Brief to the Justice Committee on Bill C-6: An Act to amend the Criminal Code (conversion therapy)

By Sarah Robertson

I have serious problems with Bill C-6, in particular the concept of conversion therapy for transgender people.

> **Definition of *conversion therapy***
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> **320.101** In sections 320.102 to 320.106, ***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. For greater certainty, this definition does not include a practice, treatment or service that relates
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> **(a)** to a person's gender transition; or
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> **(b)** to a person's exploration of their identity or to its development.

This bill does not define how to determine whether a child is homosexual or transgender. There is no clear diagnostic test for determining whether anyone is truly homosexual or transgender, other than to ask and hope the client knows what they are talking about. At what age is a child able to determine whether they are homosexual or transgender? A child who is not aware of the possibility they are homosexual, or that homosexuality is acceptable, may assume they are trans instead. Most children who present with trans identification grow out of it[1], and the only way to determine who will grow out of it may be to wait and see.

In addition, the definition of conversion therapy is not clear. It assumes that everyone knows what conversion therapy is and isn't, but there is no consensus and a great deal of conflict on this right now.

In my opinion, if Bill C-6 is going to work, it needs to be more explicit in what is considered conversion therapy for transgenderism, because there is no clear-cut therapeutic understanding of this at this time, and the definition of conversion therapy by trans activists appears to include anything that might suggest the child might be a confused or distressed homosexual instead, or in need of some other care.

I believe the bill needs to explicitly consider the following issues:

1. Is anything other than instant and complete affirmation of a transgender identity to be considered conversion therapy of transgender individuals?

Would the following be considered conversion therapy?

> Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body.

I hope not, because it's from the most recent Standards of Care, page 8, published by the World

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1 American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. See page 455 for persistence rates.

Professional Association for Transgender Health (WPATH) in 2011.[2] This is supposed to be the organization that determines the best care for transgender individuals. And yet, from what I've seen, trans advocates these days are calling for nothing less than complete affirmation. And the American Psychiatric Association advocates affirmation: "**Gender Affirming Therapy** is a therapeutic stance that focuses on affirming a patient's gender identity and does not try to "repair" it."[3] It's possible WPATH will be updating its recommendations, to keep up with trans advocacy.

2. Will "watchful waiting" be legal under this bill, or will it be considered conversion therapy?

The traditional gold standard for assessing minors was to give trans-presenting children the opportunity to explore alternatives and see if they grew out of their trans identity over time. Most did[4]. However, trans activists have labelled this approach conversion therapy and got a prominent Canadian researcher, Kenneth Zucker, fired for taking this approach.[5] He has since settled out of court with his former employer and is in private practice.[6] Will he be considered to be practicing conversion therapy if he takes the watchful waiting approach when assessing trans-presenting children? Will others?

3. Will it be legal for a therapist to explore the possibility of social contagion when a trans-identifying child asks for treatment? Or will that be considered conversion therapy?

In 2018, Lisa Littman published a paper[7] on social contagion and gender dysphoria in teenage girls, which she called Rapid Onset Gender Dysphoria, based on her interviews with parents. Abigail Shrier's (2020) book *Irreversible Damage* has explored this idea further. Essentially, trans-identifying children used to be mostly pre-adolescent males, but in the last decade or so they have become predominantly teenage girls, and they tend to identify as trans in social clusters. It looks like social contagion and appears to affect the same girls who are prone to cutting and eating disorders. Are practitioners allowed to address this? You might assume so, but both of these publications have been attacked or marginalized a great deal for being transphobic.

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2 https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care%20V7%20%202011%20WPATH.pdf?_t=1605186324

3 https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-affirming-therapy

4 American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. See page 455 for persistence rates.

5 https://www.thecut.com/2016/02/fight-over-trans-kids-got-a-researcher-fired.html

6 https://www.theglobeandmail.com/canada/toronto/article-doctor-fired-from-gender-identity-clinic-says-he- feels-vindicated/

7 Littman, L. (2018). Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. *PLoS ONE, 13*(8): e0202330.

4. Will it be legal to consider the age and cognitive developmental level of a child with gender dysphoria to see if they even understand what gender identity is (as distinct from sex)? Or will that be considered conversion therapy?

Lawrence Kohlberg[8], when examining the source of children's understanding of their sex (which he called gender identity, though he was talking about sex identity), found that five-year-olds might think it possible to turn a cat into a dog by cutting its whiskers off. Children of this age might take people literally if told they could change sex, since they typically do not understand material reality enough yet to know that literal sex change is not possible. They do tend to have an intuitive understanding of which sex they are from an early age, but don't necessarily understand sex as a logical category. I am not aware of any further research on this subject, but my impression is that children begin to understand the difference between sex and gender identity by sometime in early formal operations (age eleven to twelve or so), because it appears that that is the age at which they begin to make fun of it. Prior to that age there may be the risk that they will take things too literally.

Early formal operations is the stage at which children can understand abstract concepts such as infinity and nation-states. These are concepts we need to be able to analyze via the imagination, since they aren't concrete objects. And with concepts like the nation-state (which you might think of as concrete because there tends to be consensus on their existence, but in fact is an invented thing that has been invented because it is useful), acceptance of a national identity by everyone is not guaranteed (e.g. Taiwan). Gender identity appears to be a concept at the same level of complexity.

So it makes sense that children might not understand what gender (as opposed to biological sex) and gender identity are until that point, or later. I am not aware of any research on this from a cognitive developmental point of view, but I think it needs to be considered.

5. Will it be legal to focus on comorbidities first, instead of transitioning the child right away, when a trans-identified child also has or may have PTSD, an autistic spectrum disorder, OCD, etc., or will that be considered conversion therapy?

A 2016 online survey of 211 detransitioned women[9] (women who had lived as transmen for an average of four years before detransitioning) reported elevated rates of ADHD, Autistic Spectrum Disorder, PTSD, Obsessive Compulsive Disorder, anxiety disorders, depressive or mood disorders, personality disorders, eating disorders, dissociative identity disorders, schizophrenia and schizo-spectrum disorder, dissociation, and depersonalization compared to reported rates for the general population. Only four subjects out of the 211 did not report any of these disorders. It's hard to know how representative this survey was, but it's suggestive.

In my own case, I considered transitioning briefly in my mid-teens, circa 1980, motivated by severe sexual abuse trauma rather than by my as-yet-undiagnosed autism (it was fashionable to be androgynous back then). Had I faced the same issues in today's social climate, I would have been vulnerable to too-quick affirmation and not enough support for other issues, rather than just not enough support for other issues. Ideally you *would* get enough support for other issues.

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8 Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E. E. Maccoby (Ed.), *The development of sex differences* (pp. 82–173). Stanford: Stanford University Press.

9 This study is no longer online but I can provide a copy if anyone is interested.

But what happens if a therapist says "We had better look at this first before considering transitioning."? That is not affirmation first and might be considered conversion therapy by the patient and by activists.

6. At what age will children be considered capable of giving informed consent to puberty blockers, cross-sex hormones (with permanent effects), and removal of healthy tissue (double mastectomy, castration, hysterectomy)? Is eighteen even old enough? Is there any research on regret rates at different ages of consent for this kind of medical treatment?

I have already discussed cognitive development and how it may affect the ability of a person to understand what gender identity is in point 4. There are additional age-related issues I am less familiar with that affect the ability to give informed consent to medical treatment.

In the UK Kiera Bell case[10], where a teenage girl transitioned then later regretted it, a neuroscientist testified that adolescents tend to make different, riskier decisions than adults, especially when feeling more emotional, and that adolescents may not be equipped to make rational decisions even when given a great deal of information, due to brain maturation and experience. I don't know much about this but it seems pretty important. Will this be considered?

Furthermore, it was also discussed in the Kiera Bell decision that puberty blockers may actually affect brain development and social maturation, though not much is known about this. In this way it might be comparable to anorexia, which can interfere with good decision-making.

On top of that, how do minors make informed decisions about treatments that may affect their ability to be sexual and to have children when they are often too young to even be interested?

> There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years.[11]

I did not begin to feel sexual feelings or want children until well into my thirties. There is no way I could have understood in my teens. (Hopefully most people aren't as messed up as I was, but some may be, given we are talking about gender dysphoric people.)

In this case, the court decided that since puberty blockers – which may or may not be completely reversible – almost inevitably continue into the use of cross-sex hormones – with permanent effects – the decision to take puberty blockers should include the ability to understand the possible loss of fertility and sexual function, and that it is highly unlikely that a child under sixteen could make an informed decision on this (para. 145), no matter how much information they were given (para. 150). They also recommended that, because of the complexity of the issue, clinicians refer consent cases for sixteen- and seventeen-year-olds to the court when there's any doubt about the ability to consent (para. 147).

10 R (on the application of) Quincy Bell and A v Tavistock and Portman NHS Trust and others [2020] EWHC 3274(Admin)

11 op. cit. para 144

7. Will care providers be required to document the outcomes of treatment, including side effects of medications, suicidality, life satisfaction, and desistance, both in the short-term and long-term?

In the Kiera Bell case[12], the court decision repeatedly expressed surprise that the Gender Identity Development Service (GIDS) did not collect or collate data (the age distribution, the proportion with an autism spectrum diagnosis, the number who chose not to take puberty blockers when given the chance, the proportion who took puberty blockers and then did not proceed with other-sex hormones later on) with respect to the experimental treatment of minors with puberty blockers. Given that puberty blockers are being used off-label for transitioning (they were approved for treatment of prostate cancer and may or may not be approved for anything else), and that the transitioning of minors (and even adults) is still experimental and not well understood, I think anyone providing such services should not only be required to collect and collate data on patients, but also maintain follow-up data as much as possible. Is it fair to criminalize not providing a particular treatment (if that's what this bill does, which I think is its likely outcome even if not its intent) when so little data is available on outcomes? And if such treatments are still experimental, should data collection not be required?

8. Will it be legal to assist a formerly trans-identified person in detransitioning if that is what they want?

Detransitioned transmen (girls/women who transitioned to living as boys/men then changed their minds) may number in the hundreds or even thousands. For example, when Charlie Evans went public as a detransitioner a few years ago, she was contacted by hundreds of detransitioned transmen[13], and an online detransitioner survey found 211 subjects in one month in 2016.[14]) There are also detransitioning transwomen. Will it be legal to help them sort things out?

9. How will it be proven that someone has engaged in conversion therapy? Will any attempt to question someone's identity be considered conversion therapy, or is there a threshold of questioning that will be considered unreasonable, with a degree of reasonable questioning allowed? Who determines where that threshold might be? A minor? One or both parents? The police? A court?

In my opinion it is dangerous to assume these issues are already resolved, or can be resolved by medical practitioners as they go along, especially if medical practitioners risk loss of employment (as they already do, as described above in point 2) or criminal charges if they hesitate to immediately accept a trans identity in any client or patient, especially a minor.

I also think criminalizing unethical medical treatments is problematic in general. There are already supposed to be procedures in place to ensure ethical treatment of clients/patients, based on rigorous scientific research and debate. If these are not working, I think they need to be fixed rather than

12 R (on the application of) Quincy Bell and A v Tavistock and Portman NHS Trust and others [2020] EWHC 3274(Admin)

13 https://news.sky.com/story/hundreds-of-young-trans-people-seeking-help-to-return-to-original-sex-11827740

14 This survey is no longer available online, but I have a copy if anyone is interested.

overridden by a different mechanism. **A more important issue may be ensuring the possibility of dissent in medical or therapeutic ranks (without loss of funding, employment, or access to publication or media coverage), so that when unethical practices do emerge (as they will, no matter how much people try to prevent it), it is easier to push back against them and ensure proper debate and better outcomes.** Criminalizing specific unethical medical practices instead of improving methods for discovering and preventing unethical practices in general may be closing the barn door after the horses have escaped.