To Protect Our Youth – Enabling Access to the Best Care for Gender Dysphoria

Brief on Bill C-6

November 2020

BRIEF

Parents' Collective

We are a collective of parents of children currently in the Quebec school system, and we occasionally speak up to defend our right to give our children a moral education, in accordance with section 41 of the *Charter of Human Rights and Freedoms*.

We hereby ask Parliament to consider our requests regarding therapeutic approaches for our children.

We have also submitted a brief related to Quebec's Bill 70, An Act to protect persons from conversion therapy provided to change their sexual orientation, gender identity or gender expression.

Signatory parents

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Note: Some parents of children who identify as transgender and who contributed to this brief preferred not to sign, fearing intimidation and threats. We want parliamentarians to be aware of this situation, which hinders public debate and prevents the making of decisions in the best interests of our children.

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[2] We felt it was appropriate to identify ourselves by our children's school boards, now service centres, in order to provide a sense of where the parents are without stigmatizing the school.

Executive summary

This brief relates to Bill C-6, An Act to amend the Criminal Code (conversion therapy). Our collective agrees with the spirit of the bill, which seeks to prohibit conversion therapy, the purpose of which is to attempt to change a person's sexual orientation. However, because the concept of gender identity is included in the text of the bill, we want to ensure that it will not result in the loss of vital services to treat youth suffering from gender dysphoria.

Our concern is that, because of its wording, the bill unduly favours the affirmation therapies currently in vogue, which often include the invasive and early medicalization of children, to the detriment of exploratory psychotherapy approaches based on the precautionary principle.

The scientific literature is very clear that a significant proportion (about 80% [1]) of children who refuse to identify with their biological sex reconcile with it in adolescence. In addition, a large number of them turn out to be gay or lesbian. It is essential, in this context, that the cautious approach of watchful waiting, at least until adulthood, be protected.

In light of the current social climate, we are concerned that this legislation may discourage competent psychologists, who favour self-acceptance through a neutral exploratory approach, from treating young people who self-identify as trans for fear of being accused of engaging in "conversion therapy." Moreover, particularly given the high rate of co-morbidity observed in adolescents who identify as trans (anxiety, depression or autism), we challenge the notion that these young people would be able to give informed consent to invasive treatment that will have serious medical repercussions throughout their lives.

Finally, we condemn the ad hominem attacks that are divorced from reality, the most common being the accusation of "transphobia," aimed at parents, health professionals and "detransitioners"[3] who question the concept of gender identity and affirmation therapy, which stifle debate to the detriment of our children's well-being.

[3] Term used to refer to individuals who transition and later regret it.

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Take care of our children,
One of them could be yours.

Introduction

Sexual orientation is neither a personality disorder nor a mental illness, and any therapeutic approach aimed at remedying it is pseudo-science, undermines the dignity of the person and is ineffective. Although we are not aware of any registered therapists in Canada who incorporate such a conversion approach into their practice, some rigorist religious groups continue to do so. We understand that the bill is intended to prohibit such practices, and we support this part of the bill.

However, we are concerned about any misinterpretations that could result from introducing gender identity and the concept of “cisgender” into the definition of “conversion therapy.” We are concerned that the wording of the bill may intervene in a medical debate that currently divides health professionals on how best to treat gender dysphoria (distress caused by unease with one’s biological sex), and that the consequence will be to illogically penalize the least invasive therapeutic approach, the one based on the precautionary principle.

We fear that C-6 will result in favouring the affirmation-based approach, frequently leading to the medicalization of children as soon as they express incongruence with their biological sex, by administering growth blockers, cross-sex hormones, very often leading to particularly invasive surgical procedures (removal of breasts, testicles, vagina, breast implants, etc.). Moreover, once hormone treatment is started, it is usually continued for the rest of the individual’s life because the child is too far into the process to revert. The initially physically healthy child becomes a patient for life.

This kind of therapy requires supporting the belief that children have the competence to self-diagnose from an early age. Our parents’ collective challenges the idea that a child can give informed consent to an intensive hormonal treatment with side effects that are far from harmless (risks to brain development, osteoporosis, cancer, sterility, loss of sexual function, etc.). Children’s informed consent is even more questionable when statistics show a high rate of co-morbidity factors (autism, mental health, depression, etc.) among children who consult such clinics.

In this brief, we set out the reasons for our concerns about the bill’s wording and suggest ways to clarify the concepts. Our proposed amendments are in keeping with the spirit of the bill, which is to protect individuals from undue pressure from the medical community, but also from schools, the community, and more broadly from social pressures. In this case, they are intended to ensure that our children are protected from being pressured into rapid and invasive medicalization that will have a major lifelong impact.

1. Scope of the bill

Bill C-6 states that “conversion therapy causes harm to the persons, and in particular the children, who are subjected to it.” Consequently, the purpose of the legislation is to “protect the human dignity and equality of all Canadians.” This would be done by amending the *Criminal Code* to create offences relating to conversion therapy.

This means that the entire interpretation of the legislation is based on the proposed definition of "conversion therapy." The definition to be inserted into the *Criminal Code* in sections 320.101, and 320.102 to 320.106 would be the following:[4]

> conversion therapy means 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.

The confusion stems from the parallel drawn between sexual orientation and gender identity.

Sexual orientation refers to a person's enduring attraction to a person of the same sex, the opposite sex, or both sexes. For example, homosexuality is defined by the Merriam-Webster Dictionary as "sexual or romantic attraction to others of one's same sex." Seeking to convert a homosexual person into a heterosexual person is therefore seeking to "cure" this same-sex attraction. Sexual orientation is neither a disease nor a mental disorder. Any conversion therapy that seeks to interfere in a person's personal life is an act that violates "the human dignity and equality of all Canadians," as stated in the bill.

However, what constitutes "gender identity conversion" is not nearly as clear. The concepts of gender identity and "cisgender" are defined in the bill's legislative summary as follows [2]:

> **Gender identity** refers to an individual's deeply felt internal and individual experience of gender, which may be male or female or lie outside of the male/female binary. An individual's gender identity may differ from the sex they were assigned at birth ….
>
> **The term cisgender** refers to when an individual's gender identity aligns with the biological sex assigned to that individual at birth.

Since sex is not "assigned" but rather "recognized" at birth on an objective basis (the baby's genitals), we see these definitions as subjectively ideological and of no legal value. They are linked to the concept of "gender" that corresponds to the roles and stereotypes of what is considered feminine or masculine. Thus, they are concepts linked to social norms, which vary as these norms evolve, particularly as feminism makes progress in tackling sexual stereotypes.

How, then, should the concept of "gender identity conversion therapy," which would be considered a criminal offence, be interpreted?

In fact, gender-related therapy refers to the concept of gender dysphoria (GD), a mental health diagnosis defined in DSM-5 [3] as follows:

> **Gender dysphoria** involves a strong, persistent feeling that a person's anatomic sex does not match the person's inner sense of self as masculine, feminine, mixed, neutral, or something else (gender identity). This feeling of mismatch causes the person significant distress or greatly impairs the

[4] We prefer the English definition, as the bill's French translation fails to render the term "gender identity."

person's ability to function. **Transsexualism** is the most extreme form of gender dysphoria.

Currently, two approaches are practised and recognized by health professionals to treat children suffering from GD:

(1) **Exploratory psychotherapy**, also referred to as "watchful waiting therapy," involves offering the child psychotherapeutic supervision, sometimes over several years, to help them discover the causes of their unease, but at no point ruling out the option of future medical intervention. This approach, based on the precautionary principle, is based on the fact that a majority of children suffering from GD reconcile with their biological sex after adolescence [1,4,5].

(2) **So-called "affirmation" therapy**, which involves accepting a child's self-identification or self-diagnosis as soon as they express incongruence with their biological sex. In addition to social transition, this can quickly lead to the administration of growth blockers, cross-sex hormones, often leading to particularly invasive surgery (removal of breasts, testicles, vagina, breast implants, etc.).

Our concern is that, as worded, the bill may lead to penalizing the approach based on the precautionary principle.

Here are some concrete situations (some of them based on [6]):

- During a psychoanalysis session, a patient says: "I don't want to be a girl—I want to be a boy." Will the psychiatrist be able to explore this question as part of psychoanalysis or must they avoid continuing discussion on the subject for fear of being accused of seeking to make the patient "cisgender"?
- An anorexic patient is referred to a psychiatrist because she is in distress because of the size of her breasts and wants a mastectomy. She wants a "boy's chest." Should the psychiatrist explore gender dysphoria in the context of the patient's low body weight, or is it that once the patient says she wants to be a boy, she must necessarily be referred for surgery?
- A nine-year-old girl is referred to a psychologist for ADHD. During the evaluation, the child says, "I think I'm a boy." Does the psychiatrist have to ask, "Why do you think you're a boy?" Is such a question considered to be involving gender identity conversion or not?
- A patient changes their mind about their medical transition and asks their doctor to help them "detransition." Could the physician be accused of engaging in conversion therapy?

The reference in the bill to excluding "a practice, treatment or service that relates … to a person's exploration of their identity or to its development" from the definition of conversion therapy appears to protect developmental and exploratory psychotherapy approaches. However, as Dr. Kenneth J. Zucker, an expert on gender dysphoria in children, noted in a recent radio interview [7], this exclusion has not prevented conversion therapy legislation enacted by Ontario in 2015 from putting pressure on therapists: "This legislation has been successful in frightening clinicians away from wanting to work with families and young children who may be struggling with their gender identity."

A recent article [8] expresses concern that the false dichotomy between “affirmative therapy” and “conversion therapy” may discourage psychotherapists from treating GD. This would make it more difficult for patients seeking non-medical solutions to their distress to access appropriate mental health care.

Of course, therapy that engages in coercive tactics to force a person to change their gender identity have no place in the health care system. However, as worded, the bill risks interfering with therapeutic practices and limiting families’ access to accredited clinical practices recognized by the medical profession.

We want to draw Parliament’s attention to the fact that the goal is to protect all our children, not just a few children that some would label “trans children.” There is no objective test for diagnosing a child as “true transgender” [9]. In fact, children with gender dysphoria no longer have this condition in 61% to 98% of adult cases [1].

It is likely that all children, adolescents and young adults go through phases of instability when they question their identity, particularly their gender identity, during their psychological development. Émilie Dubreuil [10] reports that in the child psychiatry unit of the Montreal Children’s Hospital, 20% to 30% of adolescents admitted for a mental health problem (depression, suicidal thoughts, etc.) question their gender. In fall 2018, it was one out of every two patients. This means that all parents are concerned.

For all these reasons, we recommend that Parliament:

1. **refrain from intervening in a medical debate on the best approach to treat gender dysphoria; and**
2. **add the following exclusion to the definition of conversion therapy: “This definition also does not include approved clinical practices based on a developmental approach or an exploratory psychotherapy approach to gender dysphoria.”**

2. Sexual orientation and gender identity – An unfortunate lumping together

While it is legitimate to consider sexual orientation, gender identity and gender expression as related concepts when it comes to laws aimed at combating discrimination and hate speech, these concepts cannot be considered together in legislation such as this, one aimed at therapeutic approaches. Indeed, unlike sexual orientation, GD is a mental health diagnosis that may require therapy. It is interesting to note that the Royal College of Psychiatrists in the United Kingdom signed the first version of the Memorandum of Understanding on Conversion in 2015 prohibiting conversion therapy because it referred to homosexuality but refused to sign the second version in 2017 because the definition had been expanded to include transgender persons [11].

In addition, it is important to note that scientific studies of conversion therapy, or “restorative therapy,” focus only on attempts to convert sexual orientation. There are no scientific studies that address or define the concept of “gender identity conversion” [12,13].

However, any connection between sexual orientation conversion therapy and gender identity is because some young people today seem to find it easier to identify as transgender than to accept their homosexuality. Thus, researchers wonder whether identifying as trans is now valued more than identifying as gay or lesbian in certain youth settings, which would explain the particularly dramatic increase observed among adolescent girls in the 2008-2011 cohort.[5]

For example, at the Tavistock and Portman NHS Foundation Trust Clinic, which houses the Gender Identity Clinic (GIC) of the UK's National Health Service, only 8.5% of the women referred describe themselves as primarily attracted to boys. This raises important questions about the societal acceptance of young lesbians within LGBTQ culture [6], or the confusion between discomfort with not conforming to gender stereotypes and "being trans."

The link between gender dysphoria and homosexuality is concerning. The medical transition process for sex reassignment could eventually be seen as another form of conversion therapy that turns some gay or lesbian youth into heterosexuals. On April 8, 2019, *The Times* of London published an article entitled "It feels like conversion therapy for gay children, say clinicians."

For all these reasons and those mentioned above, and in order to avoid any ambiguity:

We recommend removing the reference to gender identity and "cisgender" from the definition of "conversion therapy" or at least clearly separating the clauses referring to sexual orientation from those referring to gender identity, and clearly defining what is meant by "gender identity conversion therapy."

3. Medical context

3.1 Explosion in the number of cases of gender dysphoria

In the last decade or so, a new phenomenon has emerged where there has been an explosion in the number of adolescents and young adults—mainly girls who did not show any symptoms of gender dysphoria at a younger age—who identify as transgender in adolescence.

A much-publicized study[6] based on parental anecdotes [15] refers to this phenomenon as "rapid-onset gender dysphoria."[7] One of the hypotheses put forward to explain this new form of dysphoria is that it is caused by social contagion, namely peer contagion, a process by which an individual and peers influence each other in a way that privileges emotions and behaviours that can potentially have negative effects on their development. Peer contagion is a documented phenomenon that plays a role in eating disorders such as anorexia.

Furthermore, several academics and clinicians are questioning the role of social media in the development of this type of GD [16]. Over the last decade, transgenderism and transitioning have gained a high profile in social media and online content. Researchers note that, on the one

[5] "Another parameter that has struck us as clinically important is that a number of youth comment that in some ways, it is easier to be trans than to be gay or lesbian." [14]

[6] The August 2018 article in *PLOS One* drew the ire of trans researchers and activists because it was based on parental anecdotes. It was republished after peer review and re-evaluation. The rewrite of the article was minor: nothing was substantially changed.

[7] This designation was used to emphasize that the target population is distinct from the previously documented groups of prepubertal children (which fall into the early-onset category) and adults (which fall into the late-onset category).

hand, this increased visibility has given a voice to people who were under-diagnosed and ignored in the past. On the other hand, it is likely that this online content may also have had the effect of prompting vulnerable people to believe that non-specific symptoms and vague feelings of confusion should be associated with a diagnosis of GD.

Very little research has been carried out into rapid-onset gender dysphoria. For example, researchers have little information on the persistence or desistance rates of these adolescents and young adults. Dr. Kenneth J. Zucker [17] notes an urgent need for systematic data on this new phenomenon to guide best clinical practice. Until more information is available, Dr. Zucker insists that caution should be exercised before prescribing invasive medication.

3.2 Impact of so-called “affirmative” therapy

Although affirmative therapy is becoming increasingly popular, it is challenged by many researchers, and the clinics that practise it are subject to a great deal of criticism. They are criticized for not sufficiently examining the causes that could cause distress, depression, anxiety and psychological suffering in children. They are said to be too “quick” to administer hormone blockers and drugs, many of the long-term effects of which are unknown or are known to be irreversible.

In a CBC report [10], the father of a young transgender boy reported that in a Montreal clinic, after 20 minutes, an endocrinologist prescribed puberty blockers for him, and only after he received the prescription were they referred to a psychologist.

> “On average,” said Dr. Montoro, “these blockers can be prescribed as early as 11 or 12 years of age for girls and 13 to 14 years of age for boys,” before switching to hormones at age 16, if not earlier. “Puberty blockers buy time so that the young person does not go through the wrong puberty. ... This makes it easier to transition later,” he said [10]. [translation]

However, puberty blockers are far from harmless. Michael K Laidlaw et al [9] explain that gender dysphoria in children is not an endocrine disease but becomes one as a result of puberty blockers and high doses of cross-sex hormones. The initially healthy child becomes a patient for life. Side effects are not insignificant and include risks to brain development [6], increased risk of cancer and osteoporosis, and especially a high risk of infertility and sexual dysfunction. Some researchers even argue that the minimum age for surgical treatment should be lowered, precisely because the targeted organs would already be non-functional following the administration of blockers and then cross-sex hormones.

It should be noted that all these drugs are prescribed “off label,” which means they are used for purposes other than what was approved. They all have side effects and should not be prescribed to healthy children. For example, GnRH analogues, used to delay the abnormally early onset of puberty, lead to a decrease in the normal development of bone density; high doses of testosterone in women lead to an increased risk of ovarian cancer and other metabolic abnormalities; the risk of venous thrombosis is increased fivefold in men taking estrogen. Michael K Laidlaw et al conclude that “existing care models based on psychological therapy have been shown to alleviate GD in children, thus avoiding the radical changes and health risks of GAT [Gender Affirmative Therapies]. This is an obvious and preferred therapy, as it does the least harm with the most benefit.”

Apart from the medical complications inherent in taking medication, a major criticism of the affirmation-based approach is that it would allow the problem to be viewed only from an intrapsychic perspective, as though a single facet of an individual's personality could be isolated from the others, thus ignoring the complex relationship between trauma, social anxiety or even the normal turbulence inherent in adolescence [11].

3.3 Questioning the child's "informed consent"

In the Radio-Canada report, Émilie Dubreuil [10] quotes Johanna Olson-Kennedy, Director of the Center for Transyouth and Development at Children's Hospital Los Angeles, who published a study proposing to lower the age for breast removal from 13 to 8 years. "If they regret it, they can have their breasts reconstructed later"! This statement is revealing as to the degree of freedom allowed a young person who is undergoing a transition process.

Affirmative therapy requires supporting the belief that young people are competent to self-diagnose at an early age. But can a child really give informed consent to treatments that will have lifelong effects? Many of the long-term effects of growth blockers are not known, but infertility seems inevitable when cross-sex hormones are introduced. Is a prepubescent child really able to grasp the impact of such a side effect on their life at the time of consent?

> Can patients make an evidence-based decision? The answer is no, according to Dr. Carl Heneghan of the University of Oxford. Science so far has had very little to say about puberty blockers, other than that they block it [10]. [translation]

Whether children can give informed consent is even more questionable when statistics show a high rate of co-morbidity factors (autism, depression, etc.) among children who consult such clinics. For example, studies conducted in such clinics for children and adolescents in the Netherlands and Finland show a prevalence of depression, anxiety and suicidal ideation in their patients [18,19]. In addition, autism spectrum disorders are systematically overrepresented among children referred to these clinics [20].

Furthermore, Littman et al [15] suggest that clinicians should be cautious about relying entirely on self-diagnosis when adolescents request access to medicalized transition, as these adolescents or young adults are not trained health care professionals. By diagnosing their own symptoms based on what they read on the Internet and what their friends say, they may come to the wrong conclusions. It is the clinician's role to conduct their own investigation to assess whether or not the patient would benefit from transitioning. This does not mean that the patient's convictions should be ignored, but that exploratory psychotherapy is necessary in order for the patient to further explore their symptoms in an informed manner. The role of parents is also important, and their knowledge of their young person must also be considered in order to make an informed diagnosis.

Adolescence is a period of experimentation that inevitably gives rise to all kinds of conscious or unconscious confusion, doubts and conflicts that force young people to deal with anxiety, psychological disorders and pain through the use of powerful psychological defenses such as denial or projection. These young people do not always have an accurate vision of their condition or interests. They need to be listened to and encouraged to seriously question their identification as trans in light of their experiences, beliefs and discomforts in an appropriate and

neutral way, and not be led to consider transition as the only possible solution to their discomfort.

3.4 Intimidation and ideological pressure

Clinics specializing in affirmative gender therapy have seen a dramatic increase in patients in recent years, due in part to the phenomenon of rapid onset-gender dysphoria described above. *The Times* article of November 17, 2018 notes the following:

> The Tavistock Clinic in London has reported a 1,000% increase in referrals of trans children in the past six years. The vast majority of these are teenage girls who used to be a tiny proportion of cases. This rush to provide medical sanction to a confused sense of self-affirmation has **all the hallmarks of a scandal in the making**. Most of the self-defined patients are gay young women, many with autism, depression or problems with anxiety. Many had suffered sexual abuse [21]. (emphasis ours)

There is an urgent need to be concerned about what *The Times* describes as a scandal in the making. Unfortunately, research has been slowed, if not blocked, by a climate of intimidation and political pressure.

Marcus Evans, a former member of the Tavistock Clinic Board of Governors who resigned after speaking to *The Times*, complains that clinicians working there have neither the time nor the support to conduct a thorough assessment of young patients due to a variety of pressures from peers, trans rights groups,[8] social media, young people and their families. He believes that the affirmation-based approach is driven more by political ideology than by clinical need and inhibits the clinician's curiosity and freedom to explore the child's belief system and underlying motivations. Yet these same clinicians would not simply accept or "affirm" a patient with anorexia who believes that they are overweight at 100 lb and need to go on a diet. In such a case, the therapist considers it their duty to try to understand the source of this belief, while trying to get the patient to eat. But in the case of GD, various sources of pressure and intimidation, including accusations of "transphobia," discourage therapists from investigating the causes of suffering. He notes, "This [investigation] is very difficult in the current environment, as the necessary debate and discussion is continually being closed down, either through individuals being prevented from expressing their views or being self-censoring through fear of the accusation of 'transphobia.'" [11]

In Canada, the Gender Identity Clinic (GIC) in Toronto was closed following accusations against its director, Dr. Kenneth J. Zucker, of practising "conversion therapy." Yet Dr. Zucker is one of the leading authorities in the field of gender dysphoria in children. The GIC's policy was to help individuals better understand the sources of their discomfort before recommending medical interventions. The investigation completely exonerated Dr. Zucker [22].

Accusations of transphobia are very effective in intimidating psychotherapists and anyone else in society who dares question the merits of affirmative therapy. It is also very effective in

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[8] It should be noted that there are trans people who are critical of these organizations, including Stonewall. https://www.stonewall.org.uk/

justifying a policy of boycotting psychotherapists who do not favour an affirmation-based approach.

3.5 Complaints

In countries that have been sex-transition pioneers, scandals are beginning to erupt. In particular, an internal report written by the chief of staff of the Tavistock Clinic in London (home to the UK's largest Gender Identity Development Service [GIDS]) is alarming. Dr. David Bell wrote that "the GIDS service as it now functions [is] not fit for purpose and children's ends are being met in a woeful, inadequate manner and some will live on with the damaging consequences." [23]

In Sweden, following several medical abuses, a report commissioned by the government to evaluate gender services for children concluded that there are no scientific studies to explain the increased demand for health care for gender dysphoria, that there are few studies into the long-term effects of gender-affirming therapy and that no relevant randomized controlled trials in children and adolescents have been found [25]. In other words, right now we are experimenting on our children!

We recommend that the government commission independent studies on the therapeutic processes followed by gender-affirming clinics in Canada, as the British and Swedish governments are doing.

There have recently been three complaints against the Tavistock Clinic and the NHS, including one from a nurse concerned that the clinic is prescribing "experimental treatments" to young children without sufficient prior assessment [26]. The other two complaints were from a mother of a 15-year-old girl with autism and from Keira Bell, a 23-year-old woman who "detransitioned" as an adult. Lawyers argue that the Centre's approach is illegal because children cannot be asked to give informed consent for this type of treatment, and that the potential risks of treatment are not adequately explained [24]. The judgment, which is expected very soon in the case of Keira Bell, could have a significant impact on the way GD is treated in England.

Contrary to what some would have us believe, the number of cases of people who have transitioned and who regret it in adulthood continues to increase. There are increasing reports of young "detransitioners" who have undergone hormone therapy or mutilation and blame their therapist or the health care system for failing to protect them [27,28,29].

This is the backdrop against which C-6 must be considered. If nothing is done to advocate the precautionary approach, and if, on the contrary, political actions such as this one—namely, those that favour an affirmation-based approach to GD—are taken, politicians will be responsible for the predictable abuses and damage to our children's lives.

Conclusion

We urge all Members of Parliament to be mindful of the possible implications of misinterpreting C-6. We understand that the goal is to protect individuals from coercive methods of forcing a person to change their sexual orientation or gender identity, and we welcome such an initiative. However, the wording of the bill should not end up limiting access to vital psychotherapy and mental health resources for children in favour of an invasive medicalized approach, the long-term effects of which are largely unknown.

The dramatic increase in the number of young people referred to gender transition clinics across the West is alarming. This phenomenon is still poorly understood, and health professionals are currently quite divided [30] on how best to treat these young people. This means that it is essential to ensure all the conditions are met for calm social debate, objective scientific research and an exhaustive medical study, free of ideological or political pressure, in order to explore all aspects of transidentity, including the long-term effects of treatment, the concept of informed consent of children, the phenomenon of social contagion, the roles of social media and the co-morbidity factors that often accompany GD.

Although Parliament's intent is a noble one, we fear that the politics that will be brought in by this law will further stifle debate and put additional pressure on health professionals, psychoanalysts and psychotherapists who, for fear of being accused of "transphobia," will rather give up treating GD, thereby limiting the medical resources available to parents and children.

Children suffering from GD suffer a great deal of psychological distress and should be able to benefit from the most appropriate approach for their particular condition. Statistics show that many of these children realize in adolescence that they are gay or lesbian. But what happens when they are referred, without further investigation, to transition protocols? The real winners will be the drug companies who benefit from the lifelong medicalization of a growing cohort of children.

We urge Parliament to make the recommended amendments to C-6 and to follow the recommendations in this brief to ensure that the physical and mental integrity of our children is actually protected, as required by the spirit of the law.

As the Hippocratic Oath says: **First, do no harm.**

List of recommendations

1. We recommend that the government refrain from intervening in a medical debate on the best approach to treat gender dysphoria.
2. We recommend adding the following exclusion to the definition of conversion therapy: “This definition also does not include approved clinical practices based on a developmental approach or an exploratory psychotherapy approach to gender dysphoria.”
3. We recommend removing the reference to gender identity and “cisgender” from the definition of “conversion therapy” or at least clearly separating the clauses referring to sexual orientation from those referring to gender identity, and clearly defining what is meant by “gender identity conversion therapy.”
4. We recommend that the government commission independent studies on the therapeutic processes followed by gender-affirming clinics in Canada, as the British and Swedish governments are doing.

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