.[9] They need research and support for their medical needs. They will not be helped by legislation which labels their experience of changing gender identity as a myth.

Affirming Approach as Gay Conversion Therapy?

Some members of the gay and lesbian communities have their own concerns about the affirming approach. The studies on desistance also found that many of the children who showed gender non-conforming behaviour as children grow up to be same sex attracted adults.[10] Some parents may find it easier to accept that their child was born in the "wrong body" than a child who is same sex attracted or gender non-conforming.[11]

A recent review of the literature on the affirming approach published in *The British Psychological Journal* concludes:

> The counterargument to unquestioning gender affirmation is that the process of medical transition may itself prove to be another form of conversion therapy, creating a new cohort of life-long patients dependent on medical services and turning at least some lesbian and gay young people into simulacra of straight members of the opposite sex. [12]

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6 Jesse Singal, "What's Missing From the Conversation About Transgender Kids," The Cut, July 25, 2016, https://www.thecut.com/2016/07/whats-missing-from-the-conversation-about-transgender-kids.html.

7 Lisa Marchiano, "The Ranks of Gender Detransitioners Are Growing. We Need to Understand Why," *Quillette*, January 2, 2020, https://quillette.com/2020/01/02/the-ranks-of-gender-detransitioners-are-growing-we-need-to-understand-why/.

8 "NHS Gender Clinic 'should Have Challenged Me More' over Transition," *BBC News*, March 1, 2020, sec. Health, https://www.bbc.com/news/health-51676020.

9 "Gender Care Consumer Advocacy Network," GCCAN, accessed March 2, 2020, https://www.gccan.org.

10 Michael Biggs, "Research Evidence: Gender-Atypical Tots More Likely to Become Gay or Lesbian," *4thWaveNow* (blog), August 7, 2018, https://4thwavenow.com/2018/08/07/research-evidence-gender-atypical-tots-likely-to-become-gay-or-lesbian-not-trans/.

11 Lucy Bannerman, "It Feels like Conversion Therapy for Gay Children, Say Clinicians," *The Times*, April 7, 2019, http://archive.fo/FYWSN.

12 Lucy Griffin et al., "Sex, Gender and Gender Identity: A Re-Evaluation of the Evidence," *BJPsych Bulletin*, 2020, 1–9, https://doi.org/10.1192/bjb.2020.73.

Does Science Support the Affirming Model?

Supporters of the affirming model claim that it is backed by science and endorsed by major medical organizations. It is true that various major medical organizations have endorsed the affirmative model of care but they have made these endorsements on the basis of very weak scientific evidence.

The basis for the current affirming model is the World Professional Association for Transgender Health ("WPATH"), *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People,* published in 2012.[13] Although these guidelines are often relied on in Canada they have never been formally reviewed and approved by the organizations that evaluate medical guidelines to ensure that they have not been influenced by bias or conflict of interest.[14]

The American Academy of Pediatrics has also issued a statement policy that supports affirmative care for gender dysphoria in children and adolescents. Dr. James Cantor has reviewed the evidence for this statement and he concludes, "Not only did AAP fail to provide compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are despite the existing evidence." [15]

Carl Heneghan, the editor of the British Medical Journal and a professor of evidence based medicine at the University of Oxford, recently published a review of the current evidence on hormone treatment of children and adolescents with gender dysphoria. He concluded,"The current evidence base does not support informed decision making and safe practice in children."[16]

Marcus Evans, a former governor of the Tavistock Clinic, which is the only public gender clinic for children in the United Kingdom, resigned because of his concern over how the clinic was handling the medical transition of children. He writes,

> The 'affirmative approach' risks sending children down a path towards concrete and sometimes irreversible medical interventions for what is in very many cases a psychological problem. This approach, in my view, is driven by political ideology rather than clinical need and inhibits the clinician's curiosity and freedom to explore a child's underlying belief systems and motivations.[17]

The National Health Service in the United Kingdom has recently made major changes to the transgender guidance on its website. It no longer claims that puberty blockers are reversible and

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[13] *Standards of Care for the Health of Transsexual, Transgender, and GenderNonconforming People*, 7th ed. (World Professional Association for Transgender Health (WPATH, 2012), https://www.wpath.org/publications/soc.

[14] LisaMacRichards, "Bias, Not Evidence Dominates WPATH Transgender Standard of Care," *Canadian Gender Report* (blog), October 1, 2019, https://genderreport.ca/bias-not-evidence-dominate-transgender-standard-of-care/.

[15] James M. Cantor, "Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy," *Journal of Sex & Marital Therapy*, December 14, 2019, 1–7, https://doi.org/10.1080/0092623X.2019.1698481. A free version can be found at http://www.sexologytoday.org/2018/10/american-academy-of-pediatrics-policy.html.

[16] Carl Heneghan and Tom Jefferson, "Gender-Affirming Hormone in Children and Adolescents," *BMJ EBM Spotlight* (blog), February 25, 2019, https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

[17] Marcus Evans, "Freedom to Think: The Need for Thorough Assessment and Treatment of Gender Dysphoric Children," *BJPsych Bulletin*, 2020, 1–5, https://doi.org/10.1192/bjb.2020.72.

provides much more information on the risks of hormone therapy.[18] It is also conducting a comprehensive review of gender identity services for children and young people.[19]

In Sweden, the National Council for Medical Ethics is conducting an investigation into the treatment of gender dysphoria in children. The Swedish pediatric society has issued a letter in support on an investigation by which concludes:

> Giving children the right to independently make life-changing decisions at an age when they cannot be expected to understand the consequences of those decisions, lacks scientific evidence and is contrary to established medical practice.[20]

Canada should not be moving to entrench the affirming model of care through criminal law at a time when a growing number of professionals throughout the world are questioning it.

Co-existing Mental Health Conditions

The diagnosis and treatment of gender dysphoria is difficult because it often co-exists with other mental health conditions such as depression, post-traumatic stress and eating disorders. Many gender dysphoric or gender confused youth are on the autism spectrum. The possible interaction between gender dysphoria and autism is still poorly understood and more work is needed on appropriate clinical guidelines.[21]

Canadian Gender report has heard accounts from many Canadian parents of how their children were approved for medical transition without proper mental health assessment. Several parents have indicated that they would be prepared to submit briefs if they can be assured that their names will not be published.[22]

Risks of the Affirming Model

Every stage of the affirming approach has risks. Social transition, in which the child adopts a new name, clothes and pronouns is benign in itself but it significantly increases the risk that a child's gender dysphoria will persist and he or she will go on to medical transition.[23]

If a child has not yet completed puberty, a doctor may prescribe a puberty blocker to prevent the physical changes of puberty. Supporters of the affirming model claim that puberty blockers act as a "pause button" to allow a child more time to reflect and are reversible. Neither of these claims is supported by reliable evidence.

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18 Kirkup, James. "The NHS Has Quietly Changed Its Trans Guidance to Reflect Reality | The Spectator." *The Spectator*, June 4, 2020. https://www.spectator.co.uk/article/the-nhs-has-quietly-changed-its-trans-guidance-to-reflect-reality.

19 "NHS England » NHS Announces Independent Review into Gender Identity Services for Children and Young People," accessed October 23, 2020, https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/.

20 BLF [Swedish Pediatric Society] Supports SMER's [The National Council for Medical Ethics] Letter on Gender Dysphoria, 2019-05-02, (translated with Google translate) https://www.barnlakarforeningen.se/2019/05/02/blf-staller-sig-bakom-smers-skrivelse-angaende-konsdysfori/

21 John F. Strang et al., "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents," *Journal of Clinical Child & Adolescent Psychology* 47, no. 1 (January 2, 2018): 105–15, https://doi.org/10.1080/15374416.2016.1228462.

22 Contributor, "Gender Dysphoria and Autism: A Parent Speaks Out," *Canadian Gender Report* (blog), March 9, 2020, https://genderreport.ca/gender-dysphoria-and-autism/.

23 "Could Social Transition Increase Persistence Rates in 'Trans' Kids?," *4thWaveNow* (blog), November 29, 2016, https://4thwavenow.com/2016/11/28/could-social-transition-increase-persistence-rates-in-trans-kids/.

Studies have found that 90 percent of children prescribed puberty blockers continue with medical transition. This may be because the study participants were carefully screened (something that does not always happen today) or it may be that the drugs themselves cause gender dysphoria to persist by blocking the normal changes in the brain during puberty. [24]

The claim that puberty blockers are reversible is based on experience with their use with children for precocious puberty where the drugs are stopped at the normal age for puberty. This experience may not be transferable to cases where the drugs are started at the normal age for puberty. Since so few children who are given puberty blockers for gender dysphoria actually go through normal puberty, it is not possible to say what the long term effects are.

The drugs used as puberty blockers have never received regulatory approval for use in the treatment of gender dysphoria. They are being prescribed "off label" on an experimental basis.

A clinic in Amsterdam began experimenting with puberty suppression for gender dysphoria in 1998. Clinics in North America have only used puberty blockers since 2007.[25] There is very limited published research on the effects of puberty blockers. Unpublished results from a study in the U.K report multiple problems including failure to develop adequate bone density and an increase in suicidal thoughts.[26]

Puberty is also a time when the neural networks in the brain begin to take on their adult form and hormones play a role in this process. Little is known about the effects of depriving the brain of hormones during this crucial period of growth. One study showed a significant decline in I.Q. while on puberty suppression.[27]

Puberty blockers do not, by themselves, cause sterility. However, a child on puberty blockers will not develop fertile eggs or sperm unless he or she goes off the blockers and completes natural puberty. Most children who take puberty blockers go on to cross sex hormones and this will lead to permanent sterility.

Puberty blockers may also seriously damage adult sexual function. Clinicians who support the affirming model admit they do not know enough about this issue.[28]

The next step in the affirming care model is cross sex hormones. Because gender transition of younger people is still a new field, there is little evidence on the long term effects of cross-sex hormones on a growing body. However, there is considerable evidence that testosterone treatment is harmful to females of any age. The risk of diabetes and heart disease increases. There may be numbness in the clitoris and difficulty attaining orgasm. Severe acne and male pattern baldness are common side effects. There may be mood changes and increased anger. Physical atrophy of the

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[24] Polly Carmichael et al., "Gender Dysphoria in Younger Children: Support and Care in an Evolving Context," in *WPATH Symposium* (Amsterdam, 2016), http://wpath2016.conferencespot.org/62620-wpathv2-1.3138789/t001-1.3140111/f009a-1.3140266/0706-000523-1.3140268. Michael Biggs, "The Astonishing Admission in the Health Research Authority Report: The Purpose of Puberty Blockers Is to Commit Children to Permanent Physical Transition," *Transgender Trend* (blog), October 17, 2019, https://www.transgendertrend.com/health-research-authority-puberty-blockers-commit-children-permanent-physical-transition/.

[25] Annelou L. C. de Vries et al., "Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study," *The Journal of Sexual Medicine* 8, no. 8 (August 1, 2011): 2276–83, https://doi.org/10.1111/j.1743-6109.2010.01943.x.

[26] Deborah Cohen and Hannah Barnes, "Gender Dysphoria in Children: Puberty Blockers Study Draws Further Criticism," *BMJ* 366 (September 20, 2019), https://doi.org/10.1136/bmj.l5647.

[27] Maiko A. Schneider et al., "Brain Maturation, Cognition and Voice Pattern in a Gender Dysphoria Case under Pubertal Suppression," *Frontiers in Human Neuroscience* 11 (2017), https://doi.org/10.3389/fnhum.2017.00528.

[28] Brie Jontry, "Does Prepubertal Medical Transition Impact Adult Sexual Function?," *4thWaveNow* (blog), July 9, 2018, https://4thwavenow.com/2018/07/08/does-prepubertal-medical-transition-impact-adult-sexual-function/.

reproductive organs is possible and many doctors recommend removal of the uterus and ovaries.[29] Once hormone therapy is started, it needs to be continued for life.

The final stage of affirming care is gender confirming surgery. Not all trans people undergo surgery and it is seldom performed on patients under the age of majority in Canada. However, it still has to be considered when reviewing treatment options for young patients.

Young transmen frequently undergo a double mastectomy as soon as they turn eighteen and require a hysterectomy after several years on hormone therapy. Puberty suppression can limit surgical options for young transwomen. Puberty blockers will leave them with a child size penis which makes a vaginoplasty, which uses tissue from the penis to create a neo-vagina, more difficult.[30]

Does Affirming Care Save Lives?

Advocates of the affirming model claim that it saves lives. If transgender youth are not affirmed in their identity, they claim, they are at high risk of suicide. The evidence on suicide does not support these claims.

A widely publicized study that claims to show a link between conversion therapy and suicide is by Jack Turban M.D. and others. It reviews the results of a 2015 survey of transgender people and finds a correlation between recalled exposure to conversion therapy and increased lifetime suicidal thoughts and attempts.[31] A recent critique of this study demonstrates that it has major flaws and that its conclusions are not reliable. The study is based on a convenience sample of a survey conducted by an activist organization. It therefore excluded anyone who desisted, de-transitioned or regretted transitioning. It was based on a single question and did not control for mental illness, which is one of the largest predictors of suicide risk.[32]

Transgender people are at higher risk for suicide than the general population but transgender activist groups use suicide statistics in ways which are irresponsible and misleading. The claim that transgender people have a 41% suicide risk is based on a flawed and unreliable study. [33]

Studies on suicide risk among transgender people have been done on adults and not children or adolescents. Suicide risk remains high both before and after transition. There is no evidence that delaying affirmation or medical transition will increase suicide risk in gender dysphoric youth if they receive mental health support [34]

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29 Kerry Smith, "Testosterone & Young Females: What Is Known about Lifelong Effects?," *4thWaveNow* (blog), June 18, 2018, https://4thwavenow.com/2018/06/18/testosterone-young-females-what-is-known-about-lifelong-effects/.

30 Korin Miller and Jennifer Nied, "Jazz Jennings Just Posted A Hospital Photo After Her 3rd Gender Confirmation Surgery," *Women's Health*, February 5, 2020, https://www.womenshealthmag.com/health/a23828566/jazz-jennings-gender-confirmation-surgery-complication/.

31 Jack L. Turban et al., "Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults," *JAMA Psychiatry* 77, no. 1 (January 1, 2020): 68–76, https://doi.org/10.1001/jamapsychiatry.2019.2285.

32 Roberto D'Angelo et al., "One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria," *Archives of Sexual Behavior*, October 21, 2020, https://doi.org/10.1007/s10508-020-01844-2.

33 "The 41% Trans Suicide Attempt Rate: A Tale of Flawed Data and Lazy Journalists," *4thWaveNow* (blog), August 3, 2015, https://4thwavenow.com/2015/08/03/the-41-trans-suicide-rate-a-tale-of-flawed-data-and-lazy-journalists/.

34 J. Michael Bailey and Ray Blanchard, "Suicide or Transition: The Only Options for Gender Dysphoric Kids?," *4thWaveNow* (blog), September 8, 2017, https://4thwavenow.com/2017/09/08/suicide-or-transition-the-only-options-for-gender-dysphoric-kids/.

Does Affirming Care Help?

The claim that the puberty suppression and hormone therapy in adolescents is beneficial is based on one published study from the Netherlands which followed a group of 55 patients for one year following gender reassignment surgery. The study group was very small and came from only one clinic which provided extensive assessment and psychological support. The study did not evaluate the long term physical effects of medical transition.[35]

Even the evidence that gender transition benefits adults is weak. In 2019 the American Journal of Psychiatry published a major study based on Swedish data claimed to demonstrate that gender affirming surgery resulted in reduced use of mental health services.[36] After a number of professionals wrote letters to the editor criticizing the statistical methods on the study, the editors requested a review of the data and the journal has now published a correction which states that the study did not find any evidence that gender affirming surgery improved mental health.[37] Unfortunately, the erroneous claim of the flawed study was widely publicized while the correction has received little publicity.

There has not been enough time to evaluate the affirming for model for children and teens properly. A patient who started cross sex hormones at age 16 in 2007 would be 29 years old in 2020. Most Canadian youth who are receiving cross sex hormones and surgery are still in their early twenties. We do not know how they will react as they reach the age when their peers are marrying and starting families. Stories of happy trans people promoted by activist organizations are not a replacement for unbiased research.

Changes in the Sex Ratio

Since the time the early studies on gender dysphoric youth were conducted, clinicians have seen a large increase in the number of referrals to gender clinics and a change in the sex ratio[38] A Canadian clinic with a patient population of 68% male to 32% female from 1999 to 2005 saw the ratio change for 36% male to 64% female in 2006 to 2013.[39]

This kind of radical change in a patient population suggests that some new factors are in play. Many parents have reported that their daughters began to identify as transgender in their teens without showing any prior signs of gender dysphoria as children. There is one study which suggests that the growth of transgender identification in adolescent girls could be partly explained by social contagion through peer groups and social media. [40]

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35 Annelou L. C. de Vries et al., "Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment," *Pediatrics* 134, no. 4 (October 2014): 696–704, https://doi.org/10.1542/peds.2013-2958.

36 Richard Bränström and John E. Pachankis, "Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study," *American Journal of Psychiatry* 177, no. 8 (August 1, 2020): 727–34, https://doi.org/10.1176/appi.ajp.2019.19010080.

37 "Correction of a Key Study: No Evidence of 'Gender-Affirming' Surgeries Improving Mental Health," *Society for Evidence Based Gender Medicine* (blog), August 30, 2020, https://segm.org/ajp_correction_2020.

38 Madison Aitken et al., "Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria," *The Journal of Sexual Medicine* 12, no. 3 (March 2015): 756–63, https://doi.org/10.1111/jsm.12817.

39 George Davis, "Increase in Transgender Teens," *TRANS RESEARCH* (blog), accessed March 15, 2020, https://transresearch.info/tag/increase-in-transgender-teens/.

40 Lisa Littman, "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," *PLOS ONE* 13, no. 8 (August 16, 2018): e0202330, https://doi.org/10.1371/journal.pone.0202330.

Supporters of the affirming model have criticized the methodology of the study but, in fact, it is consistent with many of the studies cited to support the affirming model.[41]

A recent article by Annelou De Vries, who is one of the leading researchers in the Amsterdam gender clinic, concludes that adolescent onset gender dysphoria may represent a new developmental pathway which has not been adequately studied and which may benefit from approaches other than affirmation.[42]

Can Children Consent to Gender Transition?

We assert that children do not have the capacity to consent to irreversible and invasive treatments that will increase risk factors for their future physical health, restrict their fertility options and impair sexual enjoyment. The human brain continues to develop until around age 25, and the part that controls risk assessment and long term decision making is the last to develop. [43]

Every medical treatment requires informed consent. A full informed consent process requires that the patient be capable of consenting, that the consent be given freely and without undue influence and coercion, and that the doctor fully disclose the risks of the proposed treatment and discuss any alternatives.

The risks of transition are substantial. The biological risks were discussed in the previous section. There are also social risks of becoming isolated from family members and of the greatly reduced pool of people who are prepared to enter into a long term intimate relationship. Psychological risks include distraction from normal challenges of personal development and demoralization if transition does not work out:[44]

This is a long list and includes many concepts that are beyond the understanding of a child or adolescent. A 12 year old who has never had any sexual feelings cannot understand what loss of sexual function means. A 16 year old who is immersed in online friendships will have difficulty imagining life as a lonely 30 year old. It is quite likely that an adolescent with multiple mental health challenges would see an attempt to explain adequately the risks of transition as a form of conversion therapy.

Gender transition is not a series of independent stages which can be considered one at a time. Each step creates its own pressure to move on to the next step. Children who are started on puberty blockers almost invariably go on to cross sex hormones. Several years of testosterone will damage the uterus and make a hysterectomy a medical necessity. A full, ethical informed consent process should consider this.

A recent article on the issue of informed consent says, with considerable understatement,

> Asking a child or adolescent to make a decision on whether they wish to put at risk their fertility, their genital development, their capacity for full sexual function and their brain

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41 Lisa Littman, "The Use of Methodologies in Littman (2018) Is Consistent with the Use of Methodologies in Other Studies Contributing to the Field of Gender Dysphoria Research: Response to Restar (2019)," *Archives of Sexual Behavior* 49, no. 1 (2020): 67–77, https://doi.org/10.1007/s10508-020-01631-z.

42 Annelou L.C. de Vries, "Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents," *Pediatrics*, September 21, 2020, e2020010611, https://doi.org/10.1542/peds.2020-010611.

43 Suzanne O'Rourke et al., "The Development of Cognitive and Emotional Maturity in Adolescents and Its Relevance in Judicial Contexts : Literature Review" (Scottish Sentencing Council, February 2020), https://www.scottishsentencingcouncil.org.uk/media/2044/20200219-ssc-cognitive-maturity-literature-review.pdf.

44 Stephen B. Levine, "Informed Consent for Transgendered Patients," *Journal of Sex & Marital Therapy* 45, no. 3 (April 3, 2019): 218–29, https://doi.org/10.1080/0092623X.2018.1518885.

> development, in a context of an expressed need to resolve their immediate distress is thus ethically problematic...[45]

Informed consent must be given freely. Parents are being coerced into consenting to medical transition for their children by misleading suicide statistics or by the involvement of child protection services.[46]

Finally, an ethical informed consent process needs to include discussion of alternative treatments. Many adult detransitioners have found alternatives to transition for coping with gender dysphoria.

In children, research has shown that gender dysphoria resolves by itself during puberty in the majority of cases. In other cases, it may resolve after treatment for underlying conditions such as depression or trauma. There are new therapeutic techniques such as cognitive behavioural therapy and dialectical behavioural therapy which have been used in the treatment of eating disorders, which are often closely associated with gender dysphoria.

Conversion therapy legislation disrupts the informed consent process by denying patients alternatives to medical transition. It makes absolutely no sense that it should be legal to treat troubled teenagers with drugs that will destroy their reproductive systems and make them lifelong medical patients but illegal to help them accept their bodies through talk therapy.

There is an inconsistency between the proposed federal legislation and provincial laws on informed consent by minors. Many provinces allow mature minors to consent to medical procedures without the approval of their parents. These laws are sometimes invoked to permit minors to begin medical gender transition. The bill would ban all conversion therapy on minors with or without consent. Thus a mature minor might be found capable of consenting to a double mastectomy but could not give valid consent to talk therapy to overcome her dislike of her breasts.

Conclusions

The question here is not whether the affirmative model is beneficial or not. It is whether there should be criminal legislation which makes the affirming model the only permissible way of treating gender dysphoria. The standard of evidence for that question should be something very near certainty.

The answer is no. The evidence in support of the affirming model still depends on a small number of studies over a short period of time. There is growing concern about the model throughout the world. Treatment decisions on a rare and complex medical condition should be made by healthcare professionals, using the best available research, not by legislatures and courts.

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[45] David Pilgrim and Kirsty Entwistle, “GnRHa (‘Puberty Blockers’) and Cross Sex Hormones for Children and Adolescents: Informed Consent, Personhood and Freedom of Expression,” *The New Bioethics* (July 27, 2020): 1–14, https://doi.org/10.1080/20502877.2020.1796257.

[46] Heather Brunskell-Evans, “Transgender Children: Limits on Consent to Permanent Interventions,” *BMJ Sexual & Reproductive Health Blog* (blog), January 9, 2020, https://blogs.bmj.com/bmjsrh/2020/01/09/capacity-gender-2/.