

# Banning Transgender Conversion Practices

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## Introduction

On December 15, 2015, the Toronto Centre for Addiction and Mental Health (CAMH) announced that it would be closing its Gender Identity Clinic for Children and Youth. For decades, the clinic had been plagued with critiques accusing it of engaging in conversion practices.<sup>1</sup> These critiques came from academics, scholars, and community members alike. Its antiquated approach to trans care was enshrined in a nickname: the Jurassic Clarke – a pun on the name of its precursor, the Clarke Institute. Amidst reignited accusations that the clinic engaged in conversion practices and in the wake of Ontario’s Bill 77, the *Affirming Sexual Orientation and Gender Identity Act*, which came into force in June 2015 to prohibit conversion practices across the province, CAMH announced the clinic’s closure.<sup>2</sup>

Trans communities welcomed this change. The CAMH clinic had played a leading role in trans health for nearly four decades.<sup>3</sup> It had long been the sole approved source of referrals for medical transition in Ontario and, indeed, some other provinces.<sup>4</sup> Some detractors painted it as an international exporter of trans conversion practices due to its prominence in clinical and research circles. The clinic’s demise marked the end of an era not just for Ontario but also for trans health itself. Its closure in the wake of a new law prohibiting conversion practices offers insight into both the limitations and potential of banning conversion practices.

The CAMH clinic's history begins in the 1970s, when it operated as a specialized team of the Clarke Institute in Toronto under the supervision of Susan Bradley. In the 1980s, Kenneth Zucker succeeded Bradley as head of the clinic. When the Clarke Institute merged with other organizations to form CAMH, the clinic continued to operate under the new institution.<sup>5</sup> The clinic was for a long time "among the few clinics able to produce longitudinal data and comparative research" and "generated the most highly cited writing on the topic of childhood gender diversity."<sup>6</sup> It was among the first to prescribe puberty blockers to adolescents, allowing them to transition. However, as science and our understanding of transitude – the fact of being trans – morphed into our contemporary understanding of being trans as part of normal human variation rather than as a mental disorder, the clinic's practice proved resistant to change.<sup>7</sup> A comparison between the 1995 monograph *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* by Kenneth Zucker and Susan Bradley and contemporary works by the same authors reveals few substantial changes in clinical approach.<sup>8</sup> Although the authors are more cautious in their propositions today and acknowledge a plurality of practices, they continue to view the prevention of adult trans outcomes as an appropriate and ethical clinical goal.

An external review of the clinic's practice undertaken at the request of CAMH informed the decision to wind down services. The review was ordered after the community organization Rainbow Health Alliance submitted a review of the academic literature and clinical practices on trans youth care, raising concerns that the CAMH clinic was not following accepted practices.<sup>9</sup> At the time, Ontario's ban on conversion practices was under consideration by the legislature with support from the majority government. Rainbow Health Alliance suggested that the clinic's approach would run afoul of the upcoming law, prompting further concern. The external review was conducted by psychiatrists Suzanne Zinck and Antonio Pignatiello, who completed a literature review; interviewed staff, community stakeholders, and clients, former clients, and families; reviewed written submissions from former patients; and reviewed patients' medical records. The review made recommendations based on the findings.

The report described the head of the clinic, Kenneth Zucker, as a “Mecca of knowledge and information” but found that the clinic was “out of step with current clinical and operational practices.”<sup>10</sup> According to the reviewers, there was concern and anger among stakeholders that clinicians and students affiliated with the clinic were being taught the clinic’s corrective approach.<sup>11</sup> The reviewers expressed concern that the clinic’s use of play therapy and cognitive-behavioural therapy was directive rather than exploratory and that the clinic’s approach was grounded in an assumption that gender non-conforming behaviours require intervention.<sup>12</sup> The clinicians would set out “to reduce [the] child’s desire to be of the other gender,” notably by attempting to identify the desire’s causes through individual and parental counselling, by directing parents to limit or disallow the child’s gender non-conforming behaviours in day-to-day life, and by promoting relations with peers of the same sex assigned at birth.<sup>13</sup> It is not clear from the report whether all clinicians at the clinic employed a similar approach, though the description of the clinic’s practices seems to suggest as much.

Some who worked at the clinic opined that Ontario’s upcoming ban on conversion practices would not apply to their approach.<sup>14</sup> The report did not express any view regarding the law’s application and did not confirm whether the clinic engaged in conversion practices. The authors nonetheless noted that “they cannot state that the clinic does not” engage in conversion practices, pointing to evidence that may suggest as much.<sup>15</sup> The external review’s findings do indeed suggest that conversion practices were being employed. Parents reported their children being questioned about their gender in ways that implied a negative judgment of their way of being.<sup>16</sup> The report found that the clinic pathologized children and parents and suggested that it inappropriately positioned being “heterosexual [and] cisgender as the most acceptable treatment outcome.”<sup>17</sup> The reviewers concurred with participants that promoting comfort with one’s sex assigned at birth was wrong and not consistent with current standards of practices. According to them, attempting to “treat” normal human variation surrounding gender is unlikely to succeed or be ethical.<sup>18</sup> They further faulted the clinic for not engaging collaboratively with trans communities.<sup>19</sup>

The central recommendation of the review was for the clinic to revise its assessment and treatment approaches and align them with patient-centred, affirmative care. The report authors recommended that staff refrain from attempting to reduce gender non-conforming behaviours and avoid language that pathologizes such behaviours.<sup>20</sup> The external review's recommendations were not followed by CAMH, which chose to close the clinic and terminate Zucker's employment. As William Byne has stated, echoing the external review, "[c]losure of the Ontario clinic before making alternative provisions for gender-variant children and adolescents has left a void for many needing its services."<sup>21</sup> The gap in services continues today.

For conservative commentators, the closure of the clinic and termination of Zucker's employment was evidence that "trans militants" sought to "censor" scientists. Barbara Kay, writing for the *National Post*, Canada's leading conservative newspaper, characterized critiques of the clinic's practices as symptoms of the "aggressive activism in the trans movement," suggesting that emotionalism had overtaken rational dialogue.<sup>22</sup> This belief is shared by many of Zucker's supporters. A petition opposing Zucker's firing and concluding that it was primarily political was signed by 508 individuals, many of whom are academics and scientists.<sup>23</sup> The signatories include many individuals known for their anti-trans views and activism. According to the chair of the CAMH Board of Trustees, the petition does not "provide an accurate assessment of what occurred," the closure having been motivated by CAMH's commitment to improving services in collaboration with community partners.<sup>24</sup>

Following his dismissal, Zucker sued CAMH for defamation and wrongful dismissal. In October 2018, CAMH announced that it had reached a financial settlement with Zucker and released an apology. The apology stated:

In 2015, the Centre for Addiction and Mental Health (CAMH) commissioned an external review of the Gender Identity Clinic within the Child, Youth and Family Program. The purpose of the review was to identify best practices and determine how CAMH can best serve children and adolescents with gender dysphoria and their families.

The review was not intended to examine Dr. Zucker's behaviour or specific clinical practices.

The review produced a report that was released publicly on December 15, 2015. Unfortunately, the report contained some errors about Dr. Zucker's clinical practice and interactions with patients. The report was released publicly without review or comment by Dr. Zucker. Among other errors, the report falsely states that Dr. Zucker called a patient a "hairy little vermin." That allegation is untrue.

CAMH apologizes without reservation to Dr. Zucker for the flaws in the process that led to errors in the report not being discovered and has entered into a settlement with Dr. Zucker that includes a financial payment to him.<sup>25</sup>

Many saw the settlement as a vindication of Zucker and as evidence that he was wrongfully fired. However, the attending context suggests that the implications of the settlement are narrower and, crucially, did not extend to the findings about the clinic's approach being out of line with current, non-psychopathologizing approaches to trans care. The impugning of the corrective approach employed at the CAMH clinic is certainly the most damning element of the external review. One would think that the apology would explicitly refer to any significant mischaracterizations of the approach, had there been any. Although the apology alluded to errors regarding Zucker's clinical practice, none were explicitly mentioned – a telltale silence. On the contrary, CAMH publicly stated upon the apology's release that it "stands by its decision to close the child and youth gender identity clinic following an external review which concluded the clinic was not meeting the needs of gender expansive and trans children and their families."<sup>26</sup>

It is important to understand that employment law contemplates compensation not only for the act of termination itself but also for the manner in which the person was terminated.<sup>27</sup> Even if CAMH is entitled to terminate Zucker and close the clinic for engaging in outdated and possibly unethical practices, it must do so without harming the employee's reputation and future employment prospects. Conduct and statements that are "untruthful, misleading or unduly insensitive" can lead to compensation.<sup>28</sup> Damages can also be separately sought for



defamation. Making a report public without giving interested parties an opportunity to comment on it ahead of time is a risky endeavour. For long-standing employees whose reputations are at play, having no opportunity to comment could by itself be understood as unduly insensitive. To claim that someone called a patient a “hairy little vermin” is bound to harm their reputation, regardless of whether someone else at the clinic made the statement. The reputational injury and insensitive process may turn out to attract particularly large sums of money when the person is a long-standing, well-paid employee in a managerial position. Given the apology’s emphasis on the manner of termination and the subsequent statement by CAMH reaffirming its decision to close the clinic because of its approach to care, I would caution against interpreting the settlement as a vindication of Zucker’s and the clinic’s practices.

Regardless of the legal reasons behind the settlement, many people interpreted it as evidence that critics of the clinic were politically motivated bullies seeking to suppress science. Given the volatile context in which the clinic was closed, CAMH’s handling of the closure and its subsequent settlement with Zucker may well have done a disservice to trans youth. However, characterizing the sustained critiques levied towards the clinic as emotions over reason does not appear to be justified. Emotions do run high, and, as Tey Meadow notes, “[f]or many trans activists, Ken [Zucker] and CAMH represented the pathologizing impulses of past psychiatric practice.”<sup>29</sup> It is plausible that Zucker, because of his prominence and influence within the scientific community, was disproportionately targeted by criticisms. Zucker is far from being the sole proponent of the corrective approach. Those who have criticized him and his work have not always been measured in their words. However, that does not mean that the critics are wrong. Critiques of the corrective approach find support in clinical and ethical reasoning and began appearing in the scientific literature over a decade before the clinic’s closure.<sup>30</sup> To detractors, as Jake Pyne explains, the debate surrounding the corrective approach simply “no longer qualifies as a true debate,” and a clear consensus has emerged against practices that seek to “correct” gender variance in favour of the gender-affirmative approach.<sup>31</sup>

Depicting the debate as a clash between professionals and trans activists is inaccurate. Within trans communities, some of the most vocal

opponents of the clinic's practices have been scientists and academics.<sup>32</sup> For instance, Pyne is a professor of social work who contributed to the TransPULSE research project in Ontario and held the prestigious Trudeau Doctoral Scholarship and Banting Postdoctoral Fellowship. Jemma Tosh holds a doctorate in psychology and has authored multiple peer-reviewed publications, many of which were on trans issues. Julia Serano holds a doctorate in biochemistry and molecular biophysics from Columbia University and has conducted extensive scientific research on genetics and developmental and evolutionary biology at University of California, Berkeley. Their critiques in the public realm were grounded in expertise and published in scholarly journals and books.<sup>33</sup> Pyne, Tosh, and Serano are joined by countless cis academics who similarly see significant flaws in the corrective approach. The gender-affirmative approach, now the leading approach to trans youth care, was developed in parallel to critiques of the corrective approach. Scientific knowledge, clinical experience, and community wisdom have all played crucial roles in the formulation of critiques of the corrective approach practised at the CAMH clinic.

Ideology played a role in the closure of the CAMH clinic, but it would be a mistake to characterize controversies over the clinic's practices as an opposition between ideology and science. Debates over therapeutic ethics are not value-neutral. Choosing an ethical framework within which to evaluate practices is a value-laden exercise. Someone who is guided by a desire to avoid people being trans because they see being trans as a form of mental illness is likely to reach different conclusions from the available data than someone who sees being trans as a benign human variation and sees transition as an equally acceptable life path. The controversy in many ways mirrors the controversy over the place of homosexuality within the *Diagnostic and Statistical Manual of Mental Disorders*, which was similarly characterized as "a value judgment about heterosexuality, rather than a factual dispute about homosexuality."<sup>34</sup> Given the intertwined nature of ethical judgment and clinical practice, it would be more accurate to depict the controversy as one arising between different schools of thought on trans therapeutics.<sup>35</sup> The clinic and its clinicians' desire to prevent adult trans outcomes was criticized by trans communities and trans-affirmative clinicians for being harmful to gender-creative youth and grounded in prejudiced conceptions of

trans existence. The clinic defended its view by referring to long-standing theorizations of the corrective approach.

The closure of the CAMH clinic in the wake of Ontario's Bill 77 stands as a testament to both the potential and limits of prohibiting conversion practices. It shows that these laws have some bite, even outside of the courts. Bans can discourage conversion practices not only through legal enforcement but also by encouraging peer accountability between professionals and fostering the development of an affirmative professional culture. While the external review of the CAMH clinic's services may have been partly motivated by the upcoming legal ban, it ultimately did not matter whether the practices fell under the scope of Bill 77 since the CAMH administration could dictate how the services should be rendered. On the other hand, the unclear scope of the law enabled the clinic staff's belief that it did not apply to their approach and freed them to fan out into private practice once the clinic closed. If their approach indeed constituted a conversion practice, this outcome is far from optimal.

The clinic's closure and surrounding controversy highlight some of the key fault lines of policy-making about trans conversion practices. It is one thing to ban conversion practices. It is quite another thing to effectively discourage them. Throughout this book, the need for clearer, more detailed bans and the importance of bolstering bans by developing an affirmative professional culture will be recurring themes. Clarifying our picture of what counts as trans conversion practices and how to best ban them is crucial to enlightened, effective policy-making.



Trans conversion practices refer to a range of practices seeking to discourage behaviours associated with a gender other than the person's sex assigned at birth and/or to promote gender identities that are aligned with their sex assigned at birth. They take many forms, including behavioural therapy, psychodynamic therapy, parental counselling, and interventions in a naturalistic environment.<sup>36</sup> These practices are recognized as harmful and unethical by professional, scientific, and human rights organizations. Trans conversion practices typically begin with the premise that there is something disordered, wrong, and/or undesirable about being trans

or gender creative. From the premise that there is something wrong or undesirable about being trans, proponents of conversion practices conclude that they should prevent people from being trans and transitioning socially or medically to live in their desired body and gender.

For many of those who were subjected to unrelenting attempts to alter, repress, or discourage their gender identity, trans conversion practices carry the resounding promise of life-long psychological distress. Dr. Sé Sullivan, a survivor of conversion practices, explained:

My “treatment” included stigmatizing me through a medical model of “illness,” which bore far-reaching consequences in my life. ... The psychological “treatment” I had as a child did not have my best interests at heart. It was child abuse. I developed coping mechanisms of protecting myself by hurting others before they could hurt me. Anger, fighting, sex, and drugs were the best tools I found for this. These same behaviors I used as mechanisms of defense eventually created damage of their own in both my youth and adult life. Self-loathing and shame guided all of my decisions and suicide became a frequent thought. ... As an adult, I struggle with depression, self-care, and have considered suicide over the years, including during this research project.<sup>37</sup>

Sociologist Karl Bryant spoke in similar terms about his experience of trans conversion practices: “The study and the therapy that I received made me feel that I was wrong, that something about me at my core was bad, and instilled in me a sense of shame that stayed with me for a long time afterward.”<sup>38</sup> I discuss the nature of trans conversion practices and what they include at greater length in [Chapter 1](#).

The harms of conversion practices can be understood from multiple angles. Most gravely, conversion practices persistently invalidate a core aspect of one’s personal identity and self-knowledge. People who experience conversion practices learn to be ashamed of themselves and of who they are, leading to anxiety, depression, and suicidality. For youths whose parents are involved in the conversion practices, the practices can have severe repercussions on family attachment, which is closely tied to long-term mental health outcomes, especially among marginalized

communities that may find less support within the broader society.<sup>39</sup> Conversion practices also tend to delay social and medical transition, condemning trans people who experience significant gender dysphoria to the experience of ongoing suffering.<sup>40</sup> For those who undergo conversion practices before or during puberty, this can mean undergoing undesired, difficult-to-reverse, and deeply distressing bodily changes. While not all trans people experience gender dysphoria or wish to medically transition, many do, and withholding medical transition causes part of the harms of conversion practices. So harmful are conversion practices that researchers, international bodies, and survivors often liken them to torture.<sup>41</sup>

The harm of conversion practices is borne out in quantitative research. The harms of conversion practices compound the already extreme levels of harassment, discrimination, and violence suffered by trans communities. Overall, within trans communities, 39 percent have experienced psychological distress in the last month, 48 percent had serious suicidal ideations in the last year, 7 percent attempted suicide in the last year, and 40 percent attempted suicide at some point in their lifetime.<sup>42</sup> A study by Jack Turban and colleagues has found that trans people who experienced attempts to change their gender identity greatly increased the rate of severe psychological distress, suicidal ideations, and suicide attempts long after being subjected to them.<sup>43</sup> Compared to those who did not have such experiences, trans people who had experienced trans conversion practices were 1.56 times more likely to have experienced severe psychological distress in the last month, 1.52 times more likely to have planned suicide in the last year, 1.49 times more likely to have attempted suicide in the last year, and 2.27 times more likely to have attempted suicide in their lifetime. For those who experienced conversion practices before the age of ten years old, the numbers are even grimmer. They were 1.75 times more likely to have experienced severe psychological distress in the last month, 2.82 times more likely to have planned suicide in the last year, 2.40 times more likely to have attempted suicide in the last year, and 4.15 times more likely to have attempted suicide in their lifetime. Similar outcomes were reported in a study by Amy Green and colleagues.<sup>44</sup>

That is a lot of numbers. I spell them out to emphasize how pervasive and severe the harms of trans conversion practices are. And those

numbers only capture the starkest of harms – recent severe psychological distress and suicidality. Those who have already healed with the help of therapy and social support and those who were hurt by conversion practices albeit not to the point of suicide are simply not captured by those numbers. While not everyone who experiences conversion practices will be gravely and irremediably harmed by them, it simply cannot be acceptable for practitioners to sacrifice their patients to demonstrably dangerous, degrading practices.

While patients are those most harmed by trans conversion practices, the harm does not stop there. As a transfeminine scholar, I am intimately cognizant of the disastrous reverberations of trans conversion practices on trans communities writ large. Trans conversion practices are part of a larger social project of oppressing and discrediting trans communities. The open engagement in conversion practices, especially by people in positions of authority, gives an air of legitimacy to antagonistic attitudes towards trans communities. It depicts being trans as a mental illness and something to be avoided, two common beliefs in mainstream society that underpin harassment, discrimination, and violence against trans people.<sup>45</sup> Conversion practices symbolize and perpetuate the devaluation of trans lives. Trans conversion practices are fundamentally transantagonistic – that is to say, they are intolerant, prejudiced, hostile, and discriminatory towards trans people. As the sociological theory of symbolic interactionism teaches us, humans lead fundamentally symbolic lives.<sup>46</sup> Through interactions, humans (re-)create symbols and shape the social imaginary, which we then use to arrange and direct our lives. Trans conversion practices symbolize the dehumanization and devaluation of trans people, which takes a significant psychological toll on many members of trans communities, myself included.<sup>47</sup> Indeed, working on this book was difficult for me as I had to read countless articles expressing such negative attitudes towards trans people.

As the closure of the CAMH clinic demonstrates, trans conversion practices are an ongoing concern in Canadian healthcare. Yet people often react with utter shock when I tell them that conversion practices are still common. In the United States, 13.5 percent of trans adults reported being subjected to conversion practices, a number that climbed to 18 percent among those who discussed their gender identity with a

professional.<sup>48</sup> Recent Canadian studies found that between 11 and 19 percent of trans people had experienced conversion practices.<sup>49</sup> Despite public concern over conversion practices often being limited to minors, recent studies show that conversion practices are common across all age groups. In terms of age, around half of individuals experience conversion practices before they reach the age of eighteen and the other half at or after the age of eighteen, with estimates varying by country.<sup>50</sup>

The leading trans health organization worldwide, the World Professional Association for Transgender Health, affirms that “[t]reatment aimed at trying to change a person’s gender identity and expression to become more congruent with sex assigned at birth [is] no longer considered ethical.”<sup>51</sup> Countless leading professional associations have come out in opposition to trans conversion practices, and, recently, the United Nations Independent Expert on Sexual Orientation and Gender Identity called on governments to ban conversion practices.<sup>52</sup> The professional consensus is clear. But even though conversion practices have fallen into disfavour within trans health, many licensed professionals nonetheless engage in them, and a faction of indomitable therapists and theorists continue to profess their commitment to the corrective approach, an approach that was used at the defunct CAMH clinic and that seeks to prevent children from growing up transgender. Conversion practices appear not only more common among trans people than cisgender queer people, but they also seem more likely to be done by licensed professionals. Internationally and in Canada, between a third and half of all conversion practices are by a licensed professional.<sup>53</sup> Data from the United States suggests that, among trans survivors, close to two-thirds have experienced conversion practices at the hands of a licensed professional.<sup>54</sup>

It is easy to dismiss trans conversion practices as an antiquated, dying approach in a world that is rapidly growing more accepting of trans people. However, the reality is far different. In recent years, we have seen a resurgence of advocacy in favour of trans conversion practices. With the rising visibility of trans communities came a backlash against trans youth care. Anti-trans voices allege that society is in the midst of an unprecedented epidemic of youth falsely believing themselves to be transgender due to “social contagion” and unexamined mental illness and

trauma. These allegations are spurious and wholly disconnected from the evidence. No data support the view that there is social contagion of any kind, and the rapid growth in referrals to gender identity clinics is most likely attributable to a growing public awareness of trans realities and the possibility of medical transition.<sup>55</sup> In other words, more and more people are realizing that being trans is a normal, healthy thing and that services exist to help those who wish to medically transition.

In a similar vein, some transantagonistic groups and academics have claimed that most trans children grow up to identify with the gender they were assigned at birth and that we should therefore encourage this reidentification. However, the argument is based on flawed studies that do not adequately distinguish between gender non-conforming and trans children.<sup>56</sup> Whereas trans children identify with a gender other than the one they were assigned at birth, gender non-conforming children who are not transgender identify with the gender they were assigned at birth but encroach on the social norms and expectations associated with it. Contrary to the argument, studies show that trans children and adolescents know themselves and their gender and that regret and re-transition are rare – between 0 percent and 3.8 percent – with larger studies often reporting regret and/or re-transition rates below 1 percent.<sup>57</sup> But however flawed the arguments may be, they are still being used to breathe new life into conversion practices by portraying being trans and transitioning as an undesirable, pathological outcome that should be discouraged.

As trans people become more visible, a backlash can be felt. As I write these words, conservative legislators in the United States are introducing bills to criminalize offering minors gender-affirming medical care, despite medical transition being recognized as the best practice for trans youth who desire it.<sup>58</sup> In the United Kingdom and Canada, we are seeing attempts to curtail access to medical transition for minors, led by people who view trans youth as mentally ill.<sup>59</sup> These efforts have been met with some success in the United Kingdom, where the trial decision in *Bell v Tavistock* required a court application to initiate puberty blockers.<sup>60</sup> The decision is being appealed. The same groups that are pushing for these rollbacks are often also advocating against anti-discrimination protections and trans-inclusive policies, notably when it comes to trans women's inclusion in sports and access to public facilities.<sup>61</sup> Anti-trans groups are



actively pushing for the exclusion of trans people from the protection of bans on conversion practices, arguing that gender-affirmative care is dangerous, that youths are falsely believing themselves to be trans, and that, if anything, trans conversion practices should be encouraged. We have seen this phenomenon in Canada. When the federal government proposed Bill C-6, *An Act to Amend the Criminal Code (Conversion Therapy)*, to criminalize conversion practices, a deluge of submissions urged them to remove the protection of gender identity under the law, relying on unscientific tropes and transantagonistic philosophies to prop up their position.<sup>62</sup> They argued that conversion practices targeting cisgender queer people were unethical but that those targeting trans people were not. To many of those individuals, being queer was fine, but being trans was not. By contrast, professional and community organizations were overwhelmingly in favour of including trans people under the protective fold of the law.

As these transantagonistic philosophies and movements grow in cultural prominence in all areas of social life, we will likely see a resurgence of trans conversion practices under the guise of protecting trans people against themselves. As jurisdictions worldwide turn to ban conversion practices, they must consider the prevailing landscape of anti-trans animosity and tailor their bans to ensure adequate protections for trans people. Bans on conversion practices are not a rote expression of disapproval towards a bygone practice. Trans conversion practices are alive and continue to threaten trans well-being. Effective bans on trans conversion practices are more important than ever.

In 2015, Ontario became the first Canadian province to prohibit conversion practices; the legislature acting in response to professional bodies' failure to protect trans youth.<sup>63</sup> At the federal level, the government has recently adopted Bill C-4, criminalizing conversion practices across Canada.<sup>64</sup> The federal government initially rejected the suggestion of criminalizing conversion practices, arguing that the provinces were better positioned to discourage them, but it reverted course after a report from the House of Commons Standing Committee on Health recommended legislative action at the federal level.<sup>65</sup> Trans voices have been integral to this legislative push. Erika Muse, a trans woman who testified to experiencing conversion practices at the CAMH clinic, has played an

integral role concerning both the Ontarian and federal bans.<sup>66</sup> Survivors of conversion practices have also made their voices and needs heard through grassroots coalitions such as No Conversion Canada.<sup>67</sup> In contrast to other jurisdictions where practices targeting sexual orientation have been the primary, if not the sole, focus of legislators, the Ontario ban and Canadian federal bill stand out by demonstrating serious concern, however imperfect, for the well-being of trans communities. However, even bans that were not adopted out of explicit concern over trans conversion practices usually include protections for gender identity and/or expression, recognizing the harmfulness of trans conversion practices and the deeply intertwined, inseparable histories of conversion practices targeting sexual orientation and gender identity.<sup>68</sup>

As a jurist, a bioethicist, and a concerned member of trans communities, I am interested in how bans on trans conversion practices work. What does a standard ban look like and what is its scope? What are the different variants that these laws take? Do these laws stand up to constitutional scrutiny? What are the advantages and disadvantages of legislative approaches to trans conversion practices? How may we improve (upon) them? These questions animate my writing. My goal in writing this book is to guide jurists, policy-makers, healthcare professionals, scholars, and advocates in their thinking about how to best ban conversion practices. I take as my starting point that trans conversion practices ought to be eliminated and that bans on trans conversion practices, although not a panacea, contribute towards that goal. Ebbing and flowing between interpretive, comparative, constitutional, policy, and sociological analysis, I attempt to unearth what bans on conversion practices do and how we can make them more effective.

I approach my research and writing from an openly trans-affirmative stance. Rather than extensively arguing that transantagonism is wrong – that it is wrong to seek to prevent people from being trans – I take it as a guiding premise of my book. My trans-affirmative stance is a by-product of my identity as a transfeminine scholar. An intimate understanding of the topic shapes my writing. I know that being trans is no ill and that it is no evil to be avoided. I know that being trans and living in community with other trans people is a desirable life, one that ought not to be discouraged. Much ink has been spilled debating whether trans

conversion practices are wrong, and I do not attempt to exhaustively revisit those debates.<sup>69</sup> I write to those who already desire to eliminate trans conversion practices and wish to know how to best do so. Those readers who are curious about ethical and scientific debates surrounding trans conversion practices will nonetheless find extensive references to the relevant literature throughout the book and may be interested to read my other work on the topic.<sup>70</sup> Because of my trans-affirmative outlook and the trust that members of trans communities have in my work, I have benefited from the confidences and insights of individuals who have undergone trans conversion practices throughout the research and writing process. Their experiences have guided my process. I am grateful for survivors' teachings, and I hope to do them justice. The book would have been greatly lacking without their perspectives.

The book primarily focuses on the regulation of licensed professionals. While I am also attuned to the importance of discouraging conversion practices, I chose to focus on licensed professionals because I understand the law as an enabler of behaviour. Half or more of trans conversion practices are deployed by licensed professionals. Few psychiatrists, psychologists, and social workers could keep up a thriving practice without their membership in professional associations. Membership serves as a gauge of competence and authority for members of the public. Trans people and/or their parents are likely to seek out licensed professionals in good standing when seeking out information and support. They are often lost and blame themselves for their, or their child's, gender identity and non-conforming behaviour.<sup>71</sup> This context can make them unable to critically reflect or push back against the approach that practitioners propose, making them particularly vulnerable to the pull of authority. Yet the very licensure that exacerbates conversion practices can also serve to undermine them. By operating within the law – within licensure schemes that grant them social authority – conversion practitioners open themselves up to legal regulation and professional pressures. Just as the law can enable conversion practices, it can also be used to prevent harmful professional behaviour.

I write this book as a Canadian transfeminine scholar. I was trained in Canadian law and primarily derive my knowledge of trans health and issues from scholarship and community knowledge that emerges

out of the English-speaking and French-speaking Global North. This positionality informs and limits my writing. When engaging in legal analysis throughout the book, I focus on Canadian law and, to a lesser extent, US law. Although I strive to generate generalizable knowledge that goes beyond jurisdictional idiosyncrasies, notably by engaging in comparative analysis, readers should remain aware of these limitations and how they may bias my analysis or limit its generalizability.

The book's greatest contribution to policy-making and the scholarly literature on the regulation of conversion practices lies in its suggestion of how to improve (upon) bans, which are explored in [Chapters 6 and 7](#). I propose a two-pronged approach to discouraging conversion practices, which should be implemented in close collaboration with survivor communities. My proposed approach builds upon a twofold insight. The first insight is that self-regulation and peer accountability among professionals is difficult, if not impossible, unless the professionals know what behaviours are prohibited by the law. As we saw with the CAMH clinic, existing bans often leave substantial doubt as to their scope. Bans should be drafted under a pedagogical ethos that aims to clearly and comprehensively set out the prohibited behaviours. People should be able to tell, as much as possible, whether a practice is prohibited without going through an entire, lengthy trial. The second insight is that bans are not enough and may be bolstered by intervening at the level of professional culture. By integrating a thorough appreciation of the importance of gender-affirming care and the harmfulness of trans conversion practices within professional identity, we can change professional culture and further discourage conversion practices. My two-pronged approach offers guidance to policy-makers and professional organizations, guidance that will further the fight against trans conversion practices.

The book is divided into seven chapters. [Chapter 1](#) sets out to define the notion of trans conversion practices and answers whether the corrective approach used at the CAMH clinic is a form of conversion practice. This chapter sets out the essential groundwork for the rest of the book. [Chapter 2](#) elucidates the scope of laws prohibiting trans conversion practices by taking the Ontario Bill 77 as an example. The chapter will be of greatest interest to trans health clinicians who wish to know what behaviour is prohibited by the law as well as lawyers and judges tasked with interpreting bans.

**Chapter 3** delves into the diversity of bans at the international level, offering a comparative overview that groups laws based on textual lineage and sanctions to emphasize the similarities and differences between different bans. This overview not only helps tease out the extent to which the analysis found in **Chapter 2** applies to other jurisdictions but also serves as a basis for analyzing the pros and cons of bans in **Chapter 5**. The chapter will be of greatest interest to lawyers and judges who are interpreting bans as well as policy-makers curious to know how other jurisdictions have drafted their bans.

**Chapter 4** analyzes the political and constitutional arguments being deployed against bans on trans conversion practices. In it, I consider and rebut the suggestion that bans violate therapists' freedom of expression, that they are overbroad, and that they are contrary to familial religious freedom and parental authority. While centring on Canadian and US legal knowledge in rebutting these arguments, I nevertheless strive to analyze the arguments from a general standpoint that does not overly rely on the jurisdictional particularities of Canadian and US law. The chapter will be of greatest interest to advocates and policy-makers who desire to ensure that proposed bans pass constitutional muster as well as lawyers and judges faced with a contemplated or actual legal challenge.

**Chapter 5** investigates the benefits and limitations of legislative bans on trans conversion practices. Although they have had some success in altering professional practices and have an undeniable symbolic reach, existing bans retain significant limitations. Bans are often restricted based on age and the appearance of consent. They are often insufficiently detailed. When drafted as criminal laws, they may raise additional evidentiary difficulties, disempower survivors, and contribute to the expansion of the carceral state. Bans are often limited to regulated professionals and may cause professional resentment in traditionally self-regulating professions. Bans frequently fail to provide for proper compensation of survivors and do not adequately prevent funding of conversion practices. Furthermore, many legislatures simply may be unwilling to pass bans. Taken together, these limits suggest the need for not only better bans but also multifaceted approaches that go beyond bans. This chapter will be of greatest interest to advocates and policy-makers who wish to promote measures that are most likely to discourage conversion practices.

**Chapter 6** answers the call of the preceding chapter, delving into the reasons why existing bans fail to thoroughly alter professional practice. Drawing on the sociology of professions and moral psychology, I explain that effectively discouraging trans conversion practices among professionals requires (1) the creation of laws and/or professional guidelines that clearly and comprehensively identify what counts as a conversion practice; (2) the adoption of educational initiatives that integrate gender-affirming care and opposition to conversion practices in professional identity; and (3) the development of accountability structures that ensure the visible oversight and enforcement of bans on conversion practices. This chapter will be most interesting to healthcare professionals, advocates, and policy-makers who wish to supplement bans with other effective measures for abating conversion practices.

**Chapter 7** synthesizes the teachings of the previous chapters as well as my in-depth knowledge of trans health to propose a model law for prohibiting conversion practices. The model law's distinctive features are its comprehensiveness and level of detail, as it builds on the understanding that insufficiently detailed laws are a barrier to effective self-enforcement and mutual accountability. This chapter includes lengthy annotations on each part of the model law, explaining the purpose and rationale behind every provision. It will be most interesting to policy-makers who wish to adopt as effective a ban as possible as well as lawyers, judges, and healthcare professionals who are interested in the scope that bans should have.

In addition to the seven chapters, the book contains an appendix listing statements from professional organizations that oppose trans conversion practices as well as a selection of excerpts. The list highlights the overwhelming condemnation of trans conversion practices, emphasizing the importance of bans. A glossary of terms related to trans issues and conversion practices is also included at the end of the book.

My deepest wish is for this book to support the work of those who are fighting against trans conversion practices and, in so doing, contribute to their elimination. These harmful and degrading practices have no place in our societies. They are a blight on the riches that trans people bring to the world. Trans people deserve to be respected and valued as they are.

Let's get down to business.<sup>72</sup>

# What Are Trans Conversion Practices? 1

Much of the decades-long controversy surrounding the Centre for Addiction and Mental Health (CAMH) Gender Identity Clinic for Children and Youth centred on the question of whether its approach, which I call the corrective approach, is a form of conversion practice. Disagreement abounds as to what is, or what should be, considered a conversion practice. These disagreements reverberate in the public sphere since the term “conversion practices” (and other related expressions) carries significant political weight. To engage in conversion practices is to do something that, in the eyes of most, is objectionable. In the introduction, I have suggested that the CAMH clinic engaged in conversion practices. What did I mean when I said that? This chapter lays the terminological groundwork for the rest of the book by answering these questions: what are conversion practices and do they include the corrective approach, which aims at preventing youth from growing up trans? As the following section explains, trans conversion practices should be understood as sustained efforts to promote gender identities that are aligned with one’s sex assigned at birth and/or to discourage behaviours associated with a gender other than the one assigned at birth. Applying this definition, it is clear that the corrective approach that was employed at CAMH is a form of conversion practice.

## Defining Trans Conversion Practices

Various definitions of conversion practices have been offered in the literature, though few have been extensively discussed, explained, and defended. Most commonly, the definitions foreground the attempt, through psychological intervention, to change gender identity and expression.<sup>1</sup> The definition often encompasses gender identity and sexual orientation.<sup>2</sup> After reviewing the limits of the existing definitions, I propose the one mentioned in the preceding paragraph. Definitions for conversion practices often focus on change to gender identity (or sexual orientation) and, in doing so, fail to accurately capture and communicate the practices' harm. Conversion practices often target gender-creative children not only because they may grow up to be transgender but also because their gender non-conformity is understood to indicate, or be constitutive of, being psychologically disordered. When I speak of gender-creative youth, I am referring to young people, especially of a prepubertal age, who exhibit strong, ongoing behaviour patterns associated with a gender other than the one they were assigned at birth. They are also called gender independent, gender variant, gender expansive, and gender diverse. Gender-creative youths who undergo conversion practices are routinely made to feel broken or wrong for being as they are, with practitioners acting as if they are trying to repair or fix them – as the alternative moniker “reparative therapy” suggests. It may be more helpful to understand conversion practices not as an attempt to convert gender identity or sexual orientation but, rather, to convert them into gender-normative subjects. Because they cast gender creativity as undesirable, trans conversion practices seek to promote identification with one's sex assigned at birth and to discourage behaviours that are associated with a different sex assigned at birth. In the conversion literature, queerness is traditionally viewed as a failure of masculinity or femininity – a “gender role problem.”<sup>3</sup> Framing the issue around changes to gender identity fails to encapsulate the harm done to youth whose gender identities are difficult to identify and risks obscuring the harm of trans conversion practices to those gender-creative youth who grow up to be cisgender.

We often do not know how people, and especially children, identify. Although affirmations of gender by youth such as “I am a girl” are more strongly associated with growing up trans than statements such as



“I want to be a girl,” distinguishing between the two types of affirmation is not a perfect litmus test.<sup>4</sup> Children repeatedly told by parents that they are of a certain gender (“you’re a boy!”) or taught that gender is based on anatomy (“girls have vaginas, boys have penises!”) may internalize parental teachings and couch their gender identity as “I want to be” rather than “I am.”<sup>5</sup> Conversely, and even though this phenomenon remains rare, children assigned male at birth who are prevented from wearing dresses and told that “dresses are for girls” may tell their parents “I am a girl” because they want to wear dresses. Only with further conversation can we clarify what the child means.

Even if we assume that people have a well-defined gender identity, which I do not believe to always be the case,<sup>6</sup> our ability to identify that gender identity is imperfect.<sup>7</sup> Practitioners must have a big-picture understanding of the child’s familial and social context to adequately interpret the language of gender-creative children in less clear-cut cases. Children do not always speak the same language as adults. Focusing on change fails to account for practices applied to youth whose gender identity is ambiguous. We must hold space for those cases by focusing on the fact that gender creativity – which includes people whose gender identities remain unclear or undetermined – is seen as disorderly and warranting intervention and targeted for conversion into normativity. By shifting the focus from gender identity changes to the psychopathologization of gender creativity, we may avoid unnecessary debates as to the true meaning of individual children’s affirmations and instead focus on the pressure to identify with one’s sex assigned at birth.

Focusing on changes to gender identity risks erasing the harm of conversion practices on those who do not grow up to be trans. Not all gender-creative children express a gender identity that differs from the one they were assigned at birth. Not all of them grow up to be trans. Many children assigned male at birth who wear dresses grow up to be cis gay men. Even those who are diagnosed with either Gender Identity Disorder under the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* or Gender Dysphoria under the fifth edition of the same book sometimes identify with the gender they were assigned at birth.<sup>8</sup> According to Diane Ehrensaft, some “protogay” children “find

themselves exploring gender on the way to affirming their sexual orientation identities.”<sup>9</sup>

Trans conversion practices are frequently applied indiscriminately to all gender-creative children – many of whom cannot reasonably be labelled trans. I call them “trans” conversion practices to draw attention to their goal of avoiding trans outcomes. I do not intend to suggest that only those who are trans or who would grow up to be trans are targeted and/or harmed. Children who do not grow up to be trans are also harmed by conversion practices. Karl Bryant, a cisgender sociologist who was a patient of the University of California Los Angeles Gender Identity Clinic, explains that “it’s hard to overstate the harm that [knowing others see you as disordered for being gender creative] can inflict.”<sup>10</sup> Being told that you are wrong in some fundamental sense because of your gender non-conformity is harmful, regardless of whether you are trans or not.

In his academic work, Bryant has also highlighted the close relationship between gay and trans conversion practices, helping us understand why the latter may be deeply harmful to children who grow up to be cisgender and gay.<sup>11</sup> Rather than replacing homoantagonism with transantagonism, trans conversion practices involve a symbiotic relationship between homoantagonism and transantagonism that places gender-conforming cisgender lives at the top of the hierarchy of desired outcomes (often regardless of whether they are straight or not), to the detriment of gender non-conforming cisgender and transgender lives.<sup>12</sup> Because gender non-conforming cisgender people are often gay, trans conversion practices disproportionately impact cisgender gay individuals compared to cisgender straight ones. Defining trans conversion practices solely by the purpose of changing gender identity – neglecting how they target behaviour – underestimates their harm since they are also harmful to children who are not trans and will not grow up to be trans. Our definition must be adapted to account for these experiences.

In response to the problems with defining trans conversion practices around change, other theorists have proposed definitions that centre on the prevention of transgender identification and of gender non-conforming behaviour.<sup>13</sup> Julia Temple Newhook and colleagues offer a nuanced definition of conversion practices, highlighting that it originally referred to faith-based practices that sought to change sexual orientation

but has expanded in recent years to include practices that seek to change gender identity or promote a preferred gender identity outcome.<sup>14</sup> Their definition better captures the goals of conversion practices – such as the promotion of preferred gender identity outcomes – and acknowledges the historicity of language. Unspoken in the definition is the shared understanding that the preferred gender identity outcome is aligned with the child’s sex assigned at birth – we would not typically speak of conversion practices if someone were trying to make children trans. This distinction is important given the possible ethical differences between encouraging conformity to social norms and discouraging it. Individuals are subject to societal pressures towards conformity, and encouraging conformity reinforces those pressures whereas discouraging conformity provides an alternative and counterweight to them. Actively promoting trans outcomes, although ethically questionable, would not typically be seen as conversion practices.

Building upon previous attempts to define conversion practices and the limitations of focusing on changes to gender identity, I propose the following definition of trans conversion practices. Trans conversion practices refer to sustained efforts to promote gender identities that are aligned with the person’s sex assigned at birth and/or to discourage behaviours associated with a gender other than the person’s sex assigned at birth. Trans conversion practices are not exclusively practised on trans people and are often applied to people exhibiting gender non-conforming behaviour independently of gender identity.<sup>15</sup> The belief that being trans or gender creative is undesirable underpins the practices and often comes hand in hand with the belief that being trans or gender creative is pathological. Trans conversion practices take many forms, including behavioural therapy, psychodynamic therapy, parental counselling, and interventions in a naturalistic environment.<sup>16</sup> Play psychotherapy, limit setting on gender non-conforming behaviour, and the encouragement of peer relations with children of the same sex assigned at birth are commonly used in contemporary forms of conversion practices.

### **Is the Corrective Approach a Conversion Practice?**

How far does the notion of conversion practices extend? Does it extend to all practices that seek to discourage being trans or reducing the likelihood

of growing up trans? The corrective approach, which was promulgated by clinicians at the now closed CAMH clinic, featured prominently in the Canadian conversation on trans conversion practices and in Ontario's Bill 77, the *Affirming Sexual Orientation and Gender Identity Act*.<sup>17</sup> Also known as the psychotherapeutic, therapeutic, or pathological response approach, it has long played a prominent role in trans health and continues to be defended today.<sup>18</sup> I chose to call it the corrective approach to avoid the positive connotations of "therapeutic" and because the term pithily encapsulates its motivation: to "correct" gender creative children's identities and/or behaviours. Does the corrective approach fall under the umbrella of conversion practices? If it does, as I suggest in this section, then it is a mark of quality for bans on conversion practices to prohibit it.

Whether the corrective approach amounts to conversion practices has been controversial in the academic literature. Opponents of the approach have frequently likened it to conversion practices, whereas proponents of the approach have denied the accusations.<sup>19</sup> The corrective approach is directed towards gender-creative youth: its proponents adopt different approaches for children, adolescents, and adults. The belief that gender identity is malleable in children but typically not in adolescents and adults underpins the division into three groups.<sup>20</sup> However, the belief that corrective approaches should not be directed at adolescents and adults is not an unwavering commitment. Challenging adolescents' and adults' gender identity and delaying transition are often predicated on the same view that being transgender is pathological and that transition should be avoided as much as possible. Debates on the proposed developmental pathway of "rapid-onset gender dysphoria," which purports that youth are coming out as trans out of the blue due to "social contagion," have additionally hinted at an expansion of conversion practices to adolescents, and some authors have recently argued in favour of allowing conversion practices for adults.<sup>21</sup>

The goal of the corrective approach is to "cure" or "correct" trans and gender creative youth. According to a recent chapter co-authored by Jack Turban, Annelou L.C. de Vries, and Kenneth Zucker, this approach seeks "to reduce the child's cross-gender identification and gender dysphoria" and to "facilitate a gender identity that is more congruent with the patient's [sex assigned at birth]" through psychosocial interventions.<sup>22</sup>

The work of Susan J. Bradley and Kenneth Zucker, closely associated with the corrective approach, identifies the prevention of adult trans outcomes as one justification for the approach. They state that “prevention of transsexualism in adulthood [is] so obviously clinically valid and consistent with the ethics of our time that they constitute sufficient justification for therapeutic intervention.”<sup>23</sup> Other justifications include the elimination of peer ostracism through enforced gender conformity and the treatment of other mental illnesses.<sup>24</sup> The reference to “other” mental illnesses in the context of the corrective approach is explained by its underlying view that gender variance and transitude have pathological foundations. As aptly summarized by Turban and Ehrensaft, “[t]his treatment approach presumes cisgender identification to be desirable, preventing the future need for hormonal intervention and protecting the child from the stigma of being a transgender individual.”<sup>25</sup>

The proposed descriptions for the approach have evolved and become more nuanced. Current explanations of the approach often centre on wanting children to become comfortable in their skin and in the gender/sex they were assigned at birth, a description that has demonstrated considerable staying power over the last few decades.<sup>26</sup> Though rarely stating outright that the aim is to prevent adult trans outcomes, proponents of the approach nonetheless note that they find no “particular quarrel with the prevention of transsexualism as a treatment goal for children.”<sup>27</sup> Of course, comfort in one’s body and gender/sex assigned at birth is little better as a goal. Ultimately, it is just another way of saying that they do not want children to be trans or to grow up to be trans. Despite evolving descriptions, the corrective approach remains intent on reducing “the likelihood of [Gender Identity Disorder] persistence.”<sup>28</sup> The reduction in distress and discomfort towards gendered bodily features brought about by gender transition does not seem to satisfy the proponents of the corrective approach.<sup>29</sup> According to the corrective approach, Gender Dysphoria – as a diagnosis under the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* – remains a clinical problem even though people who have transitioned may lead perfectly happy lives free of distress towards their bodies. Gender Dysphoria (and, before it, Gender Identity Disorder) not only persists if there is ongoing distress towards one’s body but also if the person would be distressed if they

had not medically transitioned.<sup>30</sup> Under this logic, reducing the likelihood of Gender Dysphoria (or Gender Identity Disorder) persisting is essentially the same as reducing the likelihood of someone continuing to be trans. As sociologist Tey Meadow explains, the corrective approach holds that “short of psychologically damaging treatments, children should be encouraged to avoid transition if at all possible.”<sup>31</sup> Unfortunately, proponents of the approach do not believe that it is tantamount to psychologically damaging treatment. Nor do they place much weight on its inherently demeaning nature for transgender people.

The corrective approach departs from prominent forms of trans conversion practices that have preceded it, which used a classic behavioural approach to change children’s behaviours and identities. Proponents of the corrective approach are critical of classical behavioural therapy. However, they are critical of it not because behavioural therapy, and especially aversion therapies, may be harmful and degrading but, rather, because targeting behaviours alone may not “fully alter internal gender schemas” and children could “revert to their cross-gender behavioural preferences in the absence of external cues or incentives.”<sup>32</sup> Instead, they rely on regular play psychotherapy, parent counselling, and parental limit setting on gender non-conforming behaviour.<sup>33</sup> The identification of factors that are said to contribute to gender identity and gender non-conformity also plays a crucial role in the treatment plan, with parents (and especially mothers) frequently being identified as a contributing cause of gender creativity in children.<sup>34</sup>

As Meadow explains, contrasting older approaches to the more recent gender-affirmative model,

[b]efore the emergence of the trans child as a recognizable social category, psychiatry enlisted a binaristic understanding of gender development; on the one hand, there was normative gender, scaffolded by appropriate heterosexual dyadic parenting, and on the other, there was disordered gender. Disordered gender, whether underwritten by deficient parenting or psychopathology, was, in effect, a misperception on the part of the child about the relationship between body and psyche. It was a simple, dichotomous system. Children were either normatively gendered or psychiatrically ill.<sup>35</sup>

This explanation adroitly captures the conceptual logic under which the corrective approach operates – though the assumption of parental heterosexuality may be slowly waning. Gender creativity and being transgender are seen as constitutive of mental illness, and this assumption is so deeply rooted that it is rarely spelled out by theorists of the corrective approach and, instead, simply assumed.

The corrective approach plainly falls under the definition of conversion practices that I have proposed. However, proponents of the approach have long rejected labels such as “reparative therapy” and “conversion therapy.”<sup>36</sup> It is unclear whether their claim that the corrective approach is not a conversion practice reflects a genuine theoretical position or a desire not to be associated with the politically loaded connotations of terms like “conversion practices.” As far as I am aware, proponents of the corrective approach have not detailed their reasons for rejecting the terms. Some have suggested that the corrective approach should be treated differently because while sexual orientation is fixed, gender identity is malleable before puberty.<sup>37</sup> However, this argument understates the malleability of sexual orientation while overstating the evidence of the malleability of gender identity. The 2009 American Psychological Association’s report on conversion practices assumed that sexual orientation can change and evolve, and it built its recommendations around the lack of evidence of malleability rather than on evidence of fixedness.<sup>38</sup> With respect to gender identity, the data used to support the claim that gender identity is malleable in youth was criticized for failing to distinguish trans and gender-creative youth from gender non-conforming youth who are cisgender.<sup>39</sup> Had they been valid, the studies would not have established that gender identity is malleable, rather than naturally evolving or fluid, like sexual orientation. It is not the same to say that gender identity is prone to change over time and that gender identity is malleable. Drivers can change the course of their car, but it does not mean that ramming into it with a truck is an effective or safe way of changing its direction.

Although not a proponent of the approach, William Byne, a professor of psychiatry at the Icahn School of Medicine at Mount Sinai, has argued that the corrective approach should not be construed as conversion therapy because there is no consensus over appropriate treatment for gender-creative youth, unlike treatment regarding sexual orientation.<sup>40</sup>

This critique is not convincing. Expressions such as “conversion therapy,” “reparative therapy,” and “conversion practices” do not imply the presence of consensus and can be deployed in its absence. What stands at the philosophical heart of these terms is a distinctively negative stance towards queerness and, through extension, transitude. The presence of consensus is of little matter. On the contrary, the expressions were being used long before a consensus was reached that these practices were unethical. The expression “reparative therapy” appears in the 1965 book *Sexual Inversion: The Multiple Roots of Homosexuality*, nine years before the 1974 reprint of the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* declassified homosexuality.<sup>41</sup> The term was still prominently used by proponents of conversion practices long after the practices became discredited. As for conversion therapy, the term was used in the 1970s and 1980s, a time of significant debate surrounding the treatment of people who sought out conversion practices.<sup>42</sup> Yet, even if consensus was required before saying that an approach constitutes a conversion practice, the relevant consensus exists: attempting to change people’s gender identity or to prevent them from growing up trans is unethical. Although the consensus over the best treatment for gender-creative youth is still emerging, there is a consensus that treatments seeking to align individuals’ gender identity and gender expression with their sex assigned at birth are unethical.<sup>43</sup> We may not yet have reached a clinical consensus over which approach is the best, but a consensus was reached over the inadequacy of the corrective approach and other attempts to discourage trans outcomes.

The label of “conversion practices” groups together a wide range of practices based on shared traits and assumptions. Since the corrective approach seeks to discourage behaviours associated with a gender other than the one assigned at birth and/or promote gender identities that are aligned with the person’s sex assigned at birth, it falls under the umbrella of trans conversion practices. Whether the corrective approach is outlawed by bans on trans conversion practices will be considered in greater detail in the next chapter. Since the corrective approach is the most thoroughly theorized form of trans conversion practices, this book will frequently refer to the work of proponents of the corrective approach as exemplars of conversion practices.





What counts as conversion practices is controversial and perhaps nowhere more so than in trans health. During the decades-long contestation of the CAMH clinic's approach to care, what counts as a conversion practice and whether the clinic's corrective approach falls under the umbrella has remained at the heart of the public debate. As I understand them throughout this book, trans conversion practices are sustained efforts to promote gender identities that are aligned with one's sex assigned at birth and/or to discourage behaviours associated with a gender other than the one assigned at birth. Shared by these practices is the philosophy that being trans or transitioning is pathological, undesirable, and something to be avoided. They can involve attempting to change, discourage, or repress the person's gender identity. They can also involve attempting to discourage gender transition. Whatever their form, they are trans conversion practices.

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