BRIEF TO STANDING COMMITTEE ON JUSTICE AND HUMAN RIGHTS – Re: Bill C-6

I am writing this brief to express my concerns about the inclusion of gender identity in the proposed legislation that would ban conversion therapy (Bill C-6). Sexual orientation and gender identity are separate concepts which require different medical and legal treatment.

Policies and research which have been cited in support of a ban on conversion therapy to change sexual orientation do not apply to changing gender identity. Gender identity medicine, particularly for younger patients, is still a developing area and much more research is needed. A ban on conversion therapy would prevent necessary research and expose patients to potentially harmful treatments.

Lesbians, gays and bisexuals do not have a mental health condition and do not require any sort of therapy. Multiple studies have shown that sexual orientation cannot be changed by therapy. Every major mental health professional organization rejects the practice. However, Gender Dysphoria is a mental disorder identified in the DSM-5. People whose sense of gender identity does not match their sex at birth do require some form of therapy. They suffer mental distress because their body is not aligned with their mind. There are two possible ways of treating this condition. Either modify the mind to align with the body or modify the body to align with the mind.

There is ongoing disagreement in the medical profession as to which approach is best. This is a developing area and the research studies are limited. Nevertheless, many professional bodies have endorsed the affirming approach, which usually means modifying the body, as the only acceptable way of treating gender dysphoria.

Supporters of the affirming approach claim that it is supported by science and point to standards of care of various professional associations. However, when these standards of care are examined closely they do not stand up. They often rely on low quality studies and, in many cases, the studies simply do not support the conclusions being drawn.

The affirming approach involves several stages. The first is social transition which involves adopting a name, pronouns and dress of the preferred gender. If a child has not started puberty, he or she may be given a puberty blocking drug. This is followed by cross sex hormones, which will trigger changes in physical appearance to match the desired gender. The final step is one or more “gender affirming” surgeries.

These procedures are being performed at much younger ages than previously. In the United States there have been cases of breasts being removed from trans-identified females as young as 13 and vaginoplasty (removal of penis and testicles and construction of an artificial vagina) being performed on trans-identified males as young as 16 years of age.

Medical transition has serious health risks. Medical transition includes puberty blocking drugs, cross sex hormones and surgery. This results in permanent damage to the child’s health, including irreversible sterilization, loss of sexual function, arrested bone growth and weaker bones, and increased risk of heart disease, blood clots, strokes and osteoporosis. Once hormone treatment is started, it generally continues for life.

A legislated ban on conversion therapy will lock in the affirming approach as the only way to treat gender dysphoria. In practical terms, this means that if a young woman is in distress because she hates her breasts and believes she is a man, a psychiatrist or psychologist may refer her to a surgeon for a double mastectomy. A clinician who attempts to explore the causes of her distress and assist her to accept her female body, would risk criminal charges. It would be acceptable to give drugs to children with multiple mental health issues which will sterilize them, but criminal to attempt to resolve their distress through talk therapy.

Gender dysphoria is often associated with other mental health conditions such as autism spectrum disorders, eating disorders and post-traumatic stress. There is growing concern by mental health professionals throughout the world that gender dysphoria is being over diagnosed and that medical transition is being used as the first line treatment. The affirmation-only policies adopted by many professional associations make it difficult for responsible clinicians to do proper diagnosis and treatment of gender confused patients with complex mental health issues. Adding in criminal law would make a bad situation worse. In addition, detransitioners seeking help will have a difficult time finding a therapist to help them when therapists feel under threat of criminal charges and/or losing their license if they assist a detransitioners to re-identify with their birth sex.

There is no clear evidence that the affirming approach is the best or only way to deal with gender dysphoria. Before the affirming approach became common, studies found that between 60 and 90 percent of children who experienced gender dysphoria as children would desist when they started puberty. Therefore, blocking puberty means blocking a natural process that allows children to become comfortable in their natural bodies and thus prevent unnecessary medical interventions. In addition, once children are given puberty blockers, studies have found that over 90 percent of children who go on puberty blockers persist and go on to cross sex hormones. The combination of puberty blockers follow by cross sex hormones will result in sterility and reduction or loss of sexual feeling.

Treatment of gender dysphoria in children and youth is still experimental. The drugs for blocking puberty and cross-sex hormones are being used off-label. That is, they have never received regulatory approval for treatment of gender dysphoria.

Children do not have the capacity to consent to life altering treatments. 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. An adolescent does not have the mental maturity to understand what it means to be sterilized.

In 2009 the number of children referred to gender clinics each year was very low, with natal boys slightly outnumbering natal girls. Today the number of referrals has massively increased and natal girls outnumber natal boys by two to one. In any other area of medicine this type of dramatic growth and change in makeup of a patient population would be a cause for major concern but none of the leading gender clinics seem interested in studying the question.

Some patients are realizing that the risks of medical gender transitioning do not outweigh the benefits. A growing number of people, mostly young women, are de-transitioning. They found that hormone treatment and surgery did not relieve their distress and they are re-identifying as their birth sex. They now complain that they did not receive proper (or any) therapy for the underlying causes of their distress.

This is not a partisan issue. While some of the most visible opponents of gender transition are religious conservatives, the same concerns are shared by people across the political spectrum and of many faiths and none.

Members of the lesbian, gay and bisexual communities have a particular concern. Past research has shown that many people who show signs of gender confusion as children grow up to be same sex-attracted adults. Some people in the LGBT community see medical transition of gender confused children as a new form of conversion therapy (“transing the gay away”). Youth who are uncomfortable with their same-sex attractions may seek transition so they can be “straight” and/or they may be responding to external homophobia.

Further, there is growing international concern about the safety and ethics of medical transition of young people. Medical professionals in the United Kingdom, Australia, Sweden and Germany have warned that children are being given irreversible treatments without proper psychological assessment.

Supporters of the affirmative approach will argue that any other approach will result in transgender people committing suicide. There is no evidence to support this claim. There are studies that show that transgender people are at higher risk for suicide than the general population. However, people with other mental disorders

such as Depression or PTSD are also at a higher risk of suicide. In addition, these studies do not show that supporting transition is the only acceptable approach. Studies show that the risk of suicide remains high both before and after transition. Furthermore, most studies do not take into account other mental health conditions (co-morbidities) which might contribute to suicide risk.

Suicide threats always need a serious response. However, the response should be mental health treatment guided by the best available research. That cannot happen if researchers and professionals have the threat of criminal prosecution hanging over them.

It should also be noted that many children with gender dysphoria come from vulnerable populations such as children in foster care. This is unsurprising since children in foster care have experienced adverse childhood experiences including sexual abuse and other trauma. It must also be noted that indigenous children are still over-represented in the foster care system and therefore indigenous children may be disproportionately impacted by medical transition. Since the outcome of medical transition includes sterilization, it behooves the government of Canada to be extremely cautious in supporting laws and policies that may result in the disproportionate sterilization of indigenous children.

Dr. Stephen B Levine states the following: “In considering the appropriate response to gender dysphoria, it is important to know that certain groups of children have increased prevalence and incidence of trans-identities. These include: children of color, children with mental developmental disabilities, including children on the autistic spectrum (at a rate more than 7x the general population), children residing in foster care homes, adopted children (at a rate more than 3x the general population), children with a prior history of psychiatric illnesses, and more recently adolescent girls (in a large study, at a rate more than 2x that of boys).” (Page 11, Expert Affidavit of Dr. Stephen B. Levine, M.D., February 10, 2020).

In addition to the concerns noted above, Bill C-6 is also flawed in its use of trans-ideological activist language, such as terms like “cisgender” and “sex assigned at birth”, as the use of this language pre-supposes the governments acceptance of trans-ideology. Sex is not assigned at birth, it is observed. The idea of “assigning” sex comes from the experience of intersex individuals, where in the past doctors would tidy up the genitalia of babies born with anatomical abnormalities. This has nothing to do with transgenderism. Biological sex is determined at the moment of fertilization through XX/XY chromosomes and simply observed at birth. Birth sex or natal sex are neutral terms that are more accurate. Words like “cisgender”, “ciswoman” and “cisman” should be replaced with “non-transgender”, “woman” and “man.”

To support the concerns outlined in this brief, I have included a link to the following referenced material:

Document entitled **"Expert Affidavit of Dr. Stephen B. Levine, M.D."** which contains his sworn statement and expert opinion to the State of Wisconsin in a case against the Madison Metropolitan School District. Dr. Stephen B. Levine is a Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine and also maintains a private practice. He is considered an expert in the field of transgender health care and has been retained by courts of law to give expert testimony. This Affidavit contains information which is relevant to your consideration of Bill C-6.

Here's the link: http://www.will-law.org/wp-content/uploads/2020/02/affidavit-stephen-levine-with-exhibit.pdf?fbclid=IwAR0yIbAqVSAM5g9bhHq3c_i5QL_TaruCyYPXm0M2lVj2Z7amp1hbNS5K26I

Based on the concerns noted above, I request that you remove gender identity from the proposed legislation.

Submitted by:

April Kitzul
Women’s Human Rights Campaign (BC-Yukon Coordinator / Contact)