To: The Committee On Justice and Human Rights
From: Rethink Identity Medicine Ethics, Inc.
Jane Wheeler, President
Re: Bill C-6 (An Act To Amend the Criminal Code - Conversion Therapy)
Recommendations to the Committee

Introduction

Protecting the rights of gender diverse young people to have, explore and express gender variant identities and sexualities is important. Which is the intent of Bill C-6's regulation of "Conversion Therapies." However, the therapies that address same-sex sexual attraction and gender identities are distinct, with distinctly different evidentiary histories, concerns and outcomes. And should be treated differently under the law. Furthermore, the appropriateness of therapies which address gender identity in developing minors are not the same as those dealing with gender identities in adults. Specifically, we believe that exploration of gender identities and expressions in minors should not be stymied or prematurely foreclosed; and the unfettered availability of neutral exploration which neither challenges nor confirms the validity of an identity is necessary for optimal individualized care - especially when failure to do so may lead to permanent, invasive unnecessary medical procedures and harm which the children and youth can not fully evaluate or understand.

Recommended Changes to Amendment to Bill C-6

Consequently, we recommend that the definition of "conversion therapy" (Section 320.101) be amended to clarify that it does not relate to -

"a person's exploration of their identity, its development or expression and to discussions or recommendations by a licensed therapist as to the timing or appropriateness of social or medical transition to another gender, along with the risks and benefits thereof."

Without clearcut limiting language that expressly permits both exploration of the minor's gender identity, its expression and the appropriateness of transition, the prohibition set forth in Bill C-6 will have a chilling affect on neutral therapies available to minors by which they may lessen or resolve dysphoria (distress) relating to their identity, and properly and appropriately assess alternatives to medical interventions. In other words,

without clarifying language the prohibition will reify substandard care available to this population.

Gender Identity In Children and Adolescents

Unlike the research history with respect to same-sex attractions treatments, where the harms and ineffectualness of coercive therapies is well established (NOTE), the field of treating gender identity and dysphoria in children and youth is nascent with no long term follow up studies showing which approaches are best practices when addressing incongruence. Neither are the consequences of therapeutic approaches for same-sex attracted youth and those for gender incongruent youth the same. Clinical validation of an incongruent identity is part of a pathway to significant permanent affirming medical treatments. Therefore, how a gender identity in a minor is viewed can have life long physical, psychological and social consequences.

Under Bill-C6, “gender identity” is viewed as a naturally occurring trait - innate and immutable. However, there is no research establishing it as such. Rather, the exact origins of gender identities (as defined under the legislation) are not known. The consensus view is that they evolve, are emergent and can change over time. The American Academy of Pediatrics’ policy “Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents” (AAP’s Policy) describes a gender Identity as being stable or “fluid, shifting in different contexts.” It also can be congruent or incongruent with one’s designated natal sex. Where it is incongruent, it can be opposite of one’s natal sex, a combination of both sexes, somewhere in between or neither - with a “wide array” of expressions. It further states that gender identity evolves over time, much the way our bodies develop and is emergent - resulting “from a multifaceted interaction of biological traits, developmental influences, and environmental conditions.” (Rafferty 2018). (See also Drescher et al 2014.) There are no biomarkers or other objective factors by which to predict a person’s gender identity or whether it is stable or fluid. Furthermore, the level and consistency of the individual’s distress and discomfort related to their identity may vary with time and context, as can the individual’s gender expression. Finally, the AAP’s Policy states that “professional understanding of youth that identify as [transgender] is a rapidly evolving clinical field in which research on appropriate clinical management is limited.”

For these reasons, therapies which address the difficulties and distress related to incongruent identities in children and youth (which may also shift in different contexts) must be able to explore the contexts and conditions in which the identity has developed. Mere affirmation of a minor’s identity may relieve the youth’s immediate distress, but

there are no long term follow studies establishing that such an approach results in uniformly better mental, emotional and social outcomes. (D'Angelo et al. 2020.)

Early Onset

There are two predominant onset patterns in minors where an incongruent gender identity presents - in prepubescent children (which was the dominant pattern until recently and has been studied) and during adolescence - the average age 15 (which is only now being researched). Research regarding early prepubescent onset shows that a majority of these children will desist (return to a congruent gender identity) by early puberty (68-90% depending on the study Waillen et al 2008; Drummond et al 2008; Steensma et al 2013), most of whom go on to life healthy gay and lesbian lives. (Cantor 2019.) In the past, those children who persisted into adulthood reported that the incongruence of their identity was apparent to them by the age of 8.5 years old. (Rafferty 2018.) However, this is only a retrospective review of persons who persisted - it does not address how perceptions changed over time by those who desisted. Consequently, there is no research showing that a prepubescent incongruent identity is stable. Neither is there research showing that treating it as if it is stable provides children with the best environment for their identity to develop. Recent research has given clinicians concern that early affirmation of an identity may hamper the natural evolution of the identity - and fix it prematurely. (Zucker 2019.) For this reason, therapists must have the latitude to individually assess and explore possible conditions and co-morbidities that may be impacting the prepubescent child's identity formation, ability to naturally desist or adopt other gender expressions.

Adolescent Onset

While adolescents have presented with incongruent gender identities in the past, they now are doing so with no prior symptoms of distress in unprecedented numbers (e.g., 400% increase in 5 years in the U.K (Littman 2018, Hutchison et al 2020, Evans 2020); and the U.S Centers For Disease Control and Prevention reports that 2% of high school youth now identify as transgender (Johns et al 2017); with complex case histories, including differing neurodiverse profiles (1/3 are on the ASD spectrum; Strang et al 2014); and co-morbid conditions (depression, anxiety, and personality disorders (Kaltiala-Heino et al 2015). Further, nearly three-quarters of this population are girls - a complete inversion of previous statistics wherein boys had outnumbered girls in similar proportions. (70+% of these adolescents are now females; Zucker 2019.) There is widespread concern that the vastly disproportionate increase in adolescent girls presenting with diverse gender identities may reflect concomitant increases in social

and sexual anxiety, depression, self- harm, eating disorders, homophobia and body rejection known to affect them at the onset of somatic and psycho/social changes during puberty.

Clearly, gender variant youth now develop their self-perception in a very different cultural context than previously studied; and the extent of the cultural impact on their identity, its expression and stability - in comparison to those children who present earlier and persist into adolescence - is not known. However, there are now numerous online networks of detransitioners who transitioned in adolescence (with sudden onset) who are now detransitioning in their 20s (e.g.,16k on Reddit Forum). Many of whom report that their past identity was shaped by internalized regressive cultural stereotypes including misogyny and homophobia. This suggests that cultural influence on some is extensive and for some their self perceived identities (though intense) are not stable. For these reasons, the care provided to this population is under review and being studied both n the United Kingdom (NHS England 2020) and Sweden (BLF 2019)

The Need For Clear Therapeutic Latitude

Adolescence is a complex adjustment to physical and emotional changes that take place during puberty. Depression, anxiety, social isolation, eating disorders, and identity explorations are commonplace at this time. Often youth need help to navigate the complex issues of gender, sexual orientation, self-esteem and cultural stereotypes. Many of which are described in the American Psychological Association's (APA) Guidelines for Psychological Practice With Girls and Women (2018), Boys and Men (2018) and Lesbian, Gay and Bisexual Clients (2011) Specifically, the APA Guidelines with respect to girls acknowledge that body and gender discomfort at puberty are common place, and that misogyny, media images, sexual violence and objectification, along with internalized stereotypes play a large role in how girls perceive themselves, their self worth and their sense of belonging. Similarly, the APA Guidelines for treating LGB Youth cite internalized misgivings, self stigmatization and homophobia as active dynamics that impact the self-perception and attitudes of persons who are same-sex attracted. Along with addressing co-morbid condition, therapists must be at liberty to explore with gender variant children and youth whether and how these dynamics may be impacting their distress, gender expression and sexuality.

Finally, with the advance of social media, young people are now well versed in the symptoms, concepts and expressions attendant to discomfort and dissatisfaction with cultural gender stereotypes. They also are readily schooled in the options of medical transitions and gender identification which provide a sense of belonging to an umbrella

community and a means of avoiding complex developmental issues. In this environment, a gender variant identity can be a means of rebranding a developmental distress which consolidates feelings and expressions into an identity that shields their dilemmas from scrutiny and clears a pathway of action. (Lemma 2018.)

Extended Assessments and Neutral Wholistic Approaches

Due to the demographic changes and new contextual dynamics, clinicians are calling for better safeguards (Bewley 2019) including "extended assessment" protocols to better asses who will benefit from medical gender affirmation and for whom additional mental health support is needed (Churcher Clarke 2019, de Vries 2020) and adoption of neutral wholistic approaches under which there is "no therapeutic target with respect to gender identity outcome." (See description of the approach described by American Psychiatric Association Task Force on Treatment of Gender Identity Disorder - Byrne et al 2012.) Rather, the goals are: (1) "to allow the developmental trajectory of gender identity to unfold naturally;" (2) to provide a full assessment and exploration of the conditions and possible co-morbidities that may be causing or contributing to the youth's self-perception and distress; and (3) to avoid over diagnosis and irreversible unnecessary medical interventions that the minor is not competent to consent to and may later regret. (D'Angelo et al 2020; Evans 2020.)

In Conclusion

In order to provide optimal care that safeguards the long term health and well being of gender variant children and youth, neutral wholistic therapeutic approaches must be clearly permitted under the restrictions of Bill C-6. (See specific language recommended above under Recommended Changes.) Without such clarifying language, clinicians will be reluctant to use available therapeutic tools to adequately assess and explore the stability of the identity or the appropriateness and timing of affirming medical interventions for fear that such explorations and discussions could be construed as a form of gatekeeping and impermissibly "designed to change" the individual's gender identity.

Jane Wheeler, President, Rethink Identity Medicine Ethics, Inc., an educational and research non-profit Delaware corporation established to promote optimal ethical care for gender and sexualities variant children and youth. We work with a diverse group of multi-specialist clinicians and interdisciplinary scholars in the fields of psychiatry, psychology, endocrinology, sociology and the law, to gather, educate and provide the public, professionals and policymakers with up to date information regarding the care

and treatment of gender variant children and youth; and advocate for evidence-based medicine to help formulate better policies, guidelines and protocols. (www.rethinkime.org)

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