OUTLAWING TRANS REPARATIVE THERAPY

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ABSTRACT

Trans reparative therapy refers to a range of practices seeking to discourage behaviours associated with a gender other than the person's gender assigned at birth and or promote gender identities that are aligned with their gender assigned at birth. This thesis explores the legal regulation of trans reparative therapy. The first chapter situates debates surrounding trans reparative therapy in the contemporary Canadian context, explains the choice of 'reparative therapy' as a terminology, and defines trans reparative therapy. The second chapter explores the scope of trans reparative therapy bans by interpreting Ontario's Bill 77, concluding that it prohibits any practice that discourage trans outcomes, and by offering a dual typology of trans reparative therapy bans. The third chapter provides a policy analysis of bans, responding to critiques levied against them, highlighting their limits and benefits, and drawing on sociological research to propose supplementary means of discouraging reparative practices.

RÉSUMÉ

Les thérapies réparatrices trans sont un ensemble de pratiques cherchant à décourager les comportements associés à un genre autre que celui assigné à la naissance et/ou qui font la promotion d'identités de genre alignées sur celui assigné à la naissance. Cette thèse explore la juridicisation des thérapies réparatrices trans. Le premier chapitre situe les débats autour des thérapies réparatrices trans dans le contexte contemporain canadien, explique le choix de la terminologie de 'thérapie réparatrice', et définit ce que sont les thérapies réparatrices trans. Le deuxième chapitre explore le champ d'application des interdictions des thérapies réparatrices trans en interprétant le Projet de loi 77 ontarien, concluant que celui-ci prohibe toute pratique qui décourage la transitude, et en offrant une typologie double des interdictions des thérapies réparatrices trans. Le troisième chapitre offre une analyse politique des lois, répondant à des critiques offertes à leur égard, soulignant leurs bénéfices et limites, et en s'inspirant de recherches sociologiques pour proposer des moyens supplémentaires de décourager les pratiques réparatrices.

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INTRODUCTION

As much as I wish it were otherwise, licensed professionals do not always act in their clients' best interests. Sometimes, their sense of their patients' best interests is skewed. When this is the case, we rely on law and professional bodies to protect the public. Yet, professional bodies can fail to act for a wide range of reasons.

Trans reparative therapy, which refers to a range of practices seeking to discourage behaviours associated with a gender other than the person's gender assigned at birth and or promote gender identities that are aligned with their gender assigned at birth, are increasingly recognised as harmful and unethical. The leading trans health organisation 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".[1]

Despite countless professional associations opposing trans reparative therapy, professional bodies have largely failed to sanction members who engage in reparative practices. In 2015, Ontario became the first Canadian jurisdiction to prohibit trans reparative therapy, the legislature acting in response to professional bodies' failure to protect trans youth.

For many of those people who were subjected to its unrelenting attempt to alter their expressed gender identity, trans reparative therapy carries the resounding promise of life-long psychological distress. Trans reparative therapy typically begins with the premise that there is something disordered, "wrong", about being trans or gender creative. From this premise is drawn

[1] Eli Coleman et al, "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7" (2012) 13:4 International Journal of Transgenderism 165 at 175.

the conclusion that attempting to prevent a person from identifying with a gender other than the one they were assigned at birth is an appropriate clinical goal. Although such therapies have fallen into disfavour among leading practitioners of trans health, a faction of indomitable therapists and theorists continue to profess their affection for the psychotherapeutic approach, a form of reparative therapy. Indeed, as many as 9% of trans adults report that a non-religious professional attempted to stop them from being trans.[2] Given that most trans people only come out after puberty[3] and that reparative therapy is most often aimed at pre-pubertal children, this percentage likely grossly underestimates the prevalence of reparative therapy among trans youth.

My questions as a jurist, student of bioethics, and concerned member of trans communities are thus: what is the scope of laws prohibiting trans reparative therapy across the world? Are practices such as the psychotherapeutic approach included within the prohibitions? What are the benefits and limits of laws regulating professional conduct around trans reparative therapy? How can we improve them? This thesis aims at answering these questions.

Because there is little to no academic literature considering bans on reparative therapy from a trans perspective, this thesis will contribute significantly to the emerging trans legal literature in Canada and can serve as a starting point for articles on the topic. The first chapter provides a rigorous definition of trans reparative therapy. The second chapter elucidates the scope of bans on trans reparative therapy, which has so far not been considered at length. The third chapter provides provide a critical analysis of bans, highlighting the need to supplement existing prohibitions with

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[2] Sandy E James et al, *The Report of the 2015 U.S. Transgender Survey* (Washington, DC: National Center for Transgender Equality, 2016) at 108; see also Government Equalities Office, *National LGBT Survey: Research Report* (Manchester: U.K. Government Equalities Office, 2018) at 89.

[3] James et al, *supra* note 2 at 46.

clear professional guidelines integrated in professional education to discourage the practices more effectively.

The choice to focus on prohibitions of trans reparative therapy is informed by an understanding of law as enabling behaviour. Few psychiatrists, psychologists or social workers could keep up a thriving practice without their membership in professional associations. Membership allows them to work legally and serves as a gauge of quality to members of the public. When parents of gender creative children seek out information and help in supporting their children—and, sadly, sometimes in repressing gender variant behaviour—they are likely to seek out licensed professionals in good standing, especially in psychiatry and psychology. They are often lost and blame themselves for their children's non-conforming behaviour and identity expression.[4] This context can render them unable to reflect critically on the approach proposed by practitioners, making them vulnerable to the pull of authority. It is thus all the more crucial to ensure the quality of professional practices in such a context. Professionals' reliance on it lies at the heart of state laws' ability to prevent harmful professional behaviour. Their license provides a means to regulate them.

Given the prominence of public controversies surrounding trans youth care in North America, this thesis appears particularly timely and promises to substantiate political claims levied against the psychotherapeutic approach by trans communities and researchers committed to the now-leading gender-affirmative approach. An analysis of the legality of trans reparative therapy

[4] Elizabeth Anne Riley et al, "The Needs of Gender-Variant Children and Their Parents: A Parent Survey" (2011) 23:3 International Journal of Sexual Health 181 at 187; Edgardo J Menvielle, Catherine Tuerk & Michael S Jellinek, "A Support Group for Parents of Gender-Nonconforming Boys" (2002) 41:8 Journal of the American Academy of Child & Adolescent Psychiatry 1010 at 1010.

will have far-reaching implications for professional practice and public conversations regarding them.

This thesis foregrounds a critical trans politics as a theoretical framework. Critical trans politics, as elaborated by Dean Spade in the seminal book *Normal Life*, centres material changes in living conditions rather than legal recognition.[5] Critical trans politics stand critical of narratives of progress grounded in symbolic and formal laws, instead approaching legal reform as a limited-but-sometimes-necessary component of improving lives. A central question of critical trans politics is "what role changing laws can and cannot have in changing the arrangements that cause […] harms to trans people".[6] Because law and legal reform are viewed with suspicion by critical trans politics, it is necessary that we inquire into the effectiveness and limits of law and delineate strategies to impact the lives of trans people positively beyond the limits of legal reform. Critical trans politics is influenced by critical race theory, Black feminist thought, women of colour feminism, and critical disability studies.[7] Unlike liberal approaches to legal reform that foreground legal recognition, critical trans politics are founded not on an idea of neutrality but rather on the reality of oppression.[8]

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[5] Dean Spade, *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law*, rev. ed. ed (Durham & London: Duke University Press, 2015) at 1.

[6] *Ibid* at 2.

[7] Dean Spade draws on such thinkers as Saidiya V Hartman, *Scenes of subjection: terror, slavery, and self-making in nineteenth-century America*, Race and American culture (New York: Oxford University Press, 1997); Angela Y Davis, *Are prisons obsolete?*, Open media book (New York: Seven Stories Press, 2003); A J Withers, *Disability politics and theory* (Halifax: Fernwood Pub, 2012); Kimberle Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color" (1991) 43:6 Stanford Law Review 1241; and Derrick A Bell, "Brown v. Board of Education and the Interest-Convergence Dilemma" (1980) 93:3 Harvard Law Review 518, to name but a few.

[8] Mari J Matsuda, "When the First Quail Calls: Multiple Consciousness as Jurisprudential Method" (1989) 11:1 Women's Rights Law Reporter 7.

My approach is openly trans-affirmative. It takes as a premise that attempting to change or discourage people from being trans or growing up to be trans is morally wrong. Much ink has been spilled debating whether the psychotherapeutic approach or trans reparative therapy is harmful or unethical.[9] I will not explore those debates at length, instead stipulating as legitimate the wish to suppress those practices.

This thesis may prove helpful for several readerships. It is intended for judges, jurists, legislators, trans communities, mental health professionals, healthcare institutions, and professional associations. Judges called on to interpret the scope of bans will find the thesis helpful in developing their understanding of what bans on reparative therapy, as best interpreted, effectively prohibit. Jurists will find it useful in guiding their clients who offer mental health services as well as in advocating for their trans clientele. Legislative drafters will find this thesis helpful in understanding what is prohibited, and what the limits and advantages of bans are compared to other approaches. Trans communities will find the information contained in this thesis useful in advocating for better professional practice towards trans people. Mental health professionals and healthcare institutions should be aware of their legal duties and the extent of

[9] Simon D Pickstone-Taylor, "Children with Gender Nonconformity" (2003) 42:3 Journal of the American Academy of Child & Adolescent Psychiatry 266; Kenneth J Zucker et al, "A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder" (2012) 59:3 Journal of Homosexuality 369; Kenneth J Zucker, "Commentary on Langer and Martin's (2004) 'How Dresses Can Make You Mentally Ill: Examining Gender Identity Disorder in Children'" (2006) 23:5–6 Child and Adolescent Social Work Journal 533; Susan J Langer & James I Martin, "How Dresses Can Make You Mentally Ill: Examining Gender Identity Disorder in Children" (2004) 21:1 Child and Adolescent Social Work Journal 5; Jemma Tosh, "'Zuck Off'! A commentary on the protest against Ken Zucker and his 'treatment' of Childhood Gender Identity Disorder" (2011) 13:1 Psychology of Women Section Review 10; Coleman et al, *supra* note 1; Julia Temple Newhook et al, "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender-nonconforming children" (2018) 19:2 International Journal of Transgenderism 212; Kenneth J Zucker, "The myth of persistence: Response to 'A critical commentary on follow-up studies and "desistance" theories about transgender and gender non-conforming children' by Temple Newhook et al. (2018)" (2018) 19:2 International Journal of Transgenderism 231.

their potential legal liability, which this work delineates. Lastly, I hope that this thesis will aid professional associations in sanctioning the practice of trans reparative therapy and developing clear guidelines condemning it. Disciplinary sanctions, statements, and guidelines can and should be used to protect the public from harmful practices, promoting health directly and indirectly such as by fostering positive relations between healthcare professions and trans communities.

As a transfeminine scholar, I am cognizant of the disastrous impact of trans reparative therapy on non-patients as well. The open practice of reparative therapy by licensed professionals 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 which underpin harassment, discrimination, and violence against trans people.[10] The ongoing practice of reparative therapy symbolizes the devaluation of trans lives. As the sociological theory of symbolic interactionism teaches us, humans lead fundamentally symbolic lives.[11] A symbol of the dehumanisation of trans people, trans reparative therapy takes a significant psychological toll on many members of trans communities, myself included.[12] Indeed, working on this thesis was

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[10] CROP, *Perceptions, interactions and comfort level of the heterosexual cisgender population with sexual minorities*, LGBT+ Realities Survey (Fondation Jasmin Roy, 2017); Jessica Vomiero, "Is the world more accepting of transgender people? Yes, but many people still aren't: Ipsos", *Global News* (29 January 2018), online: <https://globalnews.ca/news/3991849/transgender-people-world-accepting-ipsos-poll/>; Florence Ashley, "Don't be so hateful: The insufficiency of anti-discrimination and hate crime laws in improving trans well-being" (2018) 68:1 University of Toronto Law Journal 1; Julia Serano, *Psychology, Sexualization and Trans-Invalidations* (Philadelphia, 2009).

[11] Herbert Blumer, "Society as Symbolic Interaction" in Nancy J Herman & Larry T Reynolds, eds, *Symbolic Interaction: An Introduction to Social Psychology* (Lanham, MD: AltaMira Press, 1994) 500; Kenneth Burke & Joseph R Gusfield, *On Symbols and Society* (Chicago: University of Chicago Press, 1989); in the context of law, see Christopher E Smith, "Law and Symbolism" [1997]:3 Detroit College of Law at Michigan State University Law Review 935.

[12] The minority stress model can help us understand why expressions of prejudice and devaluation can have a long-term negative effect on transgender people. Michael Hobbes, "The Epidemic of Gay loneliness", *Highline* (2 March 2017), online: <https://highline.huffingtonpost.com/articles/en/gay-loneliness/>; Brian A Rood et al, "Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals" (2016) 1:1 Transgender Health 151.

difficult for me as I had to read countless articles expressing strong negative attitudes towards trans people.

Methodologically, I will adopt a combination of approaches to answer the research questions. I will engage at various points in expository doctrinal analysis, law-reform analysis, and comparative and historical inquiries.[13] When delineating the scope of prohibitions of trans reparative therapy and inquiring into whether they capture the psychotherapeutic approach, I will primarily adopt an expository doctrinal analysis centred on statutory interpretation. I will also undertake a comparative inquiry to highlight the differences between prohibitions in various jurisdictions. Inquiring into the benefits and limitations of such laws and how we may improve upon them, I will adopt an interdisciplinary approach common to work on law reform, blending doctrinal inquiry with critical analysis and drawing on sources from sociological research on professions.

My expository work will focus on Ontario's Bill 77 as an example of prohibitions of trans reparative therapy. The Bill has been the most politicized ban on trans reparative therapy in Canada. Its interpretation is of interest to a large number of people and is likely to find itself the object of court attention in the near future.[14] Since Bill 77 has served as a blueprint for the subsequent Nova Scotia law, an inquiry into Bill 77 is informative in a Nova Scotian context, as well as in any future province drawing inspiration from it.

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[13] Paul Chynoweth, "Legal research" in Andrew Knight & Leslie Ruddock, eds, *Advanced research methods in the built environment* (Chichester: Wiley-Blackwell, 2008) 28; Terry Hutchinson, "The Doctrinal Method: Incorporating Interdisciplinary Methods in Reforming the Law" (2015) 3 Erasmus Law Review 130.

[14] *Bill 77: An Act to amend the Health Insurance Act and the Regulated Health Professions Act, 1991 regarding efforts to change sexual orientation or gender identity*, SO 2015, c 18 [*Affirming Sexual Orientation and Gender Identity Act, 2015*] at 77.

My thesis proceeds from the assumption that certain interpretations of laws are more rationally defensible than others. Insofar as I intend to influence and enlighten judges' decisions, I do not purport to merely predict adjudicative results, as might a legal realist.[15] Judging whether an interpretation of law is more rationally defensible than others is neither a purely descriptive nor a purely normative exercise.[16] The most ethical interpretation of the law is rarely the most defensible one, and is not the one I aim at. Instead, this thesis sets out to provide the most defensible interpretation of the laws it studies.

My thesis will be divided into three chapters.

The first chapter situates trans reparative therapy in the Canadian context, highlighting the contemporary relevance of inquiries into laws prohibiting it, and setting the terminological stage for my subsequent exploration. This chapter situates trans reparative therapy in its contemporary socio-political context by considering the closure of the CAMH Gender Identity Clinic for Children and Youth. It then turns to the question of terminology, explaining the terminological choice "reparative" therapy rather than "conversion" therapy, defining the notion of reparative therapy, and considering whether the psychotherapeutic approach is a form of reparative therapy.

The second chapter delineates the scope of prohibitions of trans reparative therapy and answer the question of whether those laws prohibit the psychotherapeutic approach. The chapter

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[15] Oliver Wendell Holmes, Jr, "The Path of Law" (1897) 10 Harvard Law Review 457; Karl N Llewellyn, *The Bramble Bush: Some Lectures on Law and Its Study* (New York: Columbia University School of Law, 1930); for a critique see H L A Hart, *The Concept of Law*, 3d ed (Oxford: Oxford University Press, 2012).

[16] See e.g. Mark Greenberg, "How Facts Make Law" (2004) 10:3 Legal Theory; Mark Greenberg, "Reasons Without Values?" (2007) 2 Social Political and Legal Philosophy 133; Ronald Dworkin, "Law as Interpretation" (1982) 9:1 Critical Inquiry 179.

will provide a detailed interpretation of Ontario's Bill 77 and categorize of the various bans on trans reparative practices worldwide.

The third chapter inquires into the advantages and disadvantages of trans reparative therapy bans and how we may improve upon them. In it, I will engage in a critical analysis of legislative prohibitions of trans reparative therapy. I will consider various critiques levied against such statutory bans and respond to them. I will then lay out the benefits and limits of legislative bans on trans reparative therapy, highlighting the need to go beyond legislative approaches. Drawing on the sociology of professional identity, I suggest that establishing professional committees tasked with developing clear professional guidelines, ensuring the enforcement of those guidelines, and pursuing the integration of teaching on trans reparative therapy in the university curriculum of professionals can supplement prohibitions of reparative therapy to more effectively discourage reparative practices.

By explaining the scope of bans and proposing additional avenues of action in the fight against these unethical practices, I hope that my thesis will contribute to the elimination of trans reparative therapy in Canada and worldwide.

CHAPTER I: CONTEXT AND DEFINITION

In this chapter, I situate the Canadian debates surrounding trans reparative therapy in their contemporary sociohistorical context and lay the terminological groundwork for the rest of the thesis. In the first section, I discuss the closure of the infamous CAMH Gender Identity Clinic for Children and Youth, which occurred contemporaneously to the passage of Ontario Bill 77, which prohibited reparative therapy. In the second section, I explain why I opted for the terminology of reparative therapy rather than conversion therapy, define what is meant by trans reparative therapy, and consider whether the psychotherapeutic approach is a form of trans reparative therapy.

Closure of the CAMH Gender Identity Clinic for Children and Youth

In this section, I will show the contemporary social relevance of debates surrounding trans reparative therapy and its legal regulation by providing an overview of the closure of the CAMH Gender Identity Clinic for Children and Youth following allegations of practising reparative therapy in the wake of Bill 77. As this section shows, debates on the legal regulation of trans reparative therapy in Canada are not merely theoretical or limited to fringe practitioners but relate to contemporary clinical practices at well-regarded institutions. Debates surrounding the closure centred upon whether the clinic engaged in trans reparative therapy, highlighting the importance of clarifying the scope of trans reparative therapy and related bans.

On December 15, 2015, the Centre for Addiction and Mental Health (CAMH) announced that it would be closing its Gender Identity Clinic for Children and Youth. The closure ended a clinic which for nearly four decades had played a leading role on the scientific scene.[17]

[17] Jake Pyne, "Discredited treatment of trans kids at CAMH shouldn't shock us", *Toronto Star* (17 December 2015), online: <https://www.thestar.com/opinion/commentary/2015/12/17/discredited-

Beginning in the 1970s under the supervision of Dr. Susan Bradley, the clinic operated as a specialised team at the Clarke Institute in Toronto. In the 1980s, Dr. Kenneth Zucker succeeded Dr. Bradley as head of the clinic. When the Clarke Institute merged with other organisations to form CAMH, the clinic continued to operate under the new centre.[18]

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."[19] 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 it not as a mental illness but as part of normal human variation, the clinic's practice proved resistant to change.[20] A comparison between the 1995 monograph *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* by Susan Bradley and Kenneth Zucker and contemporary works by the same authors reveals few substantial changes in clinical approach. 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 organisation

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treatment-of-trans-kids-at-camh-shouldnt-shock-us.html>; William Byne, "Regulations Restrict Practice of Conversion Therapy" (2016) 3:2 LGBT Health 97 at 98.

[18] Tey Meadow, *Trans kids: being gendered in the twenty-first century* (Oakland, California: University of California Press, 2018) at 81.

[19] *Ibid*.

[20] Suzanne Zinck & Antonio Pignatiello, *External Review of the Gender Identity Clinic of the Child, Youth and Family Services in the Underserved Populations Program at the Centre for Addiction and Mental Health* (Toronto: Centre for Addiction and Mental Health, 2015) at 20.

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.[21]

The external review was conducted by psychiatrists Suzanne Zinck and Antonio Pignatellio. They (1) conducted a literature review, (2) interviewed staff, community stakeholders, and clients, former clients, and families, (3) reviewed written submissions from former patients, (4) and reviewed patients' medical records. The review made recommendations based on the findings.

The report described Kenneth Zucker as a "Mecca of knowledge and information" but found that the clinic was "out of step with current clinical and operational practices."[22] The reviewers expressed concern that the clinic's use of play therapy and cognitive-behavioural therapy was directing children and that the clinic's approach was grounded in an assumption that gender variant behaviours require intervention.[23] According to the reviewers, there was concern and anger among stakeholders that clinicians and students affiliated with the clinic were being taught this approach.[24]

The report did not confirm nor deny that the clinic engaged in trans reparative therapy.[25] Findings of the external review suggest that reparative therapy was being practised. Parents reported their child being questioned about their gender in ways that implied a negative judgement

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[21] *Ibid* at 1.
[22] *Ibid* at 19, 20.
[23] *Ibid* at 20. The reviewers further state that this assumption is not consistent with the research produced by employees of the clinic. Based on my earlier description of Drs. Bradley and Zucker's research as well as my detailed description of the psychotherapeutic approach in Section V, I must respectfully disagree. The assumption that gender variant behaviours require intervention is pervasive in the publications of researchers affiliated with the clinic.
[24] *Ibid* at 14.
[25] *Ibid* at 22.

of their way of being.[26] The reviewers concurred with participants that promoting comfort with gender 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.[27] They also faulted the clinic for not engaging collaboratively with trans communities.[28]

The central recommendation was revision of the assessment and treatment approaches and alignment of clinical practice 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.[29]

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."[30] The gap in services continues today.

Following his dismissal, Kenneth Zucker sued CAMH for defamation and wrongful dismissal. In October 2018, CAMH settled with Zucker, apologizing for falsely stating "that Dr.

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[26] *Ibid* at 21.
[27] *Ibid* at 22.
[28] *Ibid* at 21.
[29] *Ibid* at 25.
[30] Byne, *supra* note 17 at 98; Zinck & Pignatiello, *supra* note 20 at 25.

Zucker called a patient a 'hairy little vermin.'"[31] The quote was misattributed to him. The report "was released publicly without review or comment by Dr. Zucker", leading to the error.

The settlement was seen by many as a vindication of Zucker and evidence that he was wrongfully fired. However, I believe that the evidence suggests otherwise.

Following the settlement between Zucker and CAMH, the latter stated 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."[32] A close reading of the apology further suggests that the compensation and apology were issued not for the termination itself, but rather the manner in which he was dismissed. The apology mentions that the review "was not intended to examine Dr. Zucker's behaviour or specific clinical practices" and apologised for errors in the report rather than for terminating his employment.

Although CAMH was entitled to close the clinic and terminate Dr. Zucker's employment because of outdated and possibly unethical practices, the manner in which employment is terminated can give rise to claims for damages.[33] Conduct which is "untruthful, misleading or unduly insensitive" can lead to compensation by adding to the notice period, provides terminated

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[31] "CAMH Apology", (October 2018), online: *CAMH* <https://www.camh.ca/en/camh-news-and-stories/camh-apology>. Zucker was awarded $400,000 in general damages.

[32] The Canadian Press, "CAMH reaches settlement with former head of gender identity clinic", *CBC News* (7 October 2018), online: <https://www.cbc.ca/news/canada/toronto/camh-settlement-former-head-gender-identity-clinic-1.4854015>.

[33] *Wallace v United Grain Growers Ltd*, [1997] 3 SCR 701 (SCC); *Honda Canada Inc v Keays*, 2008 SCC 39, [2008] 2 SCR 362 (SCC).

employees time to find new employment.[34] Compensation can also be sought independently for defamation, as was the case here.

Viewing the settlement as a vindication of the clinic's practices requires misinterpreting the legal and factual context surrounding the apology. Given the volatile context of the clinic closure, which was characterised by oppositional narratives and the portrayal of trans activists as unreasonable, the poor handling of the closure and subsequent settlement may have done a disservice to trans youth regardless of the desirability of the closure or the legal effect of the settlement.[35]

For conservative commentators, the closure of the clinic and termination of Zucker's employment was evidence of trans militants' desire to censor scientists. Barbara Kay, writing for the National Post, Canada's leading conservative newspaper, characterised critiques of the clinic's practices as symptoms of the "aggressive activism in the trans movement", suggesting that emotionalism had overtaken rational dialogue.[36] This belief is shared by many supporters of Dr. Zucker.[37]

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[34] *Wallace v. United Grain Growers Ltd.*, *supra* note 33, para 98.

[35] Concerns over the review process were also raised by one of the review participants from the Oolagen Community Services and Central Toronto Youth Service focus group, noting that the review appeared "unstructured": Zinck & Pignatiello, *supra* note 20 at 14.

[36] Barbara Kay, "Scandal at CAMH — one entirely of its own making", *National Post* (3 February 2016), online: <https://nationalpost.com/opinion/barbara-kay-scandal-at-camh-one-entirely-of-its-own-making>.

[37] Jesse Singal, "How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired", *The Cut* (7 February 2016), online: <https://www.thecut.com/2016/02/fight-over-trans-kids-got-a-researcher-fired.html>. A petition opposing Zucker's firing and concluding that it was primarily political was signed by 508 individuals, many of which are academics and scientists: John Bancroft et al, "Open Letter to the Board of Trustees of CAMH", (11 January 2016), online: *ipetitions* <https://www.ipetitions.com/petition/boardoftrustees-CAMH> The signatories include a large number of 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", stating that the closure was motivated by CAMH's commitment to improving services in collaboration with community partners:

Characterising the sustained critique levied at 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."[38] It is possible that Kenneth Zucker, because of his prominence and influence within the scientific community, is disproportionately the target of criticisms. Dr. Zucker and clinicians affiliated with the CAMH clinic are far from the sole practitioners of the psychotherapeutic approach. Yet, critiques of the psychotherapeutic approach began appearing in scientific literature nearly twenty years prior to the clinic's closure.[39] According to Jake Pyne, the debate surrounding the psychotherapeutic approach "no longer qualifies as a true debate", and a clear consensus has emerged against practices which seek to correct gender variance, and in favour of the gender affirmative approach.[40]

As Jake Pyne highlights, depictions of the debate as a clash between professionals and trans activists are inaccurate. Within trans communities, some of the most vocal opponents of the clinics' practices have been scientists and academics.[41] Their critiques in the public realm were

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Sheryl Ubelacker, "CAMH youth gender identity clinic closure earns international ire", *The Star* (23 January 2016), online: <https://www.thestar.com/news/gta/2016/01/23/camh-youth-gender-identity-clinic-closure-earns-international-ire.html>.

[38] Meadow, *supra* note 18 at 56.

[39] Pyne, *supra* note 17; Pickstone-Taylor, *supra* note 9; Langer & Martin, *supra* note 9 at 18.

[40] Legislative Assembly of Ontario, Standing Committee on Justice Policy, *Affirming Sexual Orientation and Gender Identity Act, 2015*, 41-1 (3 June 2015) at JP-65 (Jake Pyne). Jake Pyne's criticism of the CAMH clinic was subject to a lawsuit which has now been settled: Pyne, *supra* note 17.

[41] For example: Pyne, *supra* note 17; Tosh, *supra* note 9; Serano, *supra* note 10. Jake Pyne is a social work scholar who contributed to the TransPULSE research project in Ontario and held a 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 UC Berkeley.

grounded in expertise and recognised by peer-reviewed publications.[42] To those voices are added those of countless cis academics who similarly see significant flaws in the psychotherapeutic approach. The gender-affirmative approach, now the leading approach to trans youth care, was developed in parallel to critiques of the psychotherapeutic approach. Scientific knowledge, clinical experience, and community wisdom have all played crucial roles in the formulation of critiques of the psychotherapeutic approach practiced by the CAMH clinic.

Ideology played a role in the closure of the CAMH clinic, but it would be a mistake to characterise 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 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*

[42] Temple Newhook et al, *supra* note 9; Jake Pyne, "Health and Well-Being among Gender-Independent Children and Their Families: A Review of the Literature" in *Supporting transgender and gender creative youth: Schools, Families and Communities in Action* (New York: Peter Lang, 2014) 27; Greta R Bauer et al, "Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada" (2015) 15:1 BMC Public Health; Jake Pyne, "The governance of gender non-conforming children: A dangerous enclosure" (2014) 11 Annual Review of Critical Psychology 79; Jake Pyne, "Gender independent kids: A paradigm shift in approaches to gender non-conforming children" (2014) 23:1 The Canadian Journal of Human Sexuality 1; Tosh, *supra* note 9; Julia M Serano, "The Case Against Autogynephilia" (2010) 12:3 International Journal of Transgenderism 176; Jemma Tosh, *Perverse Psychology: The Pathologization of Sexual Violence and Transgenderism* (New York: Routledge, 2015); Jemma Tosh, *Psychology and Gender Dysphoria: Feminist and Transgender Perspectives* (New York: Routledge, 2016); Jemma Tosh, "Working Together for an Inclusive and Gender Creative Future: A Critical Lens on 'Gender Dysphoria'" in *Supporting transgender and gender creative youth: Schools, Families and Communities in Action* (New York: Peter Lang, 2014) 27.

Manual of Mental Disorders (DSM), which was similarly characterised as "a value judgment about heterosexuality, rather than a factual dispute about homosexuality."[43]

Given the intertwined nature of ethical judgement and clinical practice, it would be more accurate to depict the controversy as one arising between different schools of thought on trans therapeutics.[44] 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 longstanding theorisations of the psychotherapeutic approach.

As the closure of the CAMH Gender Identity Clinic for Children and Youth demonstrates, trans reparative therapy is a live controversy in Canadian healthcare. Throughout the controversy, disagreement hinged in part on the conceptual scope of trans reparative therapy and on the legal scope of related bans. Clarifying our picture of what counts as trans reparative therapy is therefore crucial to resolving political and legal debates surrounding the psychotherapeutic approach, which was followed at the CAMH clinic.

Elucidating and defining reparative therapy

In this section, I define trans reparative therapy, explaining why I have opted for that terminology rather than conversion therapy, and assessing whether the psychotherapeutic approach to trans youth clinical care is a form of trans reparative therapy. This section sets out the terminological groundwork for the remainder of the thesis.

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[43] Robert L Spitzer, "The diagnostic status of homosexuality in DSM-III: a reformulation of the issues" (1981) 138:2 American Journal of Psychiatry 210.

[44] Zinck & Pignatiello, *supra* note 20 at 15.

Reparative and conversion therapy

Multiple terms have been proposed to speak of therapies that seek to avoid trans or gay outcomes. The most common terms are "conversion therapy" and "reparative therapy", with "corrective therapy" being less common yet also present within the discussions surrounding these practices. In this thesis, I have opted to use the terminology of "reparative therapy" over "conversion therapy" because it is also common and better captures the theoretical underpinnings of reparative practices. By shifting our focus from attempts to *change* gender identity to attempts to *fix* trans and gender creative people, we better characterise the approaches at stake and avoid ongoing scientific debates about the nature of gender identity.

First, the connotations of "conversion" suggests disputed theoretical assumptions about gender identity. To convert something or someone is to alter its properties.[45] Someone used to have a certain property and now they no longer have it. In the context of conversion therapy, the conversion would operate by acting on a person who is trans—through psychosocial intervention—with the intent of making them cis instead of trans. Conversion therapy, in other words, is the attempt to change a person's underlying gender identity.

Because "conversion therapy" connotes discrete changes to an underlying gender identity, the terminology implies that gender non-conforming behaviour and expressions of gender identity are the expression of a fixed gender identity, one of the fundamental aspects of people's self-conception.[46] This view often comes with the belief that gender identity is fixed at birth and biological. However, psychiatrists and psychologists associated with reparative therapy frequently

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[45] OED, *supra Oxford English Dictionary*, 3d ed (Oxford: Oxford University Press, 2009), sv convert.

[46] Diane Ehrensaft, "From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy" (2012) 59:3 Journal of Homosexuality 337.

deny that people hold an underlying true, fixed gender identity. Instead, they see the subjective experiences which constitute gender identity not as the reflection of the self but, rather, as a pathological confusion about one's true gender, seemingly defined by anatomical and hormonal development.[47]

By contrast, the terminology of "reparative therapy" avoids these connotations and remains neutral vis-à-vis the nature of gender identity. Reparative therapy connotes the reparation of something which is broken, the healing of disease, of illness, of unhealth.[48] It suggests that the targets of therapy are flawed in some sense and that reparative therapy is an attempt to bring them back into health. Various conceptions of the underlying "problem" with trans people and gender creative children exist. In the sociohistorical context, reparative therapy is most often framed as curing those who have Gender Dysphoria, previously known as Gender Identity Disorder, understood as a psychiatric diagnosis and mental illness.[49]

Whereas "conversion therapy" reveals theoretical assumptions about the psychological underpinnings of gender identity and transitude, "reparative therapy" focuses on the belief system that underpins reparative practices: reparative therapists see being trans or gender creative as evidence of disorder and as something to be "fixed".

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[47] Zucker, *supra* note 9 at 544, 549; Zucker et al, *supra* note 9 at 375, 377; Susan J Bradley & Kenneth J Zucker, "Gender Identity Disorder and Psychosexual Problems in Children and Adolescents" (1990) 35:6 The Canadian Journal of Psychiatry 477 at 478.

[48] OED, *supra* note 45, sv reparative, repair.

[49] American Psychiatric Association, *Diagnostic and statistical manual of mental disorders: DSM-5* (Washington, D.C: American Psychiatric Association, 2013). This conception of Gender Dysphoria differs from that used by WPATH (Coleman et al, *supra* note 1 at 221): "Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)".

Second, 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 solely gender non-conforming, unlike statements such as "I want to be a girl", distinguishing between the two types of claims do not provide us with a perfect litmus test.[50] Children repeatedly told by parents that they are 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".[51] 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" to be allowed to wear dresses.

Even if we assume that people have a fixed gender identity, our ability to identify that gender identity is imperfect.[52] 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. Since the terminology of "conversion therapy" focuses on *change*, it fails to fully account for reparative therapies applied to youth whose gender identity is ambiguous. By contrast, "reparative therapy" holds space for

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[50] Diane Ehrensaft, "Found in Transition: Our Littlest Transgender People" (2014) 50:4 Contemporary Psychoanalysis 571 at 586; Kristina R Olson, "Prepubescent Transgender Children: What We Do and Do Not Know" (2016) 55:3 Journal of the American Academy of Child & Adolescent Psychiatry 155 at 156; Thomas D Steensma et al, "Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study" (2013) 52:6 Journal of the American Academy of Child & Adolescent Psychiatry 582 at 588.

[51] Ehrensaft, *supra* note 50 at 586; Diane Ehrensaft, "Exploring Gender Expansive Expressions Versus Asserting a Gender Identity" in Colt Keo-Meier & Diane Ehrensaft, eds, *The gender affirmative model: an interdisciplinary approach to supporting transgender and gender expansive children*, Perspectives on sexual orientation and diversity (Washington, DC: American Psychological Association, 2018) 34 at 40.

[52] James R Rae et al, "Predicting Early-Childhood Gender Transitions" (2019) 30:5 Psychological Science 669.

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. By shifting the focus from gender identity changes to the pathologizing of gender creativity, "reparative therapy" avoid unnecessary debates as to the true meaning of individual children's affirmations and instead focuses on the pressure to identify with one's gender assigned at birth.

Third, the terminology of "conversion therapy" risks erasing the harm that reparative therapy does to 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—as it used to be known—or Gender Dysphoria under the DSM-IV/DSM-IV-TR and DSM-5, respectively, sometimes identify with the gender they were assigned at birth.[53] According to Diane Ehrensaft, some "protogay" children "find themselves exploring gender on the way to affirming their sexual orientation identities."[54] Reparative therapy, however, is frequently applied indiscriminately to all gender creative children—many of whom cannot reasonably be labelled trans.

Those who do not grow up to be trans are often harmed by reparative practices. Karl Bryant, a sociologist and past patient of the UCLA Gender Identity Clinic, says that "it's hard to overstate the harm that" knowing others see you as disordered for being gender creative "can inflict".[55] He

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[53] Temple Newhook et al, *supra* note 9 at 215; Kelley Winters, "Media Misinformation About Trans Youth: The Persistent 80% Desistance Myth", (26 July 2016), online: *GID Reform Advocates* <https://gidreform.wordpress.com/2016/07/26/media-misinformation-about-trans-youth-the-persistent-80-desistance-myth/>.

[54] Ehrensaft, *supra* note 51 at 40.

[55] Beth Schwartzapfel, "Born This Way?", *The American Prospect* (14 March 2013), online: <http://prospect.org/article/born-way>.

has also highlighted, in his academic work, the close relationship between gay and trans reparative therapy, suggesting that the latter practices may nonetheless be deeply harmful to children who grow up to be cisgender and gay.[56]

If reparative therapy is also harmful to gender creative children who are not trans, then adopting a terminology which reduces trans reparative therapy to changing a gender identity underestimates the harm of reparative therapy. "Reparative therapy" better manages to capture this harm insofar as all gender creative children are depicted as disordered by its proponents. For proponents of reparative therapy, such children's gender non-conformity is something to be repaired, addressed.

With my choice of terminology now explained, I will turn to defining trans reparative therapy and exploring whether it includes the psychotherapeutic approach used by the CAMH Gender Identity Clinic for Children and Youth.

Defining reparative therapy

Since trans reparative therapy is the intended target of bans, it is important to understand what the term means. Various definitions of reparative therapy have been offered in the literature, though few have been extensively discussed, explained, and defended. In this section, I will consider and reject definitions which centre the notion of change or the prevention of transgender identification and gender non-conforming behaviour. I will then propose a definition which overcomes the limitations of previous definitions.

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[56] Karl Bryant, "Making gender identity disorder of childhood: Historical lessons for contemporary debates" (2006) 3:3 Sexuality Research and Social Policy 23.

Most commonly, the definitions foreground the attempt, through psychological intervention, to change gender identity and expression.[57] The definition often encompasses gender identity and sexual orientation.[58] As highlighted earlier, these definitions fail to accurately depict the practices: reparative therapy targets 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 psychological disorder.

In response to these limitations, other theorists have proposed definitions which centre the prevention of transgender identification[59] and gender non-conforming behaviour.[60] Julia Temple Newhook *et al.* offer a nuanced definition of reparative therapy, highlighting that it originally

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[57] Diane Ehrensaft et al, "Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens" (2018) 19:2 International Journal of Transgenderism 251 at 8; Michelle M Telfer et al, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.1* (Melbourne: The Royal Children's Hospital, 2018) at 5; James et al, *supra* note 2 at 108; UK Council for Psychotherapy et al, "Memorandum of Understanding on Conversion Therapy in the UK, Version 2", (October 2016), online: <https://www.psychotherapy.org.uk/wp-content/uploads/2017/10/UKCP-Memorandum-of-Understanding-on-Conversion-Therapy-in-the-UK.pdf>; Ximena Lopez et al, "Statement on gender-affirmative approach to care from the pediatric endocrine society special interest group on transgender health": (2017) 29:4 Current Opinion in Pediatrics 475 at 476; Noah Adams et al, "Guidance and Ethical Considerations for Undertaking Transgender Health Research and Institutional Review Boards Adjudicating this Research" (2017) 2:1 Transgender Health 165 at 171; Laura Erickson-Schroth, ed, *Trans Bodies, Trans Selves: A Resource for the Transgender Community* (Oxford: Oxford University Press, 2014) at 612; Denise Medico, Joanie Heppell & Martin Blais, "Avis au public concernant les effets nocifs des thérapies dites de conversion ou thérapies réparatrices pour l'orientation sexuelle et le genre", (17 May 2018), online: *Ordre professionel des sexologues du Québec* <https://opsq.org/wp-content/uploads/2018/05/Avis_public_TC.pdf>.

[58] Byne, *supra* note 17 at 97 explains the evolution of definitions of reparative therapy, which initially exclusively focused on sexual orientation.

[59] Jason Rafferty, "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents" (2018) 142:4 Pediatrics e20182162 at 4.

[60] *Ibid* at 8; Gabe Murchison, *Supporting & Caring for Transgender Children* (Human Rights Campaign, American Academic of Pediatrics, & American College of Osteopathic Pediatricians, 2016) at 12; Substance Abuse and Mental Health Services Administration, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth*, (SMA) 15-4928 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015) at 1, 66; Sé Sullivan, *Conversion Therapy Ground Zero: Interrogating the Production of Gender as a Pathology in the United States* (Doctoral dissertation, California Institute of Integral Studies, 2017) [unpublished] at 3.

referred to faith-based practices which sought to change sexual orientation, but has expanded in recent years to include practices which seek to change gender identity or promote a preferred gender identity outcome.[61]

This definition better captures the goals of reparative practices—such as the promotion of preferred gender identity outcomes—and acknowledges the historicity of language.[62] Unspoken in the definition is the shared understanding that the preferred gender identity outcome is aligned with the child's gender assigned at birth—we would not typically speak of reparative therapy 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 counterweigh to them. Actively promoting trans outcomes, although ethically questionable, would not typically be seen as reparative therapy.

Building upon previous attempts to define reparative therapy and the limitations of focusing on change to gender identity, I propose the following definition of trans reparative

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[61] Temple Newhook et al, *supra* note 9 at 220. The definition bears similarities with the one found in the U.K. Memorandum of Understanding. UK Council for Psychotherapy et al, *supra* note 57: "For the purposes of this document 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or gender identity, or seeks to supress an individual's expression of sexual orientation or gender identity on that basis."; see also Pyne, *supra* note 42 at 81.

[62] The term "reparative therapy" has been associated with the work of Joseph Nicolosi and the National Association for Research and Therapy of Homosexuality: Jack Drescher, "I'm Your Handyman: A History of Reparative Therapies" (1998) 36:1 Journal of Homosexuality 19 at 20; Kenneth J Zucker, "The Politics and Science of 'Reparative Therapy'" (2003) 32:5 Archives of Sexual Behavior 399 at 399; Joseph Nicolosi, *Reparative Therapy of Male Homosexuality: A New Clinical Approach* (Northvale, NJ: Aronson, 1991). In adopting the terminology of reparative therapy, I do not intend any specific allusion to his work.

therapy. Trans reparative therapy refers to any clinical approach which 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 gender assigned at birth. Trans reparative therapy is not exclusively practised on trans people and is often applied to people exhibiting gender non-conforming behaviour independently of gender identity. The belief that being trans or gender creative is undesirable underpins the practice, and often comes hand in hand with the belief that being trans or gender creative is pathological. Trans reparative therapy takes many forms, including behavioural therapy, psychodynamic therapy, parental counselling, and interventions in a naturalistic environment.[63] Play psychotherapy, limit-setting on gender non-conforming behaviour, and the encouragement of peer relations with children of the same gender assigned at birth are commonly used in contemporary forms of reparative therapy.

Is the psychotherapeutic approach reparative therapy?

The psychotherapeutic approach,[64] which was promulgated by practitioners at the now-closed CAMH Gender Identity Clinic for Children and Youth, featured prominently in the Canadian conversation on trans reparative therapy and Ontario's Bill 77. In this subsection, I will consider whether it is a form of trans reparative therapy and conclude that it is. Since it is a form of trans reparative therapy, whether bans extend to prohibit the psychotherapeutic approach is a measure of their ability to address the social problem targeted by the ban.

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[63] Jack L Turban, Annelou LC de Vries & Kenneth J Zucker, "Gender Dysphoria and Gender Incongruence" in Andrés Martin, Michael H Bloch & Fred R Volkmar, eds, *Lewis' Child and Adolescent Psychiatry*, 5th ed (Philadelphia: Wolters Kluwer, 2018) 632 at 639.

[64] The choice of terminology is informed by Zucker, *supra* note 9 at 239; and Kelley Winters et al, "Learning to listen to trans and gender diverse children: A Response to Zucker (2018) and Steensma and Cohen-Kettenis (2018)" (2018) 19:2 International Journal of Transgenderism 246 at 247.

Whether the psychotherapeutic approach amounts to reparative therapy is controversial in the academic literature. Opponents of the approach have frequently likened it to reparative therapy, [65] whereas proponents of the approach have denied the accusations. [66] The psychotherapeutic 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 adolescence onwards underpins the division into three groups.[67] However, the belief that the psychotherapeutic approach therapy should not be practised on adolescents and adults is not an unwavering commitment. Debates on the proposed developmental pathway of rapid-onset gender dysphoria have hinted at an expansion of reparative therapy to adolescents, and some authors have recently argued in favour of allowing reparative therapy for adults.[68]

The goal of the psychotherapeutic approach is to cure 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

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[65] Winters et al, *supra* note 64 at 247; Pickstone-Taylor, *supra* note 9; Tosh, *supra* note 9; Pyne, *supra* note 42; Ehrensaft et al, *supra* note 57.

[66] Susan J Bradley & Kenneth J Zucker, "Children with Gender Nonconformity" (2003) 42:3 Journal of the American Academy of Child & Adolescent Psychiatry 266. The charge levied against Bradley & Zucker in this publication related to the alleged anti-gay rather than anti-trans nature of their practices. However, their response suggests that they would find the allegation of engaging in anti-trans practices ludicrous.

[67] Kenneth J Zucker & Doug P VanderLaan, "The self in gender dysphoria: a developmental perspective" in Michael Kyrios et al, eds, *The Self in Understanding and Treating Psychological Disorders* (Cambridge: Cambridge University Press, 2016) 222 at 226.

[68] Florence Ashley, "Rapid-Onset Gender Dysphoria: A Parental Epidemic?", (21 September 2018), online: *Impact Ethics* <https://impactethics.ca/2018/09/21/rapid-onset-gender-dysphoria-a-parental-epidemic/>; Florence Ashley, "There Is No Evidence That Rapid-Onset Gender Dysphoria Exists", (3 December 2018), online: *PsychCentral* <https://psychcentral.com/lib/there-is-no-evidence-that-rapid-onset-gender-dysphoria-exists/>; Kenneth J Zucker, Anne A Lawrence & Baudewijntje PC Kreukels, "Gender Dysphoria in Adults" (2016) 12:1 Annual Review of Clinical Psychology 217.

dysphoria" through psychosocial interventions.[69] The work of Susan J. Bradley and Kenneth Zucker, closely associated with the psychotherapeutic approach, identifies the prevention of adult trans outcomes as one justification of 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."[70] Other justifications include elimination of peer ostracism through enforced gender conformity, and treatment of "other" mental illnesses.[71]

The proposed justifications for the approach have evolved and become more nuanced. Current justifications often refer to parents' desire for "their child to be comfortable in his or her skin" or stating that they "do not have a particular quarrel with the prevention of transsexualism as a treatment goal for children"[72] rather than stating that they aim at preventing adult trans outcomes.[73]

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[69] Turban, de Vries & Zucker, *supra* note 63 at 639; see also Zucker & VanderLaan, *supra* note 67 at 226: "lf, however, the gendered sense of self is judged to still be in flux, then it is reasonable to consider an array of psychosocial treatments, including treatments that might facilitate a gender identity that is more congruent with the patient's birth sex."

[70] Kenneth J Zucker & Susan J Bradley, *Gender identity disorder and psychosexual problems in children and adolescents* (New York: Guilford Press, 1995) at 269; also reiterated in similar terms in Kenneth J Zucker & Andrew G Epstein, "Prevention of Homosexuality in Adulthood", (30 March 2006), online: *Health.am* <http://www.health.am/sex/more/prevention_of_homosexuality_in_adulthood/> (revised 22 June 2011); also see Jack L Turban & Diane Ehrensaft, "Research Review: Gender identity in youth: treatment paradigms and controversies" (2017) Journal of Child Psychology and Psychiatry, online: <http://doi.wiley.com/10.1111/jcpp.12833> at 8: "This 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."

[71] Zucker & Bradley, *supra* note 70 at 269. The relevance of other psychopathologies in the context of the psychotherapeutic approach is best explained by the belief of the authors that gender variance has pathological foundations and is thus related to those other psychopathologies.

[72] Zucker et al, *supra* note 9 at 392.

[73] *Ibid* at 383: "If the parents are clear in their desire to have their child feel more comfortable in their own skin, that is, they would like to reduce their child's desire to be of the other gender, the therapeutic approach is organized around this goal. […] If parents are uncertain about how best to address their child's GID, we offer to address this further in the course of therapeutic sessions and will suggest to the parents

Despite reframing, the psychotherapeutic approach remains intent on reducing "the likelihood of GID persistence".[74] "GID" refers to the diagnosis of Gender Identity Disorder, which was replaced by the Gender Dysphoria diagnosis in the DSM-5.[75] Proponents of the psychotherapeutic approach do not consider that reduction of gender dysphoria, understood in the sense of distress vis-à-vis gendered bodily features,[76] through medical transition amounts to remission or reduction of gender dysphoria. For the psychotherapeutic approach, gender dysphoria remains as a clinical problem even though people who have transitioned may lead perfectly happy lives free from distress toward their bodies.[77] In other words, reducing the likelihood of GID persistence means reducing the likelihood that the child will continue to identify with a gender other than the one they were assigned at birth, to be trans.

The psychotherapeutic approach departs from preceding forms of trans reparative therapy, which adopted classical behavioural therapy. Proponents of the psychotherapeutic approach are critical of classical behavioural therapy. However, they are critical of it not because behavioural therapy, and especially aversion therapies, may be harmful, but because targeting behaviours may not "fully alter internal gender schemas", which would lead children to "revert to their cross-

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that we hold off on making any specific decisions about intervention options." What addressing this further means is unclear, but in the context of the article as a whole as well as other materials describing the psychotherapeutic approach, it most plausibly involves convincing parents of the necessity of reducing the child's desire to be of the other gender. The role of parental decision would thus not be to figure out and decide what is best for the child so much as assent to proposed treatment.

[74] *Ibid* at 393; Meadow, *supra* note 18 at 58: "Those with a more classical orientation, like Ken [Zucker], believed that short of psychologically damaging treatments, children should be encouraged to avoid transition if at all possible".

[75] American Psychiatric Association, *supra* note 49; Meadow, *supra* note 18 at 63: "While Ken [Zucker] said he believes it is the distress over the incongruity that makes gender dysphoria a mental illness, no amount of shifting nomenclature can change the essential feature of its phenomenology." The quote is ambiguous; I read it as referring to a belief of Dr. Zucker according to which, wherever we situate the locus of illness, the experience of gender dysphoria remains fundamentally pathological.

[76] Coleman et al, *supra* note 1 at 221.

[77] Zucker et al, *supra* note 9 at 393.

gender behavioral preferences in the absence of external cues or incentives."[78] Instead, they rely on regular play psychotherapy, parent counselling, and parental limit-setting on gender non-conforming behaviour.[79] Identification of factors that are said to contribute to gender identity and gender non-conformity also plays a part in delineating the treatment plan.[80]

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

> Before 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.[81]

This explanation adroitly captures the conceptual logic under which the psychotherapeutic approach operates—though the assumption of parental heterosexuality may be slowly waning. Gender creativity and being transgender is seen as constitute of mental illness, and this assumption

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[78] Zucker & Bradley, *supra* note 70 at 273.

[79] Kenneth J Zucker, "'I'm Half-Boy, Half-Girl': Play Psychotherapy and Parent Counseling for Gender Identity Disorder" in Robert L Spitzer & American Psychiatric Publishing, eds, *DSM-IV-TR casebook: experts tell how they treated their own patients* (Washington, DC: American Psychiatric Publishing, 2006); Zucker et al, *supra* note 9 at 388; Turban & Ehrensaft, *supra* note 70 at 8.

[80] Zucker et al, *supra* note 9 at 374, 382. Parents are often identified by practitioners of the psychotherapeutic approach as contributing causes of gender creativity in children. For a critique of this position, see Diana Kuhl & Wayne Martino, "'Sissy' Boys and the Pathologization of Gender Non-Conformity" in Susan Talburt, ed, *Youth sexualities: public feelings and contemporary cultural politics* (Santa Barbara, CA: Praeger, 2018) 31.

[81] Meadow, *supra* note 18 at 73.

is so deeply rooted that it is rarely spelled out by theorists of the psychotherapeutic approach, and instead simply assumed.

The psychotherapeutic approach clearly falls under the definition of reparative therapy which I have proposed. However, proponents of the approach have long rejected the label of reparative therapy.[82] It is unclear whether their claim that the psychotherapeutic approach is not reparative therapy reflects a genuine theoretical position or a desire not to be associated with the politically-loaded connotations of reparative and conversion therapy. Proponents of the psychotherapeutic approach have not, as far as I am aware, detailed their reasons for rejecting the label of trans reparative therapy.

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 psychotherapeutic approach should not be construed as reparative therapy because there is no consensus over appropriate treatment for gender creative youth, unlike treatment regarding sexual orientation.[83]

This critique is not convincing. The label "reparative therapy" does not imply the presence of consensus and was being deployed in opposition to gay reparative therapy before the consensus that these practices are unethical was reached.[84]

Furthermore, the relevant consensus exists. Although the consensus over the best treatment for gender creative youth is still emerging, there is a consensus that treatments seeking to align

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[82] Bradley & Zucker, *supra* note 66. The charge levied against Bradley & Zucker in this publication related to the alleged anti-gay rather than anti-trans nature of their practices. However, their response suggests that they would find the allegation of engaging in anti-trans practices ludicrous.

[83] Byne, *supra* note 17 at 98.

[84] The term was notably used in Judd Marmor, ed, *Sexual Inversion: The Multiple Roots of Homosexuality* (New York: Basic Books, 1965), nine years before the declassification of homosexuality for the DSM-II 1974 reprint. See also Spitzer, *supra* note 43.

individuals' gender identity and gender expression on their gender assigned at birth are unethical.[85] We may not yet have reached a clinical consensus over which approach is the best, but consensus was reached over the inadequacy of the psychotherapeutic approach.

Responding to Dr. Byne's critique reveals an important distinction between terminology and ethics. Labelling a practice "reparative therapy" does not suffice to establish the immorality of the practice. Rather, the label serves to group together a wide range of practices which share certain traits and assumptions. By adopting the term "reparative therapy", I do not intend to pre-judge the legality of the practice, but rather to find a term with which to capture a range of practices including the psychotherapeutic approach. Terminological debates should not overshadow substantive debates about the legality and ethicality of clinical practices.[86]

Since the psychotherapeutic 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 gender assigned at birth", it is a form of trans reparative therapy. Whether the psychotherapeutic approach is outlawed by bans on trans reparative therapy will be considered in greater detail in the next chapter. Since the psychotherapeutic approach is the most thoroughly theorised form of trans reparative therapy, this thesis will frequently refer to the work of proponents of the psychotherapeutic approach as exemplars of reparative therapy.

In this chapter, I have show that trans reparative therapy is a live debate regarding ongoing clinical practices in Canada, defined trans reparative therapy, and argued that the psychotherapeutic approach is a form of trans reparative therapy. Bans which unintentionally fail

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[85] Coleman et al, *supra* note 1 at 175.

[86] Jake Pyne, "Is CAMH trying to turn trans kids straight?", *NOW Toronto* (1 April 2015), online: <https://nowtoronto.com/news/is-camh-trying-to-turn-trans-kids-straight/>.

to prohibit the psychotherapeutic approach have too narrow a scope. In the next chapter, I turn to the scope and legal effects of bans on reparative therapy.

CHAPTER II: PROHIBITIONS

In this chapter, I set out to elucidate the scope of trans reparative therapy bans. In the first section, I apply traditional interpretive tools to Ontario Bill 77, delineating the range of behaviours to which it applies. In the second section, I provide an overview of the growing prohibition of trans reparative therapy worldwide and propose a dual typology of trans reparative therapy bans based on textual similarity and lineage and based on the form taken by the prohibition. Despite indications, in the previous chapter, that bans may be insufficiently specific, properly interpreting them reveals their large scope which includes the psychotherapeutic approach. Although there is great diversity across jurisdictions, many similarities exist between bans in terms of both scope and legal effects.

Ontario Bill 77, the Affirming Sexual Orientation and Gender Identity Act

The Ontario legislature intervened in the therapeutic world when, on June 4th, 2015, the *Affirming Sexual Orientation and Gender Identity Act* received royal assent.[87] The statute, known as Bill 77, amended the *Regulated Health Professions Act, 1991*[88] to prohibit reparative therapy.[89]

As amended, the *Regulated Health Professions Act, 1991* provides:

> 29.1 (1) No person shall, in the course of providing health care services, provide any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age.
>
> (2) The treatments mentioned in subsection (1) do not include,

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[87] *Affirming Sexual Orientation and Gender Identity Act, 2015*, *supra* note 14 at 77.

[88] *Regulated Health Professions Act, 1991*, SO 1991, c 18 [*Regulated Health Professions Act, 1991*], s 29.1.

[89] The statute also excluded reparative therapy from insured services under the *Health Insurance Act*, RSO 1990, c H6 [*Health Insurance Act*].

(a) services that provide acceptance, support or understanding of a person or the facilitation of a person's coping, social support or identity exploration or development; and

(b) sex-reassignment surgery or any services related to sex-reassignment surgery.

(3) Subsection (1) does not apply if the person is capable with respect to the treatment and consents to the provision of the treatment.

(4) Despite the *Health Care Consent Act, 1996*, a substitute decision-maker may not give consent on a person's behalf to the provision of any treatment described in subsection (1).

(5) Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations,

(a) clarifying the meaning of "sexual orientation", "gender identity" or "seek to change" for the purposes of subsection (1);

(b) exempting any person or treatment from the application of subsection (1).

Situated in the *Regulated Health Professions Act*, the section is enforced through complaints and independent investigations by regulating bodies.

Two notions must be elucidated if we wish to determine the reach of the law: gender identity and change thereof. The elucidation of those concepts is an invitation to foray into legislative history, previous judicial determinations, the social context of the legislation, and external texts which informed the drafting of the law.

Defining "gender identity"

For Bill 77 to fulfil its legislative goal, "gender identity" must be interpreted to include self-reported gender identity. Interpreting "gender identity" as only referring to the person's underlying gender identity, as assessed by the practitioner, would prevent the Bill from effectively prohibiting trans reparative therapy since any practitioner could defend against a claim by claiming that the patient or client's underlying gender identity differs from their self-reported identity. In

this subsection, I consider the history of the term gender identity, the definition provided by the Ontario Human Rights Commission, the legislative history of Bill 77, and its social context to conclude that "gender identity" refers to self-reported identity.

History of gender identity

Gender identity originated in United States medical discourse and later made its way into Canadian law through caselaw. Although much of this case law arose outside of Ontario, other provinces' case law interpreting gender identity is relevant to Ontario given the influence that this case law had on the development of Ontarian human rights law.

Gender identity was coined in 1963 by Robert Stoller and Ralph Greeson at the International Psycho-Analytic Congress.[90] In 1964, Robert Stoller wrote that gender identity refers to the "the sense of knowing to which sex one belongs, that is, the awareness 'I am a male' or 'I am a female'", adding that it "clearly refers to one's self-image as regards belonging to a specific sex".[91] In Canadian jurisprudence, the first case which foregrounded the question of gender identity came from a Worker's Compensation Tribunal case, in 1993. The implicated individual was an adult patient of the Clarke Institute's Gender Identity Clinic, which later became the CAMH clinic. The patient had previously been diagnosed with Gender Identity Disorder.[92] The case was concerned with whether being trans precluded the worker from rehabilitation following an ankle injury. In answering negatively, the tribunal spoke of her as having a "problem" or "conflict" of gender identity to be resolved.

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[90] Kyle Kirkup, "The origins of gender identity and gender expression in Anglo-American legal discourse" (2018) 68:1 University of Toronto Law Journal 80 at 87.

[91] Robert J Stoller, "A Contribution to the Study of Gender Identity" (1964) 45 International Journal of Psycho-Analysis 220 at 220.

[92] *Decision No 716/92*, 1993 CanLII 5958 (ON WSIAT).

A few years later, the seminal case *Sheridan v. Sanctuary Investments Ltd* established that trans people could access the washrooms corresponding to their gender identity.[93] It relied on a Quebec decision that centred the notion of "identité sexuelle", the then-common French term for gender identity.[94] In *Sheridan*, expert testimony explained gender identity as "the person's inner subjective experience of femininity or masculinity", analogising a trans woman's gender identity to having "a female brain". This characterisation was adopted by the tribunal. *Sheridan* has frequently been cited in Ontario human rights cases.[95]

The term has since evolved in popular and legal usage, notably through the growing acknowledgement of non-binary genders.[96] In Quebec, Jean-Sébastien Sauvé has argued that protections for non-binary people on the protected grounds of sex were uncertain, suggesting that the province's *Charter of Human Rights and Freedoms* be amended to clarify such protections

[93] *Sheridan v Sanctuary Investments Ltd (c.o.b BJ's Lounge)*, [1999] BCHRTD No 43; 33 CHRR D/467 (BCHRT).

[94] *Commission des droits de la personne et des droits de la jeunesse c Maison des jeunes A.*, [1998] RJQ 2549; 33 CHRR 263 (QC TDP). Avoiding possible confusing, the adjudicator differentiated sexual identity from sexual orientation.

[95] See, e.g., *Forrester v Peel (Regional Municipality) Police Service Boards*, 2006 HRTO 13 (ON HRT); *Hogan v Ontario (Minister of Health & Long-Term Care)*, 2006 HRTO 32 (ON HRT); *XY v Ontario (Government and Consumer Services)*, 2012 HRTO 726, [2012] OHRTD No 715 (ON HRT).

[96] In Ontario caselaw, see *JPK v SE*, 2017 ONCJ 306 (ON CJ); *TA v Ontario (Transportation)*, 2016 HRTO 17 (ON HRT).

through the addition of "gender identity" as a protected ground.[97] In 2016, "gender identity" was added to the *Charter*.[98]

Contemporary definitions of gender identity are similar to the one provided by Stoller in 1963. The World Professional Association for Transgender Health's *Standards of Care* define gender identity as: "A person's intrinsic sense of being male (a boy or a man), female (a girl or a woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch)".[99]

Ontario Human Rights Commission definition

The definition given by the Ontario Human Rights Commission in its *Policy on preventing discrimination because of gender identity and gender expression* reflects an understanding of gender identity that is largely in line with the initial coinage: "Gender identity is each person's internal and individual experience of gender."[100]

The Ontario Human Rights Commission definition helps interpret Bill 77. Although they do not have force of law, the policies of the Commission carry an unmistakeable weight. The legislature's intention for OHRC policies to be used as interpretive tools in judicial decisionmaking is made clear in the Human Rights Code, which imposes on the Ontario Human Rights Tribunal a

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[97] Jean-Sébastien Sauvé, "L'interdiction de discriminer les personnes trans* dans la Charte des droits et libertés de la personne : pour son amélioration par l'ajout de l'« identité de genre » et de l'« expression de genre » à la liste des motifs de distinction illicites" (2015) 23 Enfances, Familles, Générations 108; I have expressed disagreement on this point in Florence Ashley, "Qui est-ille ? Le respect langagier des élèves non-binaires, aux limites du droit" (2017) 63:2 Service social 35. In my opinion, a contextualised reading of the jurisprudence establishing that trans people are protected under the ground of sex, coupled with our current understanding of non-binary identities and gender identity, would have resulted in the recognition of non-binary people as a protected class before the courts.

[98] *An Act to strengthen the fight against transphobia and improve the situation of transgender minors in particular*, SQ 2016, c 19 [*Bill 103*].

[99] Coleman et al, *supra* note 1 at 221.

[100] Ontario Human Rights Commission, *Policy on preventing discrimination because of gender identity and gender expression* (Toronto: Ontario Human Rights Commission, 2014) at 7.

duty to consider OHRC policies when requested by parties.[101] Legislatures are presumed to be aware of caselaw—and presumably their governmental bodies' policies—which interprets a term.[102] In the absence of indications otherwise, adopting the language of "gender identity," which is also found in the Ontario *Human Rights Code,*[103] should be presumed to be an adoption of the interpretation of the concept under the law.

Legislative history

The legislative history of the bill complicates this picture. Bill 77 originally specified that gender identity was "the patient's self-identified […] gender identity", but the wording was removed. The significance of this removal is ambiguous. On the one hand, the original wording could be interpreted as evidence of legislative intent. In that reading, the goal of the law is to protect self-reported gender identity, preventing defendants from arguing that they did not seek to change the patient's gender identity since the patient was merely mistaken in reporting their gender identity. The word "self-identified" may have been removed because it is unnecessary, "gender identity" already referring to self-identification.

On the other hand, its removal could be interpreted as evidence that legislators did not wish to extend protection to self-identification, and only decided to protect the "real" underlying gender identity. Yet, human rights law does not typically require proof of gender identity as a precondition of protection.[104] Assertion is sufficient in the absence of a serious reason to doubt the expressed gender identity.[105] It could be argued that mental health professionals are in a position to assess

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[101] *Human Rights Code*, RSO 1990, c H19 [*Human Rights Code*], s 45.5(2).
[102] Ruth Sullivan, *Statutory Interpretation: Essentials of Canadian Law*, 3d ed (Toronto: Irwin Law, 2016) at 179, 182.
[103] *Human Rights Code*, *supra* note 101, s 1.
[104] *Vanderputten v Seydaco Packaging Corp*, 2012 HRTO 1977 (ON HRT).
[105] *Forrester v. Peel (Regional Municipality) Police Service Boards*, *supra* note 95, paras 444–446.

whether there are serious reasons to doubt the person's self-identification, and that they are therefore in a unique position to assess the accuracy of self-reported gender identity. Unlike Quebec, Ontario requires a letter from a licensed physician or psychologist attesting that they "are of the opinion that the change of sex designation on the birth registration is appropriate" in order to change said sex designation.[106] The recognition of professionals' legitimacy in assessing whether a person is transgender, although questionable,[107] could be read as favouring an interpretation of Bill 77 which enables professionals to doubt gender self-identification and act upon that doubt. However, the legislature is presumed to know the caselaw interpreting the notion of gender identity, and thus far human rights law has relied on self-report.

Social context

A different principle of interpretation is of aid here. Plainly stated, legislation is intended to address a problem. As Justice Binnie stated in *Re Canada 3000*, "[t]he notion that a statute is to be interpreted in light of the problem it was intended to address is as old at least as the 16th century."[108] Reparative therapy is commonly justified by the belief that the person's gender identity or sexual orientation is not an expression of a true gendered self. Since it is impossible to externally confirm a person's gender identity, it will always be possible to claim that the person's self-reported gender identity or sexual orientation is mistaken. To exclude from application instances of reparative therapy where practitioners argue that the person's expressed gender

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[106] Service Ontario, *Application for a Change of Sex Designation on a Birth Registration of an Adult: 11325E* (Queen's Printer for Ontario, 2018); see also *XY v. Ontario (Government and Consumer Services)*, *supra* note 95, para 297.

[107] I criticise the practice of assessment from a bioethical standpoint in Florence Ashley, "Gatekeeping Hormone Replacement Therapy for Transgender Patients is Dehumanising" (2019) 45:7 Journal of Medical Ethics 480.

[108] *Canada 3000 Inc, Re; Inter-Canadian (1991) Inc (Trustee of)*, 2006 SCC 24; [2006] 1 SCR 865, para 36.

identity reflected a false belief would deprive the law of its ability to address the ill towards which it is directed.

Taken together, the factors considered in this subsection suggest that "gender identity" in Bill 77 should be interpreted as referring to self-reported gender identity.

Defining "seeks to change"

Insofar as Bill 77 only applies to those who seek to change gender identity—language I criticized in the first chapter—does it ban all forms of reparative therapy? In this section, I will interpret the scope of the words "seeks to change". Three aspects of the Bill are informative when interpreting these words: the removal of "or direct", the Standing Committee on Justice Policy hearings, and the list of exceptions in section 29.1(2) of Bill 77. I conclude that "seeks to change" must be interpreted as extending to all forms of reparative therapy, including the psychotherapeutic approach.

Removing "or direct" from Bill 77

The original version of the bill, as tabled by Cheri DiNovo, was not limited to services which seek to change gender identity, but also included services which seek to direct gender identity. The words "or direct" were removed from the final version of the bill at the request of members of the governing Liberal Party.[109]

The removal of "or direct" could be interpreted as evidence of an intention not to ban practices that seek to direct gender identity. Under this interpretation, mere pressure or nudging—however strong—does not constitute prohibited conduct. It is necessary that the practice amount to attempting to change the identity. This interpretation fails to prohibit the full range of trans

[109] Personal communications with Cheri DiNovo, October 5th, 2018.

reparative therapy and would leave many reparative practices legal. It would void the bill of its ability to address the very ill it seeks to prohibit. In Ontario, statutes "shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects"[110] and this object includes all practices which seek to discourage identification with a gender other than the one assigned at birth.

A second possible interpretation is that the shift from "change or direct" to "change" was motivated by a desire to tighten the language of the bill and avoid ambiguity. Under this interpretation, the fact that "or direct" was included in the original language indicates an intention to prohibit more than is captured by the word "change", though perhaps perhaps not including all instances of gender identity being directed since relatively trivial pressures could be said to amount as directing gender identity. I believe that this second interpretation is more faithful to legislative intent and better prohibits the full scope of trans reparative therapy.

Prohibiting therapies which seek to avoid adult trans outcomes

The legislative history of the bill suggests that the legislature intended Bill 77 to include the psychotherapeutic approach and other practices that aim at discouraging or reducing the likelihood of trans outcomes. Although legislative history does not constitute incontrovertible evidence of legislative intent, it is a relevant aid in determining the problem which the Bill sought to address.[111]

The Standing Committee on Justice Policy hearings prior to the third reading of Bill 77 provide evidence of legislative desire to prohibit therapies that aim at preventing or minimising adult trans outcomes. Cheri DiNovo, who sponsored Bill 77, stated before the Committee that the

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[110] *Legislation Act, 2006*, SO 2006, c 21 [*Legislation Act, 2006*], s 64(1).
[111] Sullivan, *supra* note 102 at 208; *R v Chartrand*, [1994] 2 SCR 864 at 880ff.

bill was proposed at the suggestion of TG Innerselves, among others, and was designed to lower suicidality among queer and especially trans youth.[112] Vincent Bolt spoke for the group TG Innerselves, and framed reparative therapy as practices which make patients "feel like [their] entire being [is] wrong", giving the example of Leelah Alcorn as a victim of trans reparative therapy.[113]

The testimony of Erika Muse, a trans woman who underwent reparative therapy, also highlights the broader understanding of reparative therapy which motivates Bill 77. In her opening statement to the second reading of the bill, Cheri DiNovo referred to Erika Muse's as a patient of "a specific therapist" who, she was told, "was the only option available under OHIP coverage."[114] She described how the sessions impacted her in the following terms:

> I was denied the medication I asked for that was appropriate for my age, but I had to return for more therapy. In each appointment that I came to, he would comment on newly masculinized parts of my body that had been changing due to puberty—parts he could have stopped from developing had he given me care—then asked me how I could possibly pass as a woman in my future life. He would berate me for not meeting unknown expectations and excoriated my life at that point. Sessions were not therapeutic, but abusive. […] Eventually, he relented and allowed me some care, but I think the only reason he did is that I proved to him I couldn't be fixed. […] The scars of his abuse remain. I've been suicidal and depressed due to his treatment of me.[115]

She summarized her perspective on the care provided by Ontario Health Insurance Plan (OHIP) by saying that it is "mainly abusive and to some degree conversion-therapy-based care".[116]

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[112] Legislative Assembly of Ontario, Standing Committee on Justice Policy, *supra* note 40 at JP-58.
[113] *Ibid* at JP-57.
[114] *Ibid* at JP-63.
[115] *Ibid*.
[116] *Ibid*.

Her emotional talk before the Standing Committee provides important insight into the context which gave rise to Bill 77.[117] Given that Cheri DiNovo specifically referred to her experiences at the second reading of Bill 77 and that she was invited to speak about her experience before the Committee, we have reasons to think that avoiding future experiences like hers was part of the *raison d'être* of Bill 77.

Bill 77 must be interpreted broadly if it intends to prohibit the practices that Erika Muse was subjected to. Erika Muse was a patient of the CAMH Gender Identity Clinic for Children and Youth. [118] The clinic practiced the psychotherapeutic approach, which aims at reducing the likelihood of youth growing up trans.[119] For Bill 77 to address the social problem targets, the psychotherapeutic approach and other practices that aim at discouraging or reducing the likelihood of trans outcomes must fall within the scope of the prohibition. Interpreting "seeks to change" narrowly and excluding practices demonstrating hostility to trans outcomes from the application of the bill would fail to protect those who, like Erika Muse, were part and parcel of the inspiration of the bill.

Intent to prohibit the psychotherapeutic approach was also evidenced when Cheri DiNovo, the bill sponsor, quoted Jake Pyne at second reading, saying: "If your practice does not respect gender diversity, if in fact, you insist on treating gender diversity in young people as a disorder to be cured or prevented, then you will no longer have the use of public funds to do so."[120] This quote

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[117] Sullivan, *supra* note 102 at 208; *R. v. Chartrand*, *supra* note 111 at 880ff.

[118] Cristan Williams, "#DiscoSexology Part V: An Interview With Zucker's Patient", *TransAdvocate* (2 February 2017), online: <https://www.transadvocate.com/part-v-interview-with-zuckers-patient-the-rise-and-fall-of-discosexology-dr-zucker-camh-conversion-therapy_n_19727.htm>.

[119] Zucker et al, *supra* note 9 at 393.

[120] Legislative Assembly of Ontario, *Affirming Sexual Orientation and Gender Identity Act, 2015*, 41-1 (2 April 2015) at 3345 (Cheri DiNovo).

was taken from an article in NOW Toronto which questioned the ethicality of the practices at the CAMH Gender Identity Clinic for Children and Youth.[121] Before the Standing Committee, Jake Pyne later framed the practices targeted by the bill as "treatment that seeks to correct young people", a framing that is reminiscent of the definition proposed in chapter 0 and which invites us to adopt a broad and liberal interpretation of "change" in order to include practices which seek to prevent or minimise the likelihood of adult trans outcomes.

Legislative history suggests that the legislature intended for Bill 77 to be interpreted broadly as including all forms of reparative therapy. The terms "seeks to change" should be interpreted in light of this intent, and include approaches which 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 gender assigned at birth

Interpreting subsection 29.1(1) together with subsection 29.1(2)

Subsection 29.1(2) is indicative of legislative intent. Reading subsections 29.1(1) and 29.1(2) of the law together suggests that the prohibition of reparative therapy should be interpreted broadly as including all forms of reparative therapy, including the psychotherapeutic approach. I begin by arguing that subsection 29.1(2) suggests subsection 29.1(1) should be interpreted broadly, and that all forms of reparative therapy are therefore prohibited. I then consider two possible counterarguments. The first counterargument advances that if the legislature wanted to include the psychotherapeutic approach under the prohibition, it would have done so explicitly. The second counterargument advances that many forms of reparative therapy such as the psychotherapeutic

[121] Pyne, *supra* note 86.

approach fall under an exception set out in subsection 29.1(2). As I will show, neither of these counterarguments is plausible.

For convenience, I reproduce the subsections of the act:

29.1 (1) No person shall, in the course of providing health care services, provide any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age.	29.1 (1) Nul ne doit, lorsqu'il fournit des services de soins de santé, fournir un traitement visant à changer l'orientation sexuelle ou l'identité sexuelle d'une personne de moins de 18 ans.
(2) The treatments mentioned in subsection (1) do not include,	(2) Sont exclus des traitements visés au paragraphe (1) :
(a) services that provide acceptance, support or understanding of a person or the facilitation of a person's coping, social support or identity exploration or development; and	(a) les services consistant à offrir acceptation, soutien ou compréhension à une personne ou à faciliter l'adaptation, l'accompagnement social ou l'exploration ou le développement identitaires de celle-ci;
(b) sex-reassignment surgery or any services related to sex-reassignment surgery.	(b) le changement chirurgical de sexe ou tout service qui s'y rapporte.

If subsection 29.1(1) was to be interpreted narrowly, it would be unnecessary to exclude affirmative practices in subsection 29.1(2), as they would plainly not be included in the notion of reparative therapy. This exclusion provision shows legislative awareness that subsection 29.1(1) is phrased broadly, including such a wide range of practices that they found it wise to specify that affirmative practices aren't prohibited. They did not provide an exception for practices that seek to prevent adult trans outcomes, even though they would surely be prohibited under any interpretation of subsection 29.1(1) that would also prohibit the affirmative practices set out under subsection 29.1(2). If the legislature had wanted to only prohibit practices that narrowly seek to change gender identity, but not those which seek to prevent, discourage or minimise the likelihood of adult trans outcomes, they would have explicitly excluded those practices. We must therefore

infer that all forms of reparative therapy, including the psychotherapeutic approach, are prohibited by subsection 29.1(1).

A first possible counterargument is that if the legislature wanted to prohibit the psychotherapeutic approach—which seeks to discourage or minimise the likelihood of trans outcomes—it would have done so explicitly. This counterargument is related to the argument, considered earlier in this chapter, that removing "or direct" from Bill 77 is evidence that the legislature did not intend for merely directing or discouraging gender identities to be prohibited. As I pointed out, removing these terms is equally compatible with an understanding that "seeks to change" is already sufficiently broad to capture all forms of reparative therapy. An analogous response can be given here. Subsection 29.1(2) suggests that the legislature intended subsection 29.1(1) to be interpreted broadly. If subsection 29.1(1) is broadly and liberally interpreted, it is unnecessary to specify that all forms of reparative therapy including the psychotherapeutic approach are prohibited since that is what 29.1(1) already does. This counterargument would have been more convincing had Bill 77 included a list of practices included under the prohibition. Since it does not and since subsection 29.1(1) is to be interpreted broadly, the counterargument fails.

A second possible counterargument is that some forms of reparative therapy, and especially the psychotherapeutic approach, fall under an exception set out in subsection 29.1(2). However, interpreting the exceptions set out in that subsection as shielding some forms of reparative therapy is inconsistent with both the spirit and letter of these exclusions. To understand why subsection 29.1(2) does not exclude any reparative therapy from the scope of 29.1(1). As I argue below, the textual source of subsection 29.1(2) makes it clear that it only excludes affirmative approaches. This conclusion obtains whether subsection 29.1(2) is interpreted as an exhaustive or as an illustrative list.

Subsection 29.1(2) can be interpreted as either an exhaustive list or an illustrative list. When one or more instances are mentioned that fall within a given class of things—in the present case, therapeutic practices—other instances are implicitly excluded. This is the principle of *expressio unius est exclusio alterius.*[122] The principle, however, only applies where the list is exhaustive. Its application can be rejected if, with regard to the context as a whole, the list is best interpreted as illustrative—as is the case when the *ejusdem generis* principle is applied. The *ejusdem generis* principle pulls in the other direction. When illustrative examples are given alongside general wording that expands from those examples, further instances should only be interpreted as falling under the provision if they are of the same type as the illustrative examples.[123] For example, if one were to interpret "other foodstuffs" in a statute referring to "bananas, apples, peaches, and other foodstuffs", the *ejusdem generis* rule would invite us to restrict "other foodstuffs" to fruits.

Both principles are relevant to interpreting subsection 29.1(2). Under the *ejusdem generis* principle, reparative practices may be excluded from the subsection 29.1(1) prohibition if they are in the spirit of listed exclusions, whereas under the *expressio unius* principle, they may only be excluded from the prohibition if they fall within the letter of an exclusion listed under 29.1(2).

Although at first glance subsection 29.1(2) does not appear to have the type of general wording which would invite an application of the *ejusdem generis* principle, the subsection itself can be interpreted either as an interpretive guide to subsection 29.1(1) or as an exhaustive list of exclusions to it. Put more simply, the subsections together can be read either as "reparative therapy

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[122] *Schnarr v Blue Mountain Resorts Limited*, 2018 ONCA 313 (ONCA), paras 52, 57.
[123] *Ibid*, paras 52–56.

is prohibited, and by reparative therapy we do not mean gender-affirmative care" or as "reparative therapy is prohibited but we exclude the following practices from the prohibition". The fact that the heading between 29.1(1) and 29.1(2) reads "Exception" seems to lend credence to the interpretation that the latter states an exception. However, the choice of terms "do not include" instead of a clearer statement of exception—such as "Subsection (1) does not apply with respect to […]", as found in subsection 30(1) of the same statute[124]—points in the contrary direction.

It is unnecessary to determine whether subsection 29.1(2) should be read as an exhaustive or an illustrative list because all reparative practices including the psychotherapeutic approach are contrary to both the letter and the spirit of subsection 29.1(2). Thus, even if the *ejusdem generis* principle is the applicable one, the psychotherapeutic approach remains prohibited. The textual source of subsection 29.1(2) makes it clear that both the spirit of 29.1(2) and the meaning of each individual exclusion are restricted to practices that are gender-affirmative and neutral with regards to gender identity outcomes.

Taking the textual source of subsection 29.1(2) into consideration, it appears that all psychosocial interventions that fall under the notion of reparative therapy are prohibited by Bill 77. Subsection 29.1(2) is textually lifted from the *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation.*[125] The similarity of the texts is relevant to interpretation. In *R. v. McIntosh*, the Supreme Court of Canada was faced with interpretation of the self-defence provisions under the *Criminal Code*. At the time,

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[124] *Regulated Health Professions Act, 1991*, *supra* note 88, s 30(2).
[125] It is also found in each of the U.S. state laws on reparative therapy.

the provisions bore striking textual similarity to the homologous New Zealand one. Speaking for the majority, Lamer J. relied on this similarity to interpret the Canadian law:

> If Parliament's intention is to be implied from its legislative actions, then there is a compelling argument that Parliament intended s. 34(2) to be available to initial aggressors. When Parliament revised the *Criminal Code* in 1955, it could have included a provocation requirement in s. 34(2). […]. The fact that Parliament did not choose this route is the best and only evidence we have of legislative intention, and this evidence certainly does not support the Crown's position.[126]

It seems reasonable to think that such an inference of legislative intention would also be available where the source text is non-legislative in nature. The reasoning of the Supreme Court relied not on the fact that the law's text was lifted from a law, but rather that it was lifted at all—with the implication that its meaning should be presumed to be the same except to the extent the law differs from the source material. Unlike the situation in *McIntosh*, however, subsection 29.1(2) does not significantly differ from the language of the task force report. The substitution of "and" for "or" is largely stylistic and does not alter the meaning of the listed interventions.

Given the close relationship between the two texts, the task force report is a powerful textual aid in interpreting the meaning of the legal provision. The exclusions set out in 29.1(2) are grouped together in the report under the label of "affirmative therapeutic interventions".[127] Although the task force report explicates affirmative interventions within the context of sexual orientation, their descriptions apply *mutatis mutandis* to gender identity. For instance, the state that "same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of

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[126] *R v McIntosh*, [1995] 1 SCR 686 (SCC), para 25; see also Sullivan, *supra* note 102 at 182ff.

[127] American Psychological Association, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (Washington, DC: American Psychological Association, 2009) at v.

human sexuality; in other words, they are not indicators of mental or developmental disorders"[128] would apply equally to gender identity. Having a gender identity which differs from the gender we were assigned at birth is a normal and positive variant of human gender subjectivity and is not an indicator of mental disorder, as confirmed by the DSM-5's shift in language from Gender Identity Disorder to Gender Dysphoria.[129]

The label is indicative of the spirit binding together the various 29.1(2) exclusions. Under the *ejusdem generis* principle, the psychotherapeutic approach would only be also excluded if it can be termed an affirmative therapeutic intervention—which it cannot. The label is also useful when applying the *expressio unius* principle, since it can help us interpret the meaning of listed exclusions: they must be interpreted in a way that is compatible with the label "affirmative therapeutic intervention". I now turn to the meaning of listed exclusions and conclude that none of them can be read to include the psychotherapeutic approach or any other form of reparative therapy. All forms of reparative therapy are prohibited from subsection 29.1(1) and cannot be saved by subsection 29.1(2).

Basing ourselves on the task force report, subsection 29.1(2)(a) can be subdivided into (1) acceptance and support, (2) understanding, (3) coping, (4) social support, and (5) identity exploration and development. Since subsection 29.1(2)(b) is not primarily concerned with therapeutic interventions, I will not concern myself with elucidating the precise meaning of "sex-reassignment surgery or any services related to sex-reassignment surgery."

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[128] *Ibid* at 54.
[129] American Psychiatric Association, *supra* note 49.

The notion of acceptance and support in subsection 29.1(2)(a) is grounded in the client-centred approach to therapeutic care. It is practiced through "unconditional positive regard for and congruence and empathy with the client", "openness to the client's perspective as a means of understanding their concerns", and "encouragement of the client's positive self-concept."[130] The practice is non-judgemental—and thus cannot exhibit any preference of outcome—and primarily aims at reducing distress brought on by stigma, isolation, and internalised shame.[131] In the context of clients who wish to change their gender identity, acceptance and support means addressing the conflict between identity and desire in a non-judgemental manner—the therapist must not judge the person for having difficulty accepting themselves—by exploring why they want to change their identity.

The provision of understanding in subsection 29.1(2)(a) corresponds, in the report, to comprehensive assessment. The comprehensive assessment is undertaken "in order to obtain a fuller understanding of the multiple issues that influence" the trans or gender creative person's desire not to be trans, foregrounding the interconnectedness of gender identity and whole person.[132] Depression, anxiety, substance abuse, sexual compulsivity and post-traumatic stress disorder are common among trans people, in large part due to stigma and poor self-image. Past traumatic experiences as well as cultural and family context are also crucial to gain a full picture of the person. This assessment is not geared towards identifying factors which may lead people to be trans or gender creative, as is the case under the psychotherapeutic approach.[133] Approaches that seek to understand why a person identifies the way they do, especially in the hopes of acting upon

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[130] American Psychological Association, *supra* note 127 at 55.
[131] *Ibid*.
[132] *Ibid* at 56.
[133] Zucker et al, *supra* note 9.

that identification, would not fall under the notion of understanding as set out in the task force report and, thus, subsection 29.1(2).

The task force report encourages mental health professionals to empower patients with strategies that "resolve, endure, or diminish stressful life experiences" because being trans or gender creative ca be a difficult experience.[134] This section of the report corresponds to the notion of coping in subsection 29.1(2)(a). A range of coping strategies are proposed, including multiple common therapeutic interventions such as cognitive-behavioural therapy, mindfulness-based therapy, and narrative therapy. Like acceptance and support, those interventions aim at reducing distress brought on by stigma, isolation, and shame.

The inclusion of social support in subsection 29.1(2)(a) reflects the task force's recognition that "struggling with a devalued identity without adequate social support has the potential to erode psychological well-being."[135] Access to mutual support groups, self-help groups, welcoming communities, and psychotherapy are all encouraged by the task force report for their positive impact on minority stress, marginalisation, and isolation. The gender-affirmative approach to trans youth care has indeed long foregrounded the importance of support groups and group treatment for gender creative youth and their parents.[136]

The facilitation of identity exploration and development, the final intervention in subsection 29.1(2)(a), is also detailed in the task force report. According to the report, these

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[134] American Psychological Association, *supra* note 127 at 57.
[135] *Ibid* at 59.
[136] Miriam Rosenberg, "Children With Gender Identity Issues and Their Parents in Individual and Group Treatment" (2002) 41:5 Journal of the American Academy of Child & Adolescent Psychiatry 619; Menvielle, Tuerk & Jellinek, *supra* note 4; Edgardo Menvielle, "A Comprehensive Program for Children with Gender Variant Behaviors and Gender Identity Disorders" (2012) 59:3 Journal of Homosexuality 357. Gender Creative Kids Canada also hosts multiple support groups.

interventions are predicated on the idea that "conflicts among disparate elements of identity appear to play a major role in the distress of those seeking" reparative therapy.[137] Identity is understood in a holistic manner and is not limited to gender identity: "[I]dentity comprises a coherent sense of one's needs, beliefs, values, and roles, including those aspects of oneself that are the bases of social stigma, such as age, gender, race, ethnicity, disability, national origin, socioeconomic status, religion, spirituality, and sexuality."[138] Identity development refers to a specific, active manner of "exploring and assessing one's identity", in light of its various components, "and establishing a commitment to an integrated identity."[139] In line with the gender-affirmative model, the role of mental health professionals is to facilitate this process without preference for the end outcome. As the report clearly sets out, "the treatment does not differ, although the outcome does."[140] Gender creative youth may grow up male, female, or non-binary. They may have a clear relationship to various components of gender—identity, expression, norms, and roles—or not.[141] Contrary to the oft-repeated distinction made by proponents of the psychotherapeutic approach between the malleability of gender identity and the fixedness of sexual orientation, the task force report assumes that sexual orientation can evolve and change over time.[142] Their discussion of identity exploration and development, though set out in the context of sexual orientation, is equally

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[137] American Psychological Association, *supra* note 127 at 60.
[138] *Ibid*.
[139] *Ibid*.
[140] *Ibid*.
[141] I spoke about messy identities and my own complicated relationship to gender labels in Florence Ashley, "Genderfucking Non-Disclosure: Sexual Fraud, Transgender Bodies, and Messy Identities" (2018) 41:2 Dalhousie Law Journal 339. Anecdotally, I know many trans people who have similarly complicated relationships to gender, and yet have grown comfortable with this messiness.
[142] American Psychological Association, *supra* note 127 at 61.

applicable to gender identity and would preclude interventions which seek to discourage, prevent or minimise the chance of developing or maintaining a certain gender identity.[143]

All of the subdivisions of the task force report that inform subsection 29.1(2)(a) share a vision of therapeutic interventions which have for goals helping the person accept their gender identity and develop a positive self-image and helping them manage the difficulties and distress associated with being trans or gender non-conforming. The list can be best summarised as "affirmative therapeutic interventions" for those who are struggling with their gender identity. Reparative therapy is inconsistent with these goals. The psychotherapeutic approach's avowed goal of preventing trans outcomes—whether couched in terms of "prevention of transsexualism in adulthood" [144] or reducing "the likelihood of GID persistence" [145] —through psychosocial interventions is diametrically contrary to the affirmative view espoused in the task force report and Bill 77.

Psychosocial interventions that are part of reparative therapy, such as the psychotherapeutic approach, are prohibited by subsection 29.1(1). This conclusion can be reached whether we interpret subsection 29.1(2) as a closed or open list. Neither the *ejusdem generis* nor the *expressio unius est exclusio alterius* principles saves the psychotherapeutic approach, as it does not fall under the listed exclusions and does not comport with the affirmative spirit which underpins them. If the legislature wished to exclude some reparative practices from the scope of the prohibition, it would have done so. The fact that it chose to provide an exception for affirmative

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[143] The laws of Colorado, Connecticut, Delaware, Massachusetts, Nevada, New Hampshire, New Mexico, Oregon, Vermont, and Washington explicitly state that interventions seeking to alter gender identity are excluded from the scope of acceptable identity exploration and development.

[144] Zucker & Bradley, *supra* note 70 at 269.

[145] Zucker et al, *supra* note 9 at 393.

practices but not the psychotherapeutic approach—despite the latter falling much closer to the language of "seeks to change gender identity"—is evidence of the legislative intent to prohibit all forms of reparative therapy.

In light of the bill's legislative history, social context, external co-texts, and previous judicial determinations, the best reading of Bill 77 prohibits trans reparative therapy in all its forms, including but not limited to the psychotherapeutic approach, is prohibited by Bill 77. In the next section, I turn to other laws prohibiting reparative therapy, highlighting the similarities and differences between the various statutes.

Other jurisdictions

In this section, I provide an overview of the growing prohibition of trans reparative therapy worldwide and propose a dual typology of trans reparative therapy bans based on textual similarity and lineage, and based on sanctions. The classification by textual similarity and lineage is helpful in interpreting the scope of different jurisdictions' laws and how they may differ from the interpretation given to Bill 77 in the previous section. The classification by sanctions offers a picture of the different ways by which reparative therapy bans can operate, which may be subject to different limitations, as explored in the next chapter.

Growing worldwide prohibitions

As of 2018, two Canadian provinces, one country, and fourteen U.S. jurisdictions have legislated against anti-trans reparative therapy.[146] Ontario and Nova Scotia are the only provinces

[146] Drescher et al. provide a list of attempted prohibitions of gay reparative therapy within the United States, some of which also included attempted bans on trans reparative therapy: Jack Drescher et al, "The Growing Regulation of Conversion Therapy" (2016) 102:2 J Med Regul 7.

that prohibit reparative therapy.[147] The sole known country to have clearly and expressly banned reparative therapy is Malta, although a bill is under consideration in Ireland. By "clearly", I am alluding to Uruguay, whose law may or may not have the effect of prohibiting reparative therapy. In the United States, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Maine, Maryland, Massachusetts Nevada, New Hampshire, New Jersey, New Mexico, New York State, Oregon, Puerto Rico, Rhode Island, Vermont, and Washington prohibit trans reparative therapy. The provisions of each of those jurisdictions can be found in the Annex of this thesis. In addition, many jurisdictions are considering a ban, including Alberta.[148] Some jurisdictions such as California have prohibited gay reparative therapy, but not trans reparative therapy.

The list found in the Annex is tentative, and some limits merit mention. Although I have sought to include all known prohibitions on reparative therapy, my positionality as a resident of Canada who only speaks two languages—French and English—constrains my access to global knowledge. Countries whose widely-spoken languages do not include French or English and whose political advances are not the subject of international news coverage are more difficult to track. Though it may be tempting to assume that English-speaking countries and, to a lesser extent,

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[147] Although Manitoba is frequently cited as a province having prohibited reparative therapy, no law or regulation appears to have been passed which would ban the practice: David Larkins, "Manitoba bans conversion therapy", *Toronto Sun* (22 May 2015), online: <https://torontosun.com/2015/05/22/manitoba-bans-conversion-therapy/>. The only apparent change on the books is a new page on the Manitoba government website which claims that conversion therapy has no place in he province's public healthcare system, and calls on professional associations to ensure that conversion therapy is not practiced: "Position on Conversion Therapy", online: *Manitoba Health, Seniors and Active Living* <https://www.gov.mb.ca/health/conversion_therapy.html>. The impact of such statements remains uncertain, as they do not have any legal standing but may be accorded weight by regulatory colleges. Adjudicators regularly use sources which do not have the force of law in making their judgements: Lorne Sossin & Charles W Smith, "Hard Choices and Soft Law: Ethical Codes, Policy Guidelines and the Role of the Courts in Regulating Government" (2003) 40:4 Alberta Law Review 867 However, they are not accountable to those sources, unlike with laws, which may inhibit their consistent application.

[148] Other states include Iowa, Michigan, Minnesota, Ohio, and Pennsylvania. The Senate Puerto Rico has also introduced a bill which would prohibit trans reparative therapy.

European countries would lead the way on reparative therapy bans, such an assumption would be little more than a reflection of Euro-American bias. For example, Argentina, a South American, Spanish-speaking country, is frequently noted as a leader in trans rights. In 2016, the Washington Blade called Argentina's laws "one of the world's most comprehensive transgender rights laws under which people can legally change their gender without surgery."[149] Although violence against trans people remains rampant in many South American countries including Argentina, we should reject the assumption that countries of the Global South are less legislatively advanced when it comes to trans rights.

Another limitation of my list flows from the uncertain scope of some laws. Uruguayan law states that "[i]n no case may a mental health diagnosis be established solely on the basis of sexual orientation and gender identity." [150] Similar laws precluding mental health diagnoses for orientation, but not gender identity, were passed in Argentina and Chile. Those laws serve as a middle ground between a legislative ban and a direct application of professional malpractice and disciplinary laws. Although they do not speak of reparative therapy, they emphasize a commitment to de-pathologizing views on gender identity—undermining the premises of reparative therapy, which sees trans and gender creative people as disordered. The laws also highlight the inseparability of mental healthcare, human dignity, and human rights: "Human dignity and human rights principles constitute the primary frame of reference for all legislative, judicial, administrative, educational and other measures and in all fields of application relating to mental

[149] Michael K Lavers, "Argentina joins global LGBT rights initiative", *Washington Blade* (24 March 2016), online: <http://www.washingtonblade.com/2016/03/24/argentina-joins-global-lgbt-rights-initiative/>.

[150] *Ley de salud mental*, Ley 19529 of 2017 (Uruguay) [*Ley de salud mental*], s 4: "En ningún caso podrá establecerse un diagnóstico en el campo de la salud mental sobre la base exclusiva de [...] [o]rientación sexual e identidad de género." My translation, with the aid of Mauro Cabral.

health."[151] The legal articulation of transitude as normal human variance and of human rights as a core principle of mental healthcare may aid the inference from general legal provisions, such as medial liability, to a finding that reparative therapy is illegal. However, I have not included Uruguay's law in the Annex because it does not refer to reparative therapy.

Typologies of bans

A typology of legislative prohibitions of trans reparative therapy can be drawn in two ways. First, legal provisions can be grouped textually, based on the similarity between their texts. Second, they may be grouped based on who is subject to which kinds of sanctions.

Grouped by textual lineage

Looking to textual similarity between the legislative enactments, three broad groups can be discerned.

Laws in the first group, which includes Ontario and Nova Scotia, do not refer to reparative therapy. Instead, it prohibits practices which have for goal the alteration of gender identity. Attempts at changing gender expression are not mentioned within the scope of the prohibition, and a short list of exceptions, textually lifted from the *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation*, is offered.[152]

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[151] *Ibid*, s 3(B): "La dignidad humana y los principios de derechos humanos constituyen el marco de referencia primordial de todas las medidas de carácter legislativo, judicial, administrativo, educativo y de cualquier otra índole y en todos los ámbitos de aplicación que guarden relación con la salud mental."

[152] American Psychological Association, *supra* note 127 at v.

The second group includes Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Maine, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Puerto Rico, Rhode Island, Vermont, and Washington. Oregon's law states that:

> (1) A mental health care or social health professional may not practice conversion therapy if the recipient of the conversion therapy is under 18 years of age.
>
> (2) As used in this section:
>
> > (a)(A) "Conversion therapy" means providing professional services for the purpose of attempting to change a person's sexual orientation or gender identity, including attempting to change behaviors or expressions of self or to reduce sexual or romantic attractions or feelings toward individuals of the same gender.
> >
> > (B) "Conversion therapy" does not mean:
> >
> > > (i) Counseling that assists a client who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition; or
> > >
> > > (ii) Counseling that provides a client with acceptance, support and understanding, or counseling that facilitates a client's coping, social support and identity exploration or development, including counseling in the form of sexual orientation-neutral or gender identity-neutral interventions provided for the purpose of preventing or addressing unlawful conduct or unsafe sexual practices, as long as the counseling is not provided for the purpose of attempting to change the client's sexual orientation or gender identity.[153]

A few characteristics can be extracted from the law.

Unlike the Ontario law which does not refer to the category of practices known as reparative therapy, but instead bans practices which seek to change gender identity, Oregon's law refers to reparative therapy. All laws in this group prohibit reparative therapy and proceed to define the term. Most prohibit "conversion therapy", except the District of Columbia, Hawaii,

[153] Or. Rev. Stat. §675.850

Massachusetts, New Jersey, and New York, which opted for the language of "sexual orientation change efforts" or "sexual orientation and gender identity change efforts" after the APA task force report,[154] and Puerto Rico which prohibits both "conversion" and "reparative" therapies.[155]

The legal provisions also include "attempting to change behaviors or expressions of self" within the notion of reparative therapy. Although this expression is ambiguous, it demonstrates awareness of the practice of reparative therapy and how it has operated through attempts at behavioural modifications and through the imposition of normative gender expression: "dresses are for girls".

This second group of enactments reproduces the task force report's language of "acceptance, support and understanding" as well as facilitation of "coping, social support and identity exploration or development. To this language, they add a further exception for interventions which are neutral with regards to gender identity and aim at "preventing or addressing unlawful conduct or unsafe sexual practices". The degree of specificity of this latter exception varies from jurisdiction to jurisdiction. On a surface-level analysis, this additional exception might invite a rebranding of reparative therapy around the prevention of anally-transmitted HIV, as HIV is an oft-mentioned facially-neutral reason to oppose same-sex intercourse between people assigned male at birth by proponents of gay reparative therapy.

Within this group, Hawaii, Maine, Massachusetts, and Rhode Island also prohibit advertising reparative practices.

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[154] American Psychological Association, *supra* note 127 at v.

[155] Puerto Rico's executive order is also much less specific than other laws, which is likely due to the legal and political differences between laws and executive orders.

The laws of Delaware, Massachusetts, and New Mexico distinguish themselves by defining gender identity, although those definitions seem to conflate gender identity and gender expression. Delaware defines it as:

> [A] gender-related identity, appearance, expression or behavior of a person, regardless of the person's assigned sex at birth. Gender identity may be demonstrated by consistent and uniform assertion of the gender identity or any other evidence that the gender identity is sincerely held as part of a person's core identity; provided, however, that gender identity shall not be asserted for any improper purpose.[156]

This definition is in large part self-referential: gender identity is a "gender-related identity", and aside from consistent and uniform assertion can be proven by "any other evidence that the gender identity is sincerely held as a part of a person's core identity". The requirement of consistent and uniform assertion may be prohibitively difficult to establish in young children. Overall, the definition this sheds little light as to what sort of evidence is required, or what this evidence is evidence *of* in the first place.

New Mexico instead defines it as:

> [A] person's self-perception, or perception of that person by another, of the person's identity as a male or female based upon the person's appearance, behavior or physical characteristics that are in accord with or opposed to the person's physical anatomy, chromosomal sex or sex at birth[157]

This definition, like Delaware and Massachusetts's definitions, partly conflates gender identity and gender expression. It does so by defining gender identity not only as self-perception, but also perception by others, and ties this perception to appearance, behavior or physical

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[156] Del. Code tit. 19, § 710.
[157] N.M. Stat. § 61-1-3.3.

characteristics rather than a psychological sense of belonging to a gender. This inclusion of gender expression under the notion of gender identity may create difficulties in the enforcement of trans reparative therapy bans to the extent that youth subjected to reparative therapy may not have changed their appearance or physical characteristics but may wish to do so, and because gendered behaviour is subject to conflicting interpretations. The application of the definition is also unclear when practices only seek to alter gender expression or gender identity, but not both, since gender identity in the law is defined to include both notions. Delaware, Massachusetts, and New Mexico's incorporation of gender expression within the concept of gender identity is aligned with the definition provided in the influential Yogyakarta Principles in 2006.[158] The Yogyakarta Principles plus 10, adopted in 2017, now distinguishes gender expression and gender identity.[159]

The third group is constituted solely of Malta, the first and currently only country to legislate against reparative therapy. Under Maltese law:

> "conversion practices" refers to any treatment, practice or sustained effort that aims to change, repress and, or eliminate a person's sexual orientation, gender identity and, or gender expression; such practices do not include -
>
> > (*a*) any services and, or interventions related to the exploration and, or free development of a person and, or affirmation of one' s identity with regard to one or more of the characteristics being affirmed by this Act, through counselling, psychotherapeutic services and, or similar services; or

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[158] *The Yogyakarta Principles: Principles on the application of international human rights law in relation to sexual orientation and gender identity*, March 2007 [*The Yogyakarta Principles*] at 6.

[159] *The Yogyakarta Principles plus 10: Additional principles and state obligations on the application of international human rights law in relation to sexual orientation, gender identity, gender expression and sex characteristics to complement the Yogyakarta Principles*, 10 November 2017 [*The Yogyakarta Principles plus 10*] at 6.

> (*b*) any healthcare service related to the free development and, or affirmation of one' s gender identity and, or gender expression of a person; and, or
>
> (*c*) any healthcare service related to the treatment of a mental disorder[160]

The practice prohibited, like in the second group, is explicitly reparative therapy, under the moniker "conversion practices". The definition of reparative therapy it uses is much broader than that offered in the first two groups of statutes, as it includes not only attempts to change gender identity but also attempts to "repress and, or eliminate" it. This wording facilitates interpretation and immediately undermines doubts as to whether practices such as the psychotherapeutic approach would be prohibited.

Unlike all other jurisdictions, Malta prohibits reparative therapy regardless of age, but reparative therapy on individuals under 16 years old by non-professionals will lead to heightened punishment.[161]

In lieu of the APA task force exclusions which are found in North American laws, Malta drafted its own list of services and interventions which are not covered by the prohibition of reparative therapy. Precisely which practices fall under those exceptions will have to be determined at a later date and unfortunately it will not be possible for Maltese judges to rely directly on the APA task force report to explicate each term of the list. Nonetheless, the language of affirmation and free development is reminiscent of the underlying philosophy of the task force report and thus the previously sketched interpretation of subsection 29.1(2) of the *Regulated*

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[160] *Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act*, No LV of 2016, c 567 (Malta) [*Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act*], s 2.
[161] *Ibid*, s 4.

Health Professions Act, 1991 is bound to be somewhat similar to future interpretations of Malta's law.

One notable difference that merits discussion is the exclusion of "any healthcare service related to the treatment of a mental disorder". This exception should not be read in isolation but be instead replaced within the context of the law's later definition of mental disorder:

> "mental disorder" means a significant mental or behavioural dysfunction, exhibited by signs and, or symptoms indicating a distortion of mental functioning, including disturbances in one or more of the areas of thought, mood, volition, perception, cognition, orientation or memory which are present to such a degree as to be considered pathological in accordance with internationally accepted medical and diagnostic standards, with the exclusion of any form of pathologisation of sexual orientation, gender identity and, or gender expression […][162]

The exception of treatment for mental disorders could not be used to protect practices such as the psychotherapeutic approach, as targeting the "likelihood of[163]" gender dysphoria persistence as the locus of mental illness to justify discouraging adult trans outcomes would be tantamount the pathologisation of gender identity, albeit indirect. The expression "any form of pathologisation" rather than merely "pathologisation" offers further clarity in this regard: theories which benefit from their obliquity to depict core components of trans subjectivity as pathological—such as gender dysphoria—would plainly be captured by "the exclusion of any form of pathologisation" of gender identity.

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[162] *Ibid*, s 2.

[163] The language of "likelihood of [gender dysphoria] persistence" is used by Zucker et al, *supra* note 9 at 393.

Malta's law is doubly distinguished by its decision to define gender identity within the law. Not only does the presence of a definition provide some more clarity to practitioners and members of the public who are less acquainted with trans realities, but unlike Delaware and New Mexico its definition is most well-written:

> "gender identity" refers to each person's internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance and, or functions by medical, surgical or other means) and other expressions of gender, including name, dress, speech and mannerisms[164]

The definition is drawn from the Yogyakarta Principles, an authoritative human rights guide developed by a "distinguished group of human rights experts" convened by the International Commission of Jurists and the International Service for Human Rights.[165] However, like the definitions set out by Delaware, Massachusetts, and New Mexico, the Yokyakarta Principles definition partly conflates gender identity and gender expression. Nonetheless, the distinction between various components of gender identity makes the definition significantly more precise than that offered by, for instance, WPATH, which defines gender identity as a "person's intrinsic sense of" belonging to a given gender.[166] Such precision is laudable within the context of health law, especially for judges and disciplinary bodies who may not be intimately familiar with trans therapeutics.

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[164] *Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act*, *supra* note 160, s 2.
[165] *The Yogyakarta Principles*, *supra* note 158.
[166] Coleman et al, *supra* note 1 at 221.

Grouped by sanctions

By and large, the primary mode of operation of legislative prohibitions on reparative therapy is the undertaking of disciplinary measures by professional bodies against licensed professionals.[167] In jurisdictions where the unlicensed practice of psychotherapy is legal, this means that no general prohibition against professional practice of reparative therapy exists, as those professionals who are not licensed may continue to engage in reparative practices.

The only jurisdiction whose prohibition of trans reparative therapy does not operate at least in part through disciplinary sanctions is Malta. Malta's prohibition is penal. Professionals may be subjected to fines between 2,000 and 10,000 euros or imprisonment between 3 and 24 months, whereas anyone else may be subjected to fines of between 1,000 and 5,000 euros or imprisonment between 1 and 5 months.[168] Malta's sanctions are also applicable for reparative therapy practised on adults, unlike other jurisdictions.[169]

No criminal prohibition of reparative therapy currently exists in Canada. In 2019, the federal government rejected a petition which called on parliament to criminalise reparative therapy.[170] The government agreed that reparative therapy is immoral and harmful but added that its regulation was a provincial and territorial matter.

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[167] In the case of Puerto Rico, licensing bodies are only urged to prohibit the practices, likely due to limits on the legal effects of executive orders.

[168] *Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act*, *supra* note 160, s 4.

[169] *Ibid*, ss 2, 3.

[170] "E-1833 (Conversion Therapy)", (20 September 2018), online: <https://petitions.ourcommons.ca/en/Petition/Details?Petition=e-1833>; "Petition calls for national ban on 'conversion therapy' for LGBT youth",; Perlita Stroh, "Ottawa rejects plea for nationwide conversion therapy ban", *CBC News* (23 March 2019), online: <https://www.cbc.ca/news/canada/the-national-conversion-therapy-federal-petition-1.5066899>.

The law of Connecticut also deviates from the typical form that the prohibition of reparative therapy takes. Although it provides that health professionals may be sanctioned by their respective disciplinary body, "including, but not limited to, suspension or revocation of the professional's license", it also provides for lawsuits where reparative therapy is administered "while in the conduct of trade or commerce":

> (a) It shall be unlawful for any person who practices or administers conversion therapy to practice or administer such therapy while in the conduct of trade or commerce.
>
> (b) A violation of subsection (a) of this section shall be considered an unfair or deceptive trade practice pursuant to section 42-110b of the general statutes and shall be subject to the same enforcement, liabilities and penalties as set forth in sections 42-110a to 42-110q, inclusive, of the general statutes.[171]

Being the victim of unfair and deceptive trade practices is a cause of action in Connecticut, granting a right to sue before courts without having to go through disciplinary processes. Massachusetts includes a similar cause of action, though limited to healthcare professionals.

A federal bill is being considered in the United States House of Representatives which would, if it became law, make the advertising, facilitating, and practice of reparative therapy an "unfair or deceptive act or practice" under the *Federal Trade Commission Act.*[172] Under the Act, however, proceedings can only be taken by the Federal Trade Commission.[173] This is not typically the case in states' equivalent consumer protections, which grant private parties the right to sue.[174]

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[171] Conn Gen Stat § 19a-907a (Connecticut).
[172] US, Bill HR 2119, *Therapeutic Fraud Prevention Act of 2017*, 115th Cong, 2017.
[173] Stephanie L Kroeze, "The FTC Won't Let Me Be: The Need for a Private Right of Action Under Section 5 of the FTC Act" (2015) 50:1 Valparaiso University Law Review 227.
[174] *Ibid* at 241.

Thus, despite similar wording, the federal bill would lead to third-party enforcement much like under disciplinary law.

The executive order of Puerto Rico further imposes a requirement that no reparative practices be offered as a condition of state-issued institutional licenses, and orders state agencies to create mechanisms to verify compliance.

Besides differences between the type of sanctions—disciplinary, criminal, or civil—whose conduct is prohibited also varies in some jurisdiction. Although most jurisdictions only seek to target conduct by licensed professionals, both Malta and Nova Scotia law apply to people other than licensed professionals.

In Nova Scotia: "No person in a position of trust or authority towards a young person under the age of nineteen years shall make any change effort with respect to the young person."[175] This would include parents, among other authority figures.

In Malta, whereas professionals are disallowed from engaging in reparative therapy with adults, a further prohibition—with slightly lower penalty—also exists for anyone engaging in reparative therapy on minors or otherwise vulnerable persons, or non-consensually on adults.[176]

Since many jurisdictions prohibit the unlicensed practice of psychotherapy or counselling, the absence of a prohibition of reparative therapy for non-professionals does not necessarily entail that such a practice is legal. Most U.S. states do not regulate unlicensed therapy providers.[177] The presence or absence of statutory bans on reparative practices by unlicensed individuals may thus

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[175] *An Act Respecting Sexual Orientation and Gender Identity Protection*, SNS 2018, c 28 [*Sexual Orientation and Gender Identity Protection Act*], s 7(1).
[176] *Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act*, *supra* note 160, s 3.
[177] Drescher et al, *supra* note 146 at 7.

prove important in multiple jurisdictions. Because U.S. case law refers to the state's "long-recognized power to reasonably regulate the counseling professions" in rebutting the argument that the prohibition of reparative therapy violates freedom of speech and religion, it may not be possible for U.S. states to extend their prohibition to unlicensed individuals.[178] A law that would prohibit unlicensed reparative therapy may face more difficulty than the currently existing statutes in passing constitutional muster, although the matter remains to be settled. Given that prohibiting the unlicensed practice of psychotherapy is eminently within the powers of states[179] and would have a similar impact on freedom of speech and religion with regards to reparative therapy, it is plausible that such a law would also pass constitutional muster.

In this chapter, I have argued that Bill 77 is best interpreted as including all clinical approaches that 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 gender assigned at birth. This interpretation includes the psychotherapeutic approach. Given the many similarities across bans of reparative therapy, most notably through the inclusion of language drawn from the APA task force report, it is likely that the scope of laws other than Bill 77 is similarly broad. In the next chapter, I will consider the benefits and limitations of bans on trans reparative practices. Given the similarity between bans, the analysis provided in the next chapter will apply to most jurisdictions.

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[178] *King v Christie*, (2013) 981 F Supp 2d 296 (New Jersey District Court). See also *Doe v Christie*, (2014) 33 F Supp 3d 518 (New Jersey District Court); *Pickup v Brown*, (2013) 740 F 3d 1208 (United States Court of Appeals, Ninth Circuit).

[179] *NAAP v California Bd of Psychology*, (2000) 228 F 3d 1043 (United States Court of Appeals, Ninth Circuit).

CHAPTER III: CRITICAL ANALYSIS OF PROHIBITIONS

In this chapter, I provide a policy analysis of the prohibitions of trans reparative therapy. In the first section, I consider critiques levied against such statutory bans and respond to them. In the second section, I delineate the benefits and limits of legislative bans on trans reparative therapy, highlighting the need to go beyond purely legislative approaches. In the third section, I draw on sociological research to suggest that the establishing of professional committees tasked with developing clear professional guidelines, ensuring the enforcement of those guidelines, and pursuing the integration of teaching on trans reparative therapy in the university curriculum of professionals can supplement prohibitions of reparative therapy to discourage reparative practices more effectively. While bans are partly effective in addressing the problem of trans reparative therapy, we must supplement them if we want to fully eradicate reparative practices.

Critiques and responses to critiques

Polarisation and contention have plagued public responses to legislative prohibitions on trans reparative therapy. The intersection of parenting, traditional values, and lives which challenge these values is explosive. It comes as little surprise, then, that fierce critiques have been levied against such statutes and bills.

Though the sources and forms of those critiques have been varied, they for the most part share an emphasis on freedom. Critiques have been articulated around three poles: therapist freedom of speech, overbreadth, and familial religious freedom and parental authority. Some of

those critiques have been considered and rejected by United States courts. The Supreme Court of the United States has so far refused to hear cases challenging the laws.[180]

Therapist freedom of speech

Bans on reparative therapy have been criticized for curtailing the freedom of speech of therapists engaging in talk therapy. Talk therapy, as elaborated below, is best characterised as action rather than speech, and the state's interest in curtailing harm to patients outweighs therapists' freedom of speech when exercising their professional functions.

Constitutional challenges based on therapist freedom of speech have been unsuccessfully attempted in the past. In *King v. Christie*, plaintiffs challenged the constitutionality of New Jersey's prohibition of reparative therapy on grounds that it abridged their right to freedom of speech.[181] The New Jersey District Court upheld the law, holding that it neither restricted speech nor impeded on religious liberty—an argument we will turn to in a later subsection. At the heart of the argument from freedom of expression lies the characterisation of psychotherapy as a form of speech. The plaintiffs argued that restrictions on therapists' ability to elect the type of therapy they engage in was a restriction on free speech rights because psychotherapy is carried out through talk therapy.

Freedom of expression is commonly raised in defence of sanctions levied against those accused of transantagonistic behaviours.[182] Such defences do not always reflect a belief that legal protections of freedom of expression are available or would be successful. They are often couched

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[180] Amy B Wang, "Supreme Court upholds California's ban on gay 'conversion therapy'", *The Washington Post* (2 May 2017), online: <https://www.washingtonpost.com/news/post-nation/wp/2017/04/27/lgbtq-people-were-born-perfect-a-new-bill-would-ban-conversion-therapy-nationwide/>.

[181] *King v. Christie*, *supra* note 178.

[182] I use the term "transantagonistic" instead of "transphobic" to avoid the latter term's connotations of extreme and irrational fear: Ashley, *supra* note 10 at 3–4.

as general political claims and natural rights claims. Parallels may be drawn between free speech arguments against reparative therapy bans and the freedom of expression arguments which were levied against Bill C-16, which added gender identity and expression to the Canadian Human Rights Act.[183] In both cases, freedom of speech is mobilised as a politico-legal shield for pathologizing, hostile attitudes towards trans people.[184]

The popularity of freedom of expression claims exceeds their legal plausibility. Despite all United States courts thus far declining to invalidate bans on reparative therapy on grounds of free speech—or any grounds, for that matter—therapist and jurist Richard Green described the uptake of free speech arguments by courts as having had "mixed results."[185] This ambivalent characterisation of a failed legal claim is reminiscent of Brenda Cossman's description of freedom of expression as a "deceptively attractive" "rhetorical and legal vehicle for ongoing resistance" in a post-truth era.[186] As I have mentioned, the claim that therapists enjoy the right to freedom of speech, a right that would extend to all therapeutic practices which operate primarily through oral expression, has little legal plausibility. The courts' response is also ethically and politically convincing.

In all three challenges brought against reparative therapy bans, the courts found that therapeutic practices are behaviour rather than speech, in a constitutional sense.[187] This is the case even when they involve talking therapies. As the court in *Pickup v. Brown* points out,

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[183] *An Act to amend the Canadian Human Rights Act and the Criminal Code*, SC 2017, c 13 [*Bill C-16*].
[184] See, e.g., Brenda Cossman, "Gender identity, gender pronouns, and freedom of expression: Bill C-16 and the traction of specious legal claims" (2018) 68:1 University of Toronto Law Journal 37 at 42ff.
[185] Richard Green, "Banning Therapy to Change Sexual Orientation or Gender Identity in Patients Under 18" (2017) 45:1 Journal of the American Academy of Psychiatry Law 7 at 8.
[186] Cossman, *supra* note 184 at 65.
[187] *Pickup v. Brown*, *supra* note 178; *King v. Christie*, *supra* note 178; *Doe v. Christie*, *supra* note 178.

"communication that occurs during psychotherapy does receive *some* constitutional protection, but it is not immune from regulation."[188]

Governments may regulate therapeutic behaviour because licensed therapists are sought out as competent representatives of their profession. Whatever their idiosyncrasies, the underlying promise of professional regulation is that professionals will act in light of the best available therapeutic evidence and uphold principles of care and values such as dignity in their practice. Professional associations were created in part to protect patients; to prohibit practices which are reasonably believed to be harmful to patients and the public falls within the sphere of politically legitimate government action.

Freedom of speech may shield non-professionals in the United States from prohibitions of reparative therapy. In *King v. Brown*, the court qualified its finding that the law was constitutional by adding that the law didn't preclude professionals from voicing approval for reparative therapy, only preventing them from engaging in reparative counseling. The implications of this statement, which is *obiter dictum*, have yet to be determined. From a legal standpoint, the protection of freedom of expression differs between Canada and the United States, with the First Amendment typically providing stronger protections in the latter than s. 2(b) does in the *Canadian Charter of Rights and Freedoms.*[189] It is unlikely that such an argument would hold in Canada.

Not all instances of voicing opinions on the appropriateness or efficacy of reparative therapy are morally equivalent. Expressing support for reparative therapy in a discussion regarding its efficacy and appropriateness may be more reasonably protected than expressions of support for

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[188] *Pickup v. Brown*, *supra* note 178.

[189] *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Canadian Charter of Rights and Freedoms*].

the practice in a teaching or teaching-like context, since the latter context would be an implicit encouragement of the behaviour.[190] It may be morally legitimate and politically defensible to extend prohibitions of reparative therapy to teaching.

Professionals' freedom of expression is limited by their professional obligations not to cause harm to patients. To the extent that legislative prohibitions of reparative therapy seek to regulate acts undertaken as professionals and most often within an established clinical relationship, critiques grounded in freedom of expression carry little weight. In my view, society and community interests in regulating professional behaviour and prohibiting harmful practices far outweigh the expressive interests of therapists.

The privileges of professional licensure come at the cost of curtailed liberty of action. Licensed professionals are at liberty to speak freely outside their work. Their professional practices, though they may be expressed verbally, must however respect established norms. If they are unwilling to follow those norms, they are free to stop providing therapeutic care to trans and gender creative youth and refer them to practitioners who are willing to adopt practices other than reparative ones.

Overbreadth

The second critique levied against statutory bans on reparative therapy is that although prohibiting certain forms of reparative therapy may be legitimate, the bans go too far, curtailing

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[190] I have previously argued that individuals speaking from a position of authority should be held to higher standards for their words to the extent that their claims carry the weight of their authority and are taken to be more credible by members of the public and, plausibly, junior members of their profession: Florence Ashley, "Professorship versus censorship: Should Jordan Peterson continue to be given a platform on trans rights?", *NOW Toronto* (2 January 2018), online: <https://nowtoronto.com/news/professorship-versus-censorship-jordan-peterson-speak/>.

morally acceptable practices. This critique underestimates the professional consensus that reparative therapy is unethical and fails to recognise the state's interest in curtailing unproven practices, practices that are contrary to scientific principles, and practices that are contrary to egalitarian values.

The accusation of overbreadth has primarily been couched in political terms,[191] although overbreadth has a legal meaning in the United States and Canada.[192] William Byne cautioned against legislative bans because they might restrict legitimate practices. Supporting his point, he gave the example of the closure of the CAMH Gender Identity Clinic for Children in the wake of Ontario's Bill 77.[193]

While it is true that the closure of the CAMH clinic left an unfortunate gap in services, this is not a reason to allow illegitimate and potentially harmful practices. Byne's characterisation of bans as overbroad is inconsistent with his acknowledgement that the psychotherapeutic approach practised at the CAMH clinic involved "a negative judgment of transsexuality is, nevertheless, implicit in the desire to prevent it."[194] He supports his claim that the prohibition is overbroad because no professional consensus exists over treatment of pre-pubescent gender creative youth, relying on an outdated 2011 report published by the American Psychiatric Association. Even if the 2011 report reflected current expert opinion, we must distinguish consensus over which approach is best and consensus over whether a given approach is unacceptable. Although it could be argued that no consensus exists over which approaches fall within the range of competent therapeutic care,

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[191] See e.g. Green, *supra* note 185 at 10.
[192] Keith H Holland, "The Doctrine of Substantial Overbreadth: A Better Prescription for Strong Medicine in Missouri" (2014) 79:1 Missouri Law Review 185; Hamish Stewart, "Bedford and the Structure of Section 7" (2015) 60:3 McGill Law Journal 575.
[193] Byne, *supra* note 17 at 97.
[194] *Ibid* at 98.

there is a clear consensus that reparative therapy is illegitimate. The 7th version of the WPATH *Standards of Care*, published in 2012, disavows the practice,[195] and opinion that is shared by many professional associations.[196]

Yet, even if it could be established that no consensus exists against pre-adolescent reparative therapy, bans on reparative therapy would remain reasonable. Both harmless practices and practices whose harm is unproven are regularly regulated. Under traditional bioethics approaches, clinical ethics must take into consideration beneficence, non-maleficence, respect for autonomy, and justice.[197] Neither respect for autonomy nor justice can be reduced to a harm-based analysis. Furthermore, pseudoscientific practices are routinely prohibited despite often being harmless. As pointed out in *Doe v. Christie*, a case bearing on the same New Jersey law as *King v. Christie* but brought by patients rather than therapists:

> Surely it is undisputed that a state has the power to regulate not only medical and mental health treatments deemed harmful, but also those that are ineffective or that are based not on medical or scientific principles but, instead, on pseudo-science.[198]

Professional freedom may be curtailed even if a minimum threshold of psychological harm is not proven.[199] Governments may legitimately prohibit practices that are ineffective or contrary to scientific principles. Practices can also be prohibited if they are antithetical to equality. As I will explain, each of these rationales apply to pre-pubertal reparative therapy.

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[195] Coleman et al, *supra* note 1 at 175.

[196] Florence Ashley, "List of professional organisations opposing reparative therapy targeting gender identity", online: *Florence Ashley* <https://www.florenceashley.com/resources.html>.

[197] Tom L Beauchamp & James F Childress, *Principles of biomedical ethics*, 7th ed (New York: Oxford University Press, 2013).

[198] *Doe v. Christie*, *supra* note 178.

[199] Contra Green, *supra* note 185.

First, let us consider the matter of ineffectiveness. By ineffective therapies, I mean both therapies which are proven not to be effective, as well as therapies whose effectiveness is unproven. *Doe v. Christie* most likely intended to speak only of treatments of demonstrable ineffectiveness. However, it is not difficult to convince ourselves of the legitimacy of prohibiting treatments which have not yet been proven to be effective. Although the scope of the state's legitimate prohibition of untested medicine is contested—notably through right-to-try laws[200]—it remains relatively uncontroversial that governments may prohibit access to drugs and medication which have yet been shown to be safe and effective. In Canada, the Health Products and Food Branch of Health Canada is charged with approving drugs whose safety and efficacy has been demonstrated through clinical trials.

A blanket ban on unproven therapies would be prohibitive, to be sure. I am not here arguing that the government should or may reasonably prohibit all psychosocial interventions whose safety and effectiveness lies unproven. It is more difficult to assess both the safety and efficacy of psychosocial interventions than of pharmaceutical drugs because the testing environment can rarely be adequately controlled, because neither therapist nor patient can be reliably blinded to the approach applied to them, and because assessment of clinical endpoints often relies on subject perception. Because of those various difficulties, assessing the safety and efficacy of psychosocial interventions is challenging and at times more art than science.

Nevertheless, the accepted reasonableness of prohibiting unproven drug treatment demonstrates that the absence of proven harm is not an overriding consideration. To the extent that

[200] Pamela Hallquist Viale, "The Federal 'Right To Try' Act: An Answer to New Treatments During Terminal Illness?" (2017) 8:4 J Adv Pract Oncol 334.

pre-pubertal reparative therapy is not proven to be either safe or effective, and insofar as we have reasons to prohibit them, the legislative bans are not demonstrably overbroad.

Second, even in the context of pre-pubertal youth, reparative practices are contrary to scientific principles. Demonstrating how the practice runs against scientific practices is best done by considering the argument, provided by Green, that attempts to show that trans reparative therapy is aligned with scientific principles:

> Whereas homosexuality per se was dropped by the APA as a disorder in 1973, in 1980, gender identity disorder was added, addressing cross-gender identification and behaviors of children and adults. Although homosexuality is no longer categorized as a disorder, gender identity disorder, or transsexualism, or gender dysphoria remains in the current DSM (Fifth Edition). Therefore, the argument against attempting to modify sexual orientation because it is not a disorder is not symmetrical with attempts to modify or treat gender dysphoria.[201]

The claim that gender identity disorder remains in the DSM-5 is misleading and may even be cast as dishonest. From 1980 to 2013, the DSM provided the diagnosis of Gender Identity Disorder of Childhood for gender creative children.[202] In 2013, the diagnostic category was changed to Gender Dysphoria in Children.[203] This shift in language was not neutral. It was motivated by the desire to de-pathologize gender identities which do not correspond to the person's gender assigned at birth and followed the recommendation of WPATH.[204] The diagnostic category

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[201] Green, *supra* note 185 at 8.

[202] American Psychiatric Association, *Diagnostic and statistical manual of mental disorders: DSM-III* (Washington, D.C: American Psychiatric Association, 1980); American Psychiatric Association, *Diagnostic and statistical manual of mental disorders: DSM-IV* (Washington, D.C: American Psychiatric Association, 1994); American Psychiatric Association, *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (Washington, D.C: American Psychiatric Association, 2000).

[203] American Psychiatric Association, *supra* note 49.

[204] Lin Fraser et al, "Recommendations for Revision of the *DSM* Diagnosis of Gender Identity Disorder in Adults" (2010) 12:2 International Journal of Transgenderism 80.

of gender dysphoria expresses the view that although trans people may experience clinically significant distress, their gender identity is not pathological but rather part of normal human diversity. In the words of the DSM, Gender Dysphoria "is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se."[205]

A similar shift operated between versions 10 and 11 of the International Classification of Diseases.[206] Under the 1992 version, ICD-10, the Gender Identity Disorder of Childhood diagnosis fell under the section on Mental and Behavioural Disorders. Under the latest version, published in 2018, the diagnosis was renamed Gender Incongruence in Childhood and placed under Conditions Related to Sexual Health, outside of the section on Mental, Behavioural or Neurodevelopmental Disorders. The shift was motivated by reasons similar to those which led to the DSM-5 diagnosis of Gender Dysphoria.[207] A survey of the members of WPATH found that only 7.5% of the members "had the view that it should be placed in the Mental and Behavioural Disorders chapter".[208]

Among a proliferation of statements and clear disavowals of the stance that being transgender is pathological, it is hard to take seriously Green's claim that there is an ethically

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[205] American Psychiatric Association, *supra* note 49 at 5.

[206] World Health Organisation, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (Geneva: World Health Organisation, 1992); World Health Organisation, *The ICD-11 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (Geneva: World Health Organisation, 2018).

[207] Sam Winter, "Gender trouble: The World Health Organization, the International Statistical Classification of Diseases and Related Health Problems (ICD)-11 and the trans kids" (2017) 14:5 Sexual Health 423 at 424.

[208] Sam Winter et al, "The Proposed ICD-11 Gender Incongruence of Childhood Diagnosis: A World Professional Association for Transgender Health Membership Survey" (2016) 45:7 Archives of Sexual Behavior 1605 at 1611.

significant asymmetry between sexual orientation and gender identity change efforts because of the remaining diagnostic category of Gender Dysphoria. Neither the DSM-5's Gender Dysphoria in Childhood nor the ICD-11's Gender Incongruence in Childhood supports the thesis that gender creative youth's gender identity is an appropriate target of intervention. Though I would not go as far as to call reparative therapy pseudoscience, which may suggest that such principles were never recognised by mainstream science, pre-pubescent reparative therapy runs contrary to the teachings of the DSM-5 and the ICD-11. Since being trans or gender creative is not pathological, it is not an appropriate target of psychosocial intervention. Banning pre-pubertal reparative therapy is amply justified by the fact that it is contrary to scientific principles.

Third, pre-pubertal reparative therapy promotes inequality, which is contrary to the values underpinning the Canadian constitutional order. As Byne points out in relationship to the CAMH clinic's work, "a negative judgment of transsexuality is, nevertheless, implicit in the desire to prevent it."[209] Equality is a recognised value of Canada's constitutional order, entrenched in the deepest roots of our country's *Charter of Rights and Freedoms.*[210] It no longer needs defending that legislation can properly aim at promoting equality and repressing inequality.

Practices which promote inequality—e.g. by enacting a negative evaluation of transitude—would nevertheless be legitimate if the patients' best interests significantly outweighed the value of addressing inequality. This would be the case if, for example, patients of reparative therapy were shown to fare significantly better than patients of the gender-affirmative approach. However, reparative therapy demonstrates no significant benefits to patients over other approaches. On the

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[209] Byne, *supra* note 17 at 98.
[210] *Canadian Charter of Rights and Freedoms*, *supra* note 189, s 15.

contrary, as will be detailed later in this work, all evidence points towards the gender-affirmative approach leading to better adaptation and mental wellbeing. But even if no evidence existed as to the superiority of the gender-affirmative approach, the fact that pre-pubertal reparative therapy is prejudicial to trans people suffices to resolve the uncertainty. If inequality enters consideration, it is no longer sufficient as a critique—if it were true—that no consensus exists over pre-pubertal reparative therapy's ills.

In sum, to establish that legitimate practices are prohibited by bans on reparative therapy, critiques would have to establish with sufficient certainty that pre-pubertal reparative therapy is superior to the gender-affirmative approach. Given the current state of scientific knowledge, this is an insurmountable task. The claim that bans on reparative therapy are overbroad is wholly unsupported.

Familial religious freedom and parental authority

The third critique levied against reparative therapy bans sees them as illegitimate incursions on patient and parental right to choose care aligned with their values, typically religious. This argument conflates the right to refuse care with the right to determine care. Parents and patients do not have the right, even based on religious freedom, to demand interventions that are harmful or inimical to egalitarian values.

Whereas previously noted critiques have foregrounded the rights of therapists vis-à-vis reparative therapy, this last critique takes the law to task from the perspective of the patients and their legal guardians—typically their parents. Because statutory bans on reparative therapy, with the notable exception of Maltese law, target minors, both patient and guardian religious freedom have been largely merged in arguments, under the assumption that both child and parents share the

same religion and, thus, an authentic desire to live in accordance with its precepts. In *King v. Christie*, the New Jersey statute was challenged on the basis of a patient and their parents' religious freedom and parental rights.[211] These arguments were also considered—and also failed—in *Pickup v. Brown.*[212]

The critique from religious freedom appears to be a formulation of the broader notion of parental authority and parental rights. Richard Green, sketching an objection to bans on reparative therapy on the basis of parental authority, highlights how "[v]accination laws, education, and blood transfusion provide examples of limitations and strengths of parental authority."[213] Religious objections are frequently voiced in relation to each of those, possibly because religious freedom garners more legal protections than does parental authority writ large and is enshrined in Canadian and United States constitutional orders.

Green provides, I believe, the strongest argument against reparative therapy bans based on religious freedom:

> Parental insistence on intervention to modify a child's gender behaviors on the grounds that it would diminish prospects of a life style that is anathema to their religious beliefs could have some traction, unless the consequences of intervention were substantial. Clearly, the consequences would not rise to the level of a parental demand, based on a religious tenet of Jehovah's Witnesses, to withhold a potentially life-saving blood transfusion. That is not allowed.[214]

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[211] *King v. Christie*, *supra* note 178.
[212] *Pickup v. Brown*, *supra* note 178.
[213] Green, *supra* note 185 at 9.
[214] *Ibid* at 10.

Under this argument, a parallel is drawn between reparative therapy and refusal of blood transfusions. The right to withhold blood transfusions is controversial, though many jurisdictions have affirmed courts' rights to intervene where blood transfusions are refused by parents.[215] Case-by-case analyses remain crucial, as both the risk of withholding transfusion and the chance of survival if transfusions are given vary.

Unlike withholding blood transfusions, reparative therapy is not typically life threatening in the short term, and causal links to future suicide attempts remain difficult to prove. Green has stated that he is "convinced that it is a helluva lot easier negotiating life as a gay man or lesbian woman than as a transwoman or transman."[216] Views of this kind tend to cast trans lives in abjection and suggest that they are already lives full of difficulties and suffering, although it is important to distinguish between easy lives and good lives, since difficult lives can also be overwhelmingly happy and positive ones.

If I understand it correctly, Green's argument is as follows. That parental right to refuse transfusions remains contentious is evidence that the right to religious freedom and parental authority is a weighty one, since it is seriously being considered even in the face of death. Since the harms of reparative therapy are much less than certain death until proven otherwise, we have good reasons to believe that religious freedom and parental authority should triumph over the state's legitimate interest in regulating mental healthcare practices. An implicit corollary argument

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[215] *AC v Manitoba (Director of Child and Family Services)*, [2009] 2 SCR 181; *Jehovah's Witnesses in State of Wash v King County Hosp*, (1967) 278 F Supp 488 (Washington District Court), affirmed (1998) 390 US 598.

[216] Richard Green, "To Transition or Not to Transition? That Is the Question" (2017) 9:2 Current Sexual Health Reports 79 at 82.

is that if withholding blood transfusions had the same consequences as undergoing reparative therapy, prohibiting parental refusal of blood transfusions would be unconstitutional.

This argument conflates the right to refuse care and the right to demand specific treatment. From an ethical standpoint, a significant difference exists between the harm of withholding beneficial treatment and the harm of undergoing detrimental or ineffective treatment: in the latter case, the harm requires the conscription of professionals. The difference is most clearly illustrated in the context of surgical care: though as an adult I may refuse a life-saving surgery, in no way may I demand of a surgeon that they practice detrimental or ineffective surgeries on me.[217] Patients' consent provides practitioners no defence against disciplinary action if they engage in practices which are out of line with the established standards of the profession, whether those standards are established by consensus or by statute or regulation.

The disjunction between the right to refuse care and the right to demand a specific treatment is well-recognised and well-accepted in healthcare ethics. It lies at the heart of the Hippocratic Oath: *primum non nocere*. First do no harm. In modern bioethics terminology, the ethical principle of autonomy is qualified by the ethical principle of non-maleficence. Autonomy and non-maleficence are two of the four seminal principles of bioethics—the other two being beneficence and justice.[218] Autonomy does not have precedence over non-maleficence and in cases where ineffective or detrimental care is requested, it must capitulate to the latter principle.

The right-to-try movement's challenge to the maxim of non-maleficence is limited. Although it demands experimental treatment despite these treatments' safety and efficacy having

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[217] Christian P Selinger, "The right to consent: Is it absolute?" (2009) 2:2 British Journal of Medical Practitioners 50.
[218] Beauchamp & Childress, *supra* note 197.

yet to be demonstrated, it only applies to cases where the patient's life is threatened, and all available treatment options have been exhausted.[219] The right to try is predicated on the assumption that terminally ill patients have little to lose and much to gain by experimental treatment. The right to try does not suggest that autonomy should take precedence over non-maleficence, but that in desperate cases, the combined principles of autonomy and beneficence outweigh non-maleficence.

Courts have already recognised that there is no right to demand a specific treatment in the context of reparative therapy. In rejecting the argument of religious freedom and parental authority, the court in *Pickup v. Brown* pointed out that patients do not have a right to demand specific treatments:

> Those cases cut against recognizing the right that Plaintiffs assert; it would be odd if parents had a substantive due process right to choose specific treatments for their children — treatments that reasonably have been deemed harmful by the state — but not for themselves. It would be all the more anomalous because the Supreme Court has recognized that the state has greater power over children than over adults.[220]

The ethically relevant distinction between refusing blood transfusions and undergoing reparative therapy is further strengthened by the equality considerations present in the latter case. Refusing blood transfusions is not known to emerge from prejudicial reasons. Requesting the provision of reparative therapy is: though the reasons are religious, they are predicated on the belief that queer, trans, and gender creative lives are sinful, wicked.

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[219] Goldwater Institute, "What Is Right To Try?", online: *righttotry* <http://righttotry.org/about-right-to-try/>; Viale, *supra* note 200.

[220] *Pickup v. Brown*, *supra* note 178.

While religious beliefs must be considered when establishing what is in a child's best interest, gender identity and sexual orientation must equally be considered. The United Nations Committee on the Rights of the Children's *General comment No. 14* confirms that gender identity and sexual orientation are components of the child's best interest.[221] Gender identity and sexual orientation should be considered when assessing the child's best interest. In Ontario, the two notions were added to considerations of children's best interest under the *Child, Youth and Family Services Act, 2017.*[222] Given the complex psychology underlying gender identity and sexual orientation, these two factors carry great weight in determining the child's best interests, notably with regards to the apparent difficulty in altering sexual orientation and gender identity. Although the proportion of trans-to-queer outcomes among gender creative youth is hotly debated, research demonstrates that nearly all gender creative youth grow up to be one or the other.[223] Failing to give enough weight to gender identity and sexual orientation when assessing what is in a child's best interest would be contrary to the *Canadian Charter of Rights and Freedoms*' commitment to equality.

From a symbolic standpoint, allowing state-sanctioned professionals to provide reparative therapy would impair not only the equality interests of patients but also of trans and queer communities. Allowing reparative therapy would suggest that it is acceptable to act upon the belief that being queer, trans, or gender creative is wrong and or pathological. By disavowing practices that pathologize or devalue queer, trans, and gender creative people, the government

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[221] *General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*, CRC/C/GC/14 [*General comment No. 14*].
[222] *Child, Youth and Family Services Act, 2017*, SO 2017, c 14 [*Child, Youth and Family Services Act, 2017*], ss 1(2), 74(3), 109(2), 179(2).
[223] Temple Newhook et al, *supra* note 9.

communicates that queer, trans, and gender creative people are of equal worth, fulfilling its legitimate interest of promoting equality.

In sum, neither patients nor their parents have the right to insist on reparative therapy, whether under the heading of religious freedom or parental authority. The argument, framed most cogently by Green, has been wisely rejected by New Jersey and California courts and holds little ethical or legal weight.

Benefits and limits

In this section, I discuss the benefits and limits of legislative bans on trans reparative therapy, highlighting the need to go beyond bans.

Benefits

Bans on trans reparative therapy may alter professional practices and contribute to cultural changes and the improvement of mental health in trans communities through their symbolic function.

Changes in professional practices

Legislation can encourage changes in practices among professionals despite reluctance on the part of regulatory bodies to curtail reparative therapy using the tools available to them, such as disciplinary proceedings. Speaking before the Standing Committee on Justice Policy, Joyce Rowlands of the College of Registered Psychotherapists of Ontario deemed Bill 77 unnecessary: "Our point, really, is that this matter can be dealt with by the regulatory colleges."[224] In her opinion, statutory prohibition was unnecessary because reparative practices were already

[224] Legislative Assembly of Ontario, Standing Committee on Justice Policy, *supra* note 40 at JP-61.

denounced by the professional orders and would be appropriately subject to sanctions. Jake Pyne responded to her assertion that the law as it was sufficed to prohibit the practices:

> I think it's mistaken to assert that the various colleges of the helping professions in this province have the power to address this issue adequately. If that were the case, we would not have had this problem for the past 40 years.[225]

The positive impact of Bill 77 in discouraging reparative therapy is clear from the role it played in the closure of the CAMH Gender Identity Clinic for Children and Youth, which continued to operate until the bill came into force despite decades of criticism. If its closure is positive, as many professionals and members of trans communities have perceived it, then legislative bans on trans reparative therapy show considerable promise. Although the law's chilling effect has mostly been mentioned negatively, such reactions also speak to the pedagogical role that legislation can play in shaping practices.[226] Even if trans reparative therapy is contrary to professional malpractice and disciplinary law, a law informs practitioners of their professional obligations and may motivate disciplinary bodies to enforce their regulations. As Marie-Amelie George noted, news coverage on reparative therapy in California increased by roughly 789% after the practice was prohibited by law.[227] Although the content of this news coverage was not dissected, it cannot be doubted that legislation prohibiting reparative therapy plays a significant role in educating the public, practitioners, and institutions.

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[225] *Ibid* at JP-65.

[226] *Ibid* at JP-61 (Joyce Rowlands for the College of Registered Psychotherapists of Ontario); Zinck & Pignatiello, *supra* note 20 at 13; Alice Dreger, "The Big Problem With Outlawing Gender Conversion Therapies", *Wired* (4 June 2015), online: <https://www.wired.com/2015/06/big-problem-outlawing-gender-conversion-therapies/>.

[227] Marie-Amelie George, "Expressive Ends: Understanding Conversion Therapy Bans" (2017) 68:3 Alabama Law Review 793 at 828.

Symbolic impact of laws on culture and mental health

Beyond their pedagogical and material effects, laws play a symbolic function which can precipitate cultural changes and improve the mental health of trans communities. Bans on trans reparative therapy send the message that trans and gender creative lives are equally valuable as lives that perform or conform to hegemonic gender configurations. As Marie-Amelie George explains:

> [L]aw can change the social meaning of an action. […] Even if individuals object to a policy choice, by conforming to the law, they create a cultural environment that supports the law's normative commitment. […] Thus, even if a law does not affect a specific individual's conduct, it still may have an expressive impact on that person.[228]

I do not believe that her description of bans as primarily expressive is accurate in the trans context. Nonetheless, it is undeniable, based on trans advocacy and the legislative history of Bill 77, that there are expressive elements to these laws. Expressive ends are a secondary goal, even if the primary goal is to discourage and sanction reparative therapy.

This change to social meaning can have a positive impact on the mental health of trans communities. Research has found correlations between the legalisation of same-sex marriage and significantly reduced suicidality among LGBQ students, and between laws permitting denials of services to same-sex couples and significantly increased mental distress among LGBQ adults.[229] These studies support the thesis that laws bearing on LGBTQ people have an impact on mental

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[228] *Ibid* at 826.

[229] Julia Raifman et al, "Difference-in-Differences Analysis of the Association Between State Same-Sex Marriage Policies and Adolescent Suicide Attempts" (2017) 171:4 JAMA Pediatrics 350; Julia Raifman et al, "Association of State Laws Permitting Denial of Services to Same-Sex Couples With Mental Distress in Sexual Minority Adults: A Difference-in-Difference-in-Differences Analysis" (2018) 75:7 JAMA Psychiatry 671.

health that exceeds their material effects. However, polarised media debates related to the contemplated legislative changes can have a negative effect on mental health, suggesting a need for caution.[230]

While the symbolic effects of bans on trans reparative therapy are likely positive, there is room to ask whether we might over-value such effects to the detriment of more material changes. Writing in the context of hate crime laws, Evan Vipond points out: "In passing laws that are reactionary rather than preventive, the government offers a band-aid solution under the guise of equality."[231] We must ask whether the law's message will lead to tangible impact or become yet another forgotten law on the books. At least one individual whose work appears to have motivated Bill 77 expressed the belief that the law did not apply to him, which suggests that Bill 77 may fail to alter professional practices.[232]

There is an opportunity cost to prioritising legal reforms that are primarily symbolic and fail to address the lived conditions of trans people. The symbolic effects of laws become all the more questionable in light of the relationship Marie-Amelie George establishes between symbolic ends and marriage equality: "For advocates, securing the right to marry—not just enjoy the benefits of marriage through civil unions—was essential because of the expressive function of the marriage label."[233] Indeed, the narrow focus on marriage of large-scale LGBT movements has been heavily criticized by activists and scholars for engaging in politics of respectability, legitimising the

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[230] Stefano Verrelli et al, "Minority stress, social support, and the mental health of lesbian, gay, and bisexual Australians during the Australian Marriage Law Postal Survey" (2019) Australian Psychologist, online: <http://doi.wiley.com/10.1111/ap.12380>.

[231] Evan Vipond, "Trans Rights Will Not Protect Us: The Limits of Equal Rights Discourse, Antidiscrimination Laws, and Hate Crime Legislation" (2015) 6:1 Western Journal of Legal Studies art. 3 at 19.

[232] Zinck & Pignatiello, *supra* note 20 at 13.

[233] George, *supra* note 227 at 826.

distribution of social benefits around a specific vision of the family, and failing to care for the most vulnerable members of LGBTQIA2S+ communities.[234] For Dean Spade:

> We must have a long-term view about how social change works or else we get short-sighted strategies. The struggle for same-sex marriage is a relevant example in this moment. That fight makes perfect sense from a lawyer's perspective— "These things are not equal under the law. I'm going to make them equal." It only stops making sense when you think a little more broadly about resource allocation in our movements, and about the broader context of the resistance to family and sexual regulation.[235]

Is the fight for greater trans and gender creative youth wellbeing best done through laws which may or may not implicitly recognise the legitimacy of medical and professional authority over those same youth? The involvement of professionals in trans and gender creative lives is controversial.[236] Leading scholars have opposed the existence of a diagnostic category for trans and gender creative children in the DSM and ICD, arguing that the diagnosis is stigmatising and that such children do not need medical care by virtue of being trans or gender creative.[237]

Even as models of care grow more progressive, the implicit message remains that it is scientists and professionals who determine what amounts to ethical practice, not those who are most impacted by their work. Most statutes which prohibit reparative therapy do so by entrusting

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[234] Ryan Conrad, *Against Equality: Queer Revolution, Not Mere Inclusion* (Chico, CA: AK Press, 2014); Dean Spade, "Under the Cover of Gay Rights" (2013) 37 NYU Review of Law & Social Change 79.

[235] Dean Spade, "Keynote Address: Trans Law & Politics in a Neoliberal Landscape" (2009) 18:2 Temple Political & Civil Rights Law Review 353 at 372.

[236] Evan Vipond, "Resisting Transnormativity: challenging the medicalization and regulation of trans bodies" (2015) 8:2 Theory in Action 21; Dean Spade, "Mutilating Gender" in Susan Stryker & Stephen Whittle, eds, *The Transgender Studies Reader* (Hoboken: Taylor and Francis, 2013) 315; Florence Ashley, "What does that say about me? An ethical case for the informed consent model of trans hormone replacement therapy".

[237] Sam Winter et al, "The psycho-medical case against a gender incongruence of childhood diagnosis" (2016) 3:5 The Lancet Psychiatry 404.

disciplinary bodies with the task of enforcing the ban, legitimating their power at the same time it seeks to restrict their practices.

However, we also have reasons to question whether symbolism is all bad. I have reflected on my own negativity toward symbolism in an invited contribution to the University of Toronto Press Blog, saying:

> Although I continue to believe that purely symbolic laws should be criticised, the underlying critique stays with me to this day. The symbolic is one of the most characteristic traits of human societies. We lead symbolic lives, and deal in symbols every day of our lives. What does it mean, as activists who aspire to a grounded approach, to demean symbolic change?[238]

Hope remains that the laws will significantly impact practice and thus will have tangible positive effects on people's lives. Although symbolic impacts should not be overvalued or become the primary guide to legislation purporting to improve trans and gender creative lives and although we must remain critical of the disciplinary regimes which underpin trans healthcare,[239] it retains the potential to precipitate or at least encourage cultural shifts as it communicates approval of gender-affirmative practices to practitioners and the public.

Limits

Various limits of legislative bans on trans reparative therapy as a political goal may be identified.

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[238] Florence Ashley, "Grounding Ourselves: On Bill C-16 and Symbolic Legislation", (26 January 2018), online: *University of Toronto Press Blog* <https://utorontopress.com/ca/blog/2018/01/26/grounding-ourselves-on-bill-c-16-and-symbolic-legislation/>.

[239] For a discussion of disciplinary regimes and trans life, see Spade, *supra* note 5 at 50ff.

Age restrictions and consent

With the exception of Malta, all laws prohibiting trans reparative therapy thus far have been limited to minors. The rationale for excluding adults from the application of the law is to pre-empt legislative opposition on grounds that the law interferes with individual autonomy.[240] Speaking before the Legislative Assembly of Ontario, Cheri DiNovo explained Bill 77's restriction to minors by stating: "Adults are free to do what adults will do".[241] Though many scholars, activists, and politicians may wish to also prohibit trans reparative therapy for adults, passing laws which prohibit reparative practises directed at adults may be politically difficult.[242]

There is little evidence, however, that such practices are any less harmful for adults. On the contrary, even proponents of the psychotherapeutic approach admit that reparative practices are harmful for adolescents and adults.[243] As was previously pointed out, adults are not free to demand harmful treatment despite being free to consent or refuse treatment, even if the decision may be harmful to them. Drescher *et al.* have cogently argued against this point in the context of sexual orientation:

> Conversion therapists have at times defended their actions by claiming their clients should be able to choose to take part in these therapies. We disagree […]. Sexual contact, even when consensual,

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[240] George, *supra* note 227 at 824–825.

[241] Legislative Assembly of Ontario, *supra* note 120 at 3344 (Cheri DiNovo).

[242] Legislated age-restrictions also risk being interpreted as limiting the application of professional malpractice and disciplinary law for adult trans reparative therapy, under the assumption that if legislature wanted to prohibit such practices it would have done so. However, it could be argued that the laws do not demonstrate legislative intent to exclude adult trans reparative therapy from the prohibition, but rather doubly ensure that trans reparative practices on minors are prohibited independently of the state of scientific consensus and knowledge.

[243] Zucker & VanderLaan, *supra* note 67 at 226; Green, *supra* note 185 at 10. However, see also Zucker, Lawrence & Kreukels, *supra* note 68 at 238.

> has been shown to be very detrimental to the patient and has no place in the clinical setting.[244]

Furthermore, adults who are trans or are questioning their gender are particularly vulnerable. Stigma against trans people is profoundly anchored in our culture, leading many individuals to internalise negative attitudes toward trans lives. Lack of information about therapeutic practices and the difficulty of finding alternative practitioners in given locales also create risk of less-than-fully informed consent to reparative practices. Though trans adults are capable of free and enlightened consent—we must be wary of narratives which infantilise them—we have reasons to doubt the validity of arguments in favour of allowing reparative therapy for adults. Autonomy is larger than consent,[245] and autonomy does not trump the duty of practitioners to provide competent care.

Insufficiently detailed legislative drafting

Laws prohibiting reparative practices rarely include detailed explanations of what they cover. Practitioners and institutional actors who read the law without being aware of the legislative history, social context of the statute, and link between the statute and APA report may find themselves unable to realise its scope. Multiple practitioners whose practices are routinely characterised as reparative therapy reject the label as well as the characterisation of their work as attempting to change gender identity although they maintain the prevention of adult trans outcomes as a clinical goal. This difficulty is particularly severe in jurisdictions whose laws are framed around the intention to "change gender identity" rather than "change or direct gender identity"—

[244] Drescher et al, *supra* note 146 at 9.

[245] Vikki A Entwistle et al, "Supporting Patient Autonomy: The Importance of Clinician-patient Relationships" (2010) 25:7 Journal of General Internal Medicine 741; Rebecca Kukla, "Conscientious Autonomy: Displacing Decisions in Healthcare" (2005) 35:2 Hastings Center Report 34.

as was the case in the original version of Bill 77—or "change, repress and, or eliminate" it—as is worded the Maltese law.

Although careful interpretation of the statutes clarify their meaning and scope, the impact on practice will be limited by its ability to communicate effectively which practices are prohibited and which are not.

Unregulated practitioners

In jurisdictions that do not prohibit unlicensed practice of psychotherapy, the prohibition of trans reparative therapy may fail to include a wide range of harmful practices, notably when done in a religious context. However, this limitation should be contextualised. In Canada, unlicensed practice of psychotherapy is typically prohibited, and in the United States context, strong constitutional protections of religious freedom may make it impossible to prohibit reparative practices by members of the clergy or other unlicensed individuals.[246] Furthermore, as I mentioned in the introduction, faith-based practices appear to be less responsive to legal regulation. Addressing religiously-motivated reparative therapy may be best done through non-legal approaches rather than by broadening prohibitions of trans reparative therapy to include unlicensed practitioners.

[246] George, *supra* note 227 at 822; *Pickup v. Brown*, *supra* note 178; in the United States, bans grounded in consumer protection acts may apply to unregulated practitioners: Melissa Ballengee Alexander, "Autonomy and Accountability: Why Informed Consent, Consumer Protection, and Defunding May Beat Conversion Therapy Bans" (2017) 55 University of Louisville Law Review 283.

Criminal laws

Some jurisdictions have opted for criminal bans of reparative therapy. Malta's law is penal in nature, and recent Canadian advocacy has revolved around adding reparative therapy to the *Criminal Code*. A petition to this effect was recently rejected by the federal government.[247]

Although criminal penalties may discourage practices more readily than disciplinary sanctions, the previously mentioned lack of details to the statutes' prohibition creates additional challenges in the criminal context. Interpretation of penal provisions is subject to a narrower rule of interpretation. In the words of then-Chief Justice Lamer of the Supreme Court of Canada, writing for the majority in *R. v. McIntosh*:

> It is a principle of statutory interpretation that where two interpretations of a provision which affects the liberty of a subject are available, one of which is more favourable to an accused, then the court should adopt this favourable interpretation.[248]

Judges are likely to be more reluctant to interpret provisions broadly when there is a risk of jail time, even if it means limiting the state's ability to sanction reparative therapy.[249] Should bans be interpreted narrowly, it may negatively impact the deterrent effect of the law as well as constrain future interpretation of non-criminal laws prohibiting reparative therapy.

Besides the risk of narrow interpretation, criminal bans may also create evidentiary difficulties. The accused may not be compelled to testify in a criminal trial, making it more difficult to establish the required *mens rea*. In jurisdictions such as the United States, a criminal law prohibiting reparative therapy could also grant defendants in civil suits a right not to testify, since

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[247] Stroh, *supra* note 170.
[248] *R. v. McIntosh*, *supra* note 126, para 29.
[249] *Interpretation Act*, RSC 1985, c I-21 [*Interpretation Act*], s 12.

defendants have a constitutional right not to answer questions when the answer might incriminate them. This would make it more difficult for victims of reparative therapy to prevail in a civil suit.

Professional resentment and adjudicator reluctance

Professionals may resent legislative interference in their work. Approaches to care are traditionally left to self-regulating professions. Legislation may create opposition and resentment within professional associations and discourage adjudicators from sanctioning professionals faced with disciplinary complaints. Joyce Rowlands' comments before the Ontario Standing Committee on Justice Policy raises the concern of resentment on the part of professional associations.[250] Professional bodies are tasked with licensing practitioners and maintaining the standards of the profession through disciplinary procedures, such as the College of Registered Psychotherapists, operate as a form of professional self-regulation. Whereas governments grant privileges and benefits—notably monopolies—to professionals who are licensed by regulatory bodies, the structure of licensure privileges self-regulation under the presumption that professionals are best positioned to judge each others' practices given the in-depth knowledge typically required to evaluate the quality of interventions.

Laws such as Bill 77 are incursions on a terrain traditionally left to professionals, raising concerns of legislative interference with the proper functioning of the profession. Professional resentment risks manifesting itself by a lack of policy-level engagement with reparative therapy, a hostility to developing clear guidelines opposing reparative practices, and a reluctance on the part of adjudicators to impose disciplinary sanctions on fellow professionals for practices. Adjudicators may also be led to believe that laws such as Bill 77 would not have been passed if

[250] Legislative Assembly of Ontario, Standing Committee on Justice Policy, *supra* note 40 at JP-61.

reparative therapy was already contrary to professionals' duty to provide competent care and may be reluctant to sanction professionals who they believe to be respecting this duty.[251]

Lack of compensation for patients

Most bans on reparative therapy do not provide for compensation, even though it is crucial to the wellbeing of those harmed by reparative therapy. Connecticut's law is the only one to expressly provides for compensations of patients subjected to reparative therapy. It does so by declaring that reparative therapy is an "unfair or deceptive trade practice"[252] within the meaning of the state's consumer protection laws, which grants individuals the right to sue for damages.

Whether compensation can be sought for violations of the prohibition on trans reparative therapy in other jurisdictions is less clear and will largely vary from jurisdiction-to-jurisdiction. In Canada, violations of codes of ethics, while they do not automatically constitute professional malpractice, may give rise to a civil claim where the violated provision establish an "elementary standards of care".[253] In either case, it will not be sufficient to demonstrate a violation of disciplinary law: further legal arguments will be necessary to establish that this violation falls short of the requirements of professional malpractice law—arguments which will not be detailed in this thesis.[254]

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[251] This interpretation is reminiscent of the legal principle that legislatures do not speak in vain: *AG (Que) v Carrières Ste-Thérèse Ltée*, [1985] 1 SCR 831 at 838.

[252] Conn. Gen. Stat. § 19a-907b(b) (Connecticut).

[253] *Morin v Blais*, [1977] 1 SCR 570 at 580.

[254] On this topic, see Florence Ashley, "Corriger nos pratiques : les approches thérapeutiques aux enfants trans sous l'œil du droit" in Denise Médico & Annie Pullen Sansfaçon, eds, *Les interventions affirmatives auprès des enfants et jeunes trans : perspectives multidisciplinaires* (Montreal: Presses de l'Université de Montréal, 2020).

Unwillingness to legislate

The last and perhaps biggest challenge to laws as a means of curtailing trans reparative therapy is that many jurisdictions seem unwilling to adopt a ban. Only two provinces in Canada have passed acts prohibiting reparative practices, with two more expressing an intent and interest in doing so. Sixty percent of the provinces and all three territories remain without laws against reparative therapy on the books for the foreseeable future.

In the United States, thirteen out of fifty states have prohibited trans reparative therapy. Of the remaining states, six have bills currently under consideration, and at least six states shut down proposed bills.[255] The other twenty-five states have simply refused to act thus far.

The election of conservative governments across North America makes it increasingly unlikely that legislation prohibiting trans reparative therapy will be proposed. In my home province of Quebec, the passing of such a law seems unlikely. Given the limits of trans reparative therapy bans, how can we more effectively discourage reparative practices?

Developing an affirmative professional culture

In this section, I draw on sociological research to suggest that the establishing of professional committees tasked with developing clear professional guidelines, ensuring the enforcement of those guidelines, and pursuing the integration of teaching on trans reparative therapy in the university curriculum of professionals can supplement prohibitions of reparative therapy to more effectively discourage reparative practices. These proposals do not aim to address

[255] Drescher et al, *supra* note 146 at 11.

every limitation of bans, as they primarily aim at discouraging reparative practices; for instance, the lack of patient compensation under most trans reparative therapy bans is not addressed.

To discourage practitioners from engaging in unethical behaviour, we must inform them of which practices they should refrain from and ensure that they are motivated not to engage in reparative therapy. Motivation to refrain from practices can be internal—desiring to act in accordance to one's own ethical standards or self-identity—or external—desiring to avoid the potential negative consequences of acting against prescribed norms of behaviour.

Clear professional guidelines developed by professional committees, the integration of education on trans reparative therapy in university and professional development curriculum, and the creation of a body tasked with holding professionals accountable for engaging in reparative practices contribute to greater knowledge and motivation and offer a promising way of enhancing bans on reparative therapy. The three poles of policymaking, education, and accountability are mutually reinforcing. Each pole contributes to the other poles' effectiveness toward discouraging trans reparative therapy.

Clear professional guidelines

Discouraging reparative therapy effectively requires clear professional guidelines. The scope of trans reparative therapy bans is not immediately evident from reading the law. Without an in-depth knowledge of the history of these bans and of therapeutic approaches to trans healthcare, it is difficult for practitioners to know which behaviours and interventions are prohibited and which are not.

Some professional associations have already developed detailed practice guidelines in parallel with their opposition to trans reparative therapy. The Ordre des travailleurs sociaux et des

thérapeutes conjugaux du Québec developed a dossier titled "Pratiques anti-oppressives auprès des jeunes trans" which provides strong support for the gender-affirmative approach to trans youth care.[256] A month following the publication of the dossier, the Ordre endorsed the Joint Statement on the Affirmation of Gender Diverse Children and Youth of the Canadian Association for Social Work Education and the Canadian Association of Social Workers which declared that any "attempt to alter the gender identity or expression of a young person to align with social norms is considered unethical and an abuse of power and authority."[257] The Ordre positioned its endorsement as part of a broader range of efforts to guide trans youth care that included the dossier. Professional guidance respects the spirit of professional orders, which have for main purpose the protection of the public.[258]

Research demonstrates that the malleability of ethical norms allows unethical actors to preserve their moral self-image. Individuals internalise social norms and values and then compare their behaviour to them.[259] Compliance to norms and values is psychologically satisfying, whereas failing to comply with those norms forces moral agents to negatively update their self-image.[260] However, when ethical norms are unclear, ambiguous, or malleable, people will seek to avoid

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[256] Alexis Marcoux Rouleau, Annie Pullen Sansfaçon & Edward Ou Jin Lee, "Pratiques anti-oppressives auprès des jeunes trans", online: *OTSTCFQ* <https://beta.otstcfq.org/l-ordre/evenements-et-campagnes/le-travail-social-dans-tous-ses-etats/pratiques-anti-oppressives-aupres-des-jeunes-trans>.

[257] Canadian Association of Social Workers & Canadian Association for Social Work Education, "Joint Statement on the Affirmation of Gender Diverse Children and Youth", (9 January 2015), online: <https://caswe-acfts.ca/wp-content/uploads/2014/12/Queer.jan2015.pdf>; Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec, "L'Ordre appuie la déclaration de la CASWE-ACFTS et l'ACTS", (10 January 2019), online: *OTSTCFQ* <https://beta.otstcfq.org/mots-sociaux/actualites/l-ordre-appuie-la-declaration-de-la-caswe-acfts-et-l-acts>.

[258] *Professional Code*, CQLR, c C-26 [*Professional Code*], s 23.

[259] Nina Mazar, On Amir & Dan Ariely, "The Dishonesty of Honest People: A Theory of Self-Concept Maintenance" (2008) 45:6 Journal of Marketing Research 633 at 633.

[260] *Ibid* at 634.

negatively updating their self-image by reinterpreting the behaviour as morally acceptable in a self-serving manner.[261]

This self-serving psychological process is limited by the ethical context, including the specificity of the ethical norm. The more the norm is malleable, the more people will engage in norm-violating behaviour and preserve their self-image as a good person.[262] Greater norm specificity forces people to either act more ethically, or accept that they willingly act unethically, which is psychologically undesirable.

The lack of specificity of prohibitions on trans reparative therapy allows professionals who engage in reparative practices to preserve their self-image as moral individuals despite those practices. As we have seen, some professionals who adopt the psychotherapeutic approach deny that they are acting contrary to Bill 77,[263] despite a detailed interpretation of the law revealing that the psychotherapeutic approach to fall under Bill 77's prohibition. Clear professional guidelines would preclude this moral self-image preservation and confront professionals engaging in reparative practices with the immorality of their actions.

The presence of clear guidelines also facilitates mutual enforcement of norms against trans reparative therapy. Mutual enforcement through peer shaming and peer pressures plays a significant role in defining the contours of professional practice.[264] Because of the small size of

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[261] *Ibid*.
[262] *Ibid* at 634–635.
[263] Zinck & Pignatiello, *supra* note 20 at 13.
[264] Michael Davis, "Thinking Like an Engineer: The Place of a Code of Ethics in the Practice of a Profession" (1991) 20:2 Philosophy and Public Affaires 150; Denise du Toit, "A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brishane, Australia" (1995) 21 Journal of Advanced Nursing 164; Gretchen B Sechrist & Charles Stangor, "Perceived Consensus Influences Intergroup Behavior and Stereotype Accessibility" (2001) 80:4 Journal of Personality and Social Psychology 645.

trans populations, most clinicians do not have significant clinical experience with trans people or the academic literature on therapeutic approaches to trans people. Those who engage in trans reparative therapy regularly often boast a specialisation in trans care. This difference in authority over trans care makes it difficult for most clinicians to confront practitioners of reparative therapy, despite the presence of laws which prohibit reparative practices. Concept malleability not only applies to internal behaviour evaluation, but also the evaluation of others' behaviour. The presence of clear professional guidelines offers an authoritative point of reference for clinicians not specialised in trans health in confronting practitioners of trans reparative therapy, as these guidelines would be sufficiently specific to label such practices unethical authoritatively.

Disciplinary decisionmakers are not always familiar with trans healthcare and may be unwilling to sanction practitioners more specialised and knowledgeable than them. In disciplinary proceedings regarding trans reparative practices, adjudicators are likely to fall under a scenario similar to the one described in the previous paragraph and may be unwilling to sanction a practitioner with greater expertise in trans care than them. Clear professional guidelines can enhance the disciplinary process by providing an authoritative point of reference for adjudicators, in a manner similar to the Ontario Human Rights Commission's policies, which do not have the force of law and yet have been undeniably influential on human rights jurisprudence in Ontario.[265]

The guidelines should be developed by a professional committee constituted by professionals, cis and trans, and representatives from trans communities. The inclusion of professionals and members of trans communities is essential to creating a sense of in-group

[265] See for example: Ontario Human Rights Commission, *supra* note 100.

consensus over trans therapeutics, as well as fostering a culture of trust which contributes to discouraging unethical practices.

As highlighted in the previous section, one of the factors limiting the efficacy of ban on trans reparative therapy is professional resentment. Professional orders are quintessentially defined as self-regulated and legislatively imposed prohibitions risk being perceived as undue interference in professional self-regulation. The classification of behaviour and norms as in-group or out-group has a demonstrated influence on professional practices.[266] In their work on ethical contagion, Francesca Gino, Shahar Ayal, and Dan Ariely observed that unethical behaviour by in-group members makes clinicians more likely to replicate the unethical behaviour, whereas unethical behaviour by out-group members leads them to avoid that unethical behaviour even more.[267] The reason is that professionals share a social identity with other professionals and thus see themselves as subjected to the same social norms. Because legislatures are perceived as out-group members, clinicians are less likely to internalise prohibitions of trans reparative therapy, and reparative practices by clinicians will have an outsized impact on the perceived acceptability of reparative practices despite the law.[268] To adopt the authors' metaphor, a bad apple spoils the barrel.

Clear professional guidelines established by professionals—in-group members—can help remedy this situation. Gino, Ayal, and Ariely conclude that the impact of bad apples can be minimized through techniques which stigmatize them and re-classify them as out-group members.[269] Not only do clear guidelines promoted by professionals provide a normative

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[266] Francesca Gino, Shahar Ayal & Dan Ariely, "Contagion and Differentiation in Unethical Behavior: The Effect of One Bad Apple on the Barrel" (2009) 20:3 Psychological Science 393.
[267] *Ibid* at 394.
[268] *Ibid* at 397–398.
[269] *Ibid*.

counterweight to professional who engage in reparative therapy, but they serve to disavow those practitioners and classify them as *other*. This parallels a phenomenon we already observe in trans health professional spheres in North America, in which practitioners of the psychotherapeutic approach are *persona non grata* at academic conference and subject to protests.[270]

Members of trans communities should also be included in the drafting of professional guidelines. Although codes of ethics and standards are essential to discouraging unethical behaviour, developing a culture of trust within the profession and between the profession and service-users is crucial to maintaining an effective ethical culture within professions.[271] A culture of trust is cultivated by "trusting others, being trusted and seeking to be trusted" and ensures greater compliance with legal and ethical norms of behaviour.[272] To the extent that including trans communities in institutional, professional norm-setting leads to greater trust from trans communities, their inclusion contributes to the effectiveness of banss.

Education

The second component of my proposal is the integration of education on trans therapeutic and trans reparative therapy in both university cursus and continuing professional education. Education contributes to greater knowledge of ethical norms in professional practice and plays a crucial role in relation to the internalisation of norms and values among professionals.

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[270] Tosh, *supra* note 9.
[271] Andrew Brien, "Professional Ethics and The Culture of Trust" (1998) 17:4 Journal of Business Ethics 391.
[272] *Ibid* at 402.

The formation of a strong professional identity has been linked with the ability to resist institutional and social pressures, of which transantagonism is an example.[273] Professional identity refers to the internalisation of values, knowledges, practices, etc. which are constitutive of a profession.[274] It is an internal sense of being in harmony with what it means to be a social worker, physician, psychologist, etc. Those who have a strong sense of professional identity are likelier to respect the ethical norms of the profession.[275] Professional socialisation has been shown to be a stronger determinant of behaviour than pre-socialisation biographical details.[276]

Education, both in the university and in the continuing education context, contributes to discouraging reparative therapy in multiple ways. Apart from integration in professional identity through direct learning, education also contributes to peer pressure, presents professional leaders for students and young professionals to model themselves on, and diminishes the lack of perceived professional consensus which was previously identified as a barrier to discouraging reparative therapy. However, it is important to note that the existence of accountability structures, which will be described in the next subsection, act as a mediator of training.[277] Institutions which assign responsibility for ensuring compliance with ethical norms in a clear manner see a greater positive effect from education.

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[273] Josianne Crête & Annie Pullen Sansfaçon, "Étudier le développement de l'identité professionnelle en travail social : les défis de combiner diverses approches méthodologiques" (2015) 17 Recherches Qualitatives, Hors-Série 42; Ashley, *supra* note 10; Annie Pullen Sansfaçon, Isabelle Marchand & Josianne Crête, "Explorer l'identité professionnelle chez les travailleurs sociaux en devenir: Une étude de l'expérience des étudiants québécois finissants" (2014) 27:1 Nouvelles pratiques sociales 137 at 150.

[274] Crête & Pullen Sansfaçon, *supra* note 273 at 45.

[275] *Ibid* at 44.

[276] du Toit, *supra* note 264 at 169.

[277] Alexandra Kalev, Frank Dobbin & Erin Kelly, "Best Practices or Best Guesses? Assessing the Efficacy of Corporate Affirmative Action and Diversity Policies" (2006) 71:4 American Sociological Review 589 at 606.

Peer pressure directly discourages reparative practices through injunctions not to engage in reparative therapy and social sanctions such as exclusion for violating professional norms.[278] Pressures of this kind are closely related to mutual enforcement of disciplinary measures, such as when professionals make official complaints to their order in the name of trans communities or service-users. Because of the status derived from being a member of a profession, professionals who do not work in trans healthcare have both moral and pragmatic motives to pressure others not to engage in unethical behaviour since others' unethical behaviour reflects poorly on the profession, undermining the culture of trust which lies at its roots.[279]

University professors and presenters in continuing education courses play the role of authority figures on whom students and early-career professionals model themselves. As researcher Herminia Ibarra points out, "[i]dentification with role models infuses behavior with meaning, goals, and purposes […], providing a motive for people to change their own behavior."[280] Because professors and presenters are already individuals whom professionals imitate, having professors and presenters show a commitment to affirmative practices and strong opposition to reparative practices influences practice across the profession.[281]

Education can also promote a sense of consensus within the profession, which mitigates the influence of practitioners of reparative therapy on the rest of the profession. By teaching gender-affirmative therapy as the accepted best practice and establishing the consensus against trans reparative therapy, students are invited to categorise practitioners of reparative therapy as

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[278] Josianne Crête, Annie Pullen Sanfaçon & Isabelle Marchand, "L'identité professionnelle de travailleurs sociaux en devenir : de la formation à la pratique" (2015) 61:1 Service social 43 at 50.
[279] Davis, *supra* note 264 at 166–167.
[280] Herminia Ibarra, "Provisional Selves: Experimenting with Image and Identity in Professional Adaptation" (1999) 44:4 Administrative Science Quarterly 764.
[281] *Ibid* at 774.

exceptions who do not truly belong within the profession.[282] The bad apple cannot rot the whole barrel if it is outside of it. Further evidence shows that behaviour and moral judgements among professionals are determined by whether these behaviours are perceived as shared or not.[283] Appearance of consensus matters more than the presence of consensus. It is insufficient for there to be a consensus: professionals must also know that a consensus exists on the matter.

University education is the first medium through which professional identity is formed and is the first point of contact for professionals with the values of their profession.[284] Because professional identity is most malleable in early career, university education is a promising locus of intervention in discouraging trans reparative therapy.[285] Furthermore, the centralised nature of university education in contrast to the multiplicity of contexts of clinical practice makes it easier to intervene on. However, continuing professional development is also crucial, especially since all current professionals have already graduated from university.

Developing content for university courses and continuing professional development can be done through professional committees, with integration into the curriculum being either suggested or mandated by the profession pursuant to its role in accrediting university programs and continuing professional development courses. The existence of clear professional guidelines facilitates the integration of trans health into teaching since these guidelines can serve as a point of reference for teachers and educators and as a resource for professionals. These guidelines also

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[282] Gino, Ayal & Ariely, *supra* note 266.
[283] Sechrist & Stangor, *supra* note 264 at 651.
[284] Crête & Pullen Sansfaçon, *supra* note 273; Pullen Sansfaçon, Marchand & Crête, *supra* note 273 at 145; du Toit, *supra* note 264.
[285] Ibarra, *supra* note 280 at 765; Crête & Pullen Sansfaçon, *supra* note 273 at 44.

grant new course content an allure of legitimacy and authoritativeness since they are created by a committee of their present or future professional order.

Because continuing professional development presentations are accredited on a per-event basis, greater oversight and monitoring strategies over quality of content and teaching are possible.[286] Selected providers who are known for high quality, gender-affirmative content and include trans voices in their presentations could be incentivised with money from a specially-constituted fund or a greater number of accredited hours. Similarly, attendance of continuing education events on trans health could be incentivised by offering 1.5x or 2x accreditation hours up to a certain number when attending trans health events.

Accountability structures

The third component of my proposal involves creating accountability structures which are tasked with ensuring that professionals are not engaging in reparative therapy. Besides the previously mentioned tasks of overseeing educational initiatives, this body would produce reports on the practice of trans reparative therapy among professionals and play an active role in supporting enforcement of the prohibition of reparative practices by lodging disciplinary complaints or recommending investigations into professionals they have identified through their work.

Visible enforcement and credible threats of sanctions act as a deterrent and punishment for unethical professional behaviour. Psychological models suggest that professionals contemplating

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[286] Nancy S Elman, Joyce Illfelder-Kaye & William N Robiner, "Professional Development: Training for Professionalism as a Foundation for Competent Practice in Psychology." (2005) 36:4 Professional Psychology: Research and Practice 367 at 373; see David A J Richards, "Moral Theory, the Developmental Psychology of Ethical Autonomy and Professionalism" (1981) 31 Journal of Legal Education 359 for a discussion of quality of moral education in continuing professional development.

acting unethically are in part motivated or discouraged from doing so based on their estimated likelihood of being caught.[287] Whereas unpunished practitioners of trans reparative therapy have an outsized effect in authorizing others' reparative practices, punishment helps stigmatise them and position the as out-group members which has the opposite effect: it discourages the behaviour.[288]

The enforcement function of committees can be structured in different ways depending on the jurisdiction and whether legislative changes to the distribution of power within legislative bodies are plausible. In Quebec, disciplinary complaints to professional associations are not limited to service-users and a committee would be able to lodge complaints against professionals engaging in trans reparative therapy.[289] The committee could also request an inquiry from the syndic of the order.[290] In Ontario, disciplinary complaints could also be lodged by the committee.[291] The committee could also recommend that the Registrar appoint an investigator with the approval of the Inquiries, Complaints and Reports Committee.[292] Because the appointment of an investigator depends on two entities other than the trans reparative therapy committee, it may be insufficiently effective as an enforcement mechanism. The Ontario *Health Professions Procedural Code* could be amended to enable the committee to appoint investigators, or grant them the ability to refer an allegation of misconduct to the Discipline Committee under section 36 of the *Procedural Code*.

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[287] Gino, Ayal & Ariely, *supra* note 266 at 394.
[288] *Ibid* at 397–398.
[289] *Professional Code*, *supra* note 258, s 128.
[290] *Ibid*, s 122.
[291] *Health Professions Procedural Code, Schedule II of the Regulated Health Professions Act, 1991*, SO 1991, c 18 [*Health Professions Procedural Code, Schedule II of the Regulated Health Professions Act, 1991*], s 25.
[292] *Ibid*, s 75.

The impact of enforcement structures also plays out in terms of professional identity. As was previously noted, professional identity is constituted through imitation of people in leadership and authority positions.[293] Official committees of professional associations hold a position of authority which is conducive to imitation and integration in professional identity. Seeing the committee act teaches professionals that opposing reparative practices is at the core of the profession's ethos.

Producing reports on the state of trans reparative therapy within the profession helps foster a sense of surveillance among professionals, who may see the threat of sanctions as more credible because of it. Furthermore, reports showing a high incidence of reparative therapy are likely to be perceived as failures on the part of the profession and subject it to negative press and judgement from trans communities, generating professional resentment towards practitioners engaging in reparative therapy for giving the profession a bad name. As shown by Alexandra Kalev, Frank Dobbin, and Erin Kelly's research, establishing responsibility and accountability for enforcing norms is correlated with compliance.[294] Such reports could be used to enhance the attribution of responsibility to the committee and disciplinary instances by holding them to account for their failure to extinguish trans reparative therapy.

The constitution of a committee tasked with elaborating clear professional guidelines, establishing educational initiatives, and supporting the enforcement of trans reparative therapy bans is essential to discouraging trans reparative practices more effectively and eventually eradicating the practices. The main limitation of my proposal is that it relies on the willingness of

[293] Ibarra, *supra* note 280.
[294] Kalev, Dobbin & Kelly, *supra* note 277.

professional associations and/or legislators. However, many professional associations have shown themselves willing to take a stance against trans reparative therapies,[295] and may be amenable to the proposed scheme.

Bans withstand the critiques levied against them based on therapist freedom, overbreadth, and religious freedom. They help deter reparative therapies and though they cannot eradicate them on their own, they can be supplemented by other strategies. Supplementing bans with professional committees tasked with crafting guidelines, enforcing bans, and educating providers may contribute to the further discouragement of trans reparative therapy and take us one step closer to their eradication.

[295] Ashley, *supra* note 196.

CONCLUSION

The capacity of laws such as Bill 77 in influencing practice was demonstrated with the closure of the CAMH Gender Identity Clinic for Children and Youth. Nonetheless, legislative approaches to trans reparative therapy suffer from many limits. Some such limits are political. For example, it may not be politically feasible to prohibit reparative therapy for adults. Some limits are inherent to the choice of legal vehicle: legislation is mediated by political will. Where legislation is feasible, legislators should turn to the law of Malta as a model. Though it is flawed, as all writing is, it is the best drafted law on trans reparative therapy currently in existence. In jurisdictions where politicians show an unwillingness regulate professional practices in this manner, other legal approaches will have to be considered.

Legislative bans also impact practice unequally. Large institutions like CAMH, which is composed of many people with diverse agendas and is concerned with maintaining its reputation both in the professional community and the local one, are more likely to be impacted by laws than are individual practitioners whose practices already met the disapproval of colleague and failed to change. Though the law may prohibit these practices—as I have shown in chapter II with regards to the psychotherapeutic approach—individuals may continue to practice in the absence of a judgement or disciplinary sanction against them.

Given the limits of legislative bans on trans reparative therapy, it is necessary to look beyond legislation in our fight against trans reparative therapy. Clear guidelines, education, and accountability are needed to supplement legislative measures. Although legislation can play a significant symbolic function, creating a professional culture in which reparative practices are unacceptable holds a greater promise of eradicating trans reparative therapy. Although accountability structures depend in large parts on the illegality of reparative practices, clear

guidelines and education are possible even in the absence of laws prohibiting trans reparative therapy.

I was inspired to write this thesis by my many friends and partners who underwent trans reparative therapy against their will. Many of them are still struggling with the aftermath of being taught that they were broken. This topic was never theoretical to me but takes root in the lives of real people who deserve love and acceptance. I hope that my thesis will do them justice.

My research teaches us that the psychotherapeutic approach, despite rejecting the label of reparative therapy, is illegal in Ontario and may be illegal in many other jurisdictions. This knowledge will be crucial to further advocacy, since the psychotherapeutic approach is still unfortunately practiced by some well-regarded professionals and institutions. Methodologically, my research highlights the complexity of statutory interpretation. Providing the best interpretation of a law can require specialised knowledge that is rarely available to those reading the law. Principles of legal interpretation, legislative history, legal history, social context, scientific literature, and an intimate knowledge of debates surrounding therapeutic approaches to trans youth were all needed to carefully interpret Bill 77. My thesis has strengthened my belief that we cannot assume that the existence of a law translates into effectiveness. Legal solutions, while important, are only partial answers to social problems. We must continue our conversations on trans reparative therapy even after bans are passed.

Future legal research should explore professional malpractice and disciplinary law as a potential means of sanctioning reparative practices in jurisdictions which do not have laws prohibiting reparative therapy. Since trans reparative therapy arguably does not respect the current professional consensus over standards of care in jurisdictions which do not have statutory bans on reparative practices, former and current patients may have recourse despite the absence of

legislation.[296] Because do not come with the same limits as legislation, notably with regards to age, professional malpractice and disciplinary law may also prove useful in jurisdictions which do have legislative bans on trans reparative therapy.

[296] I have argued as much in Ashley, *supra* note 254 (under review).

ANNEX: STATUTES AND BILLS PROHIBITING TRANS REPARATIVE THERAPY

CANADA:

ONTARIO, *REGULATED HEALTH PROFESSIONS ACT, 1991*[297]:

> **29.1** (1) No person shall, in the course of providing health care services, provide any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age.
>
> (2) The treatments mentioned in subsection (1) do not include,
>
> (a) services that provide acceptance, support or understanding of a person or the facilitation of a person' s coping, social support or identity exploration or development; and
>
> (b) sex-reassignment surgery or any services related to sex-reassignment surgery.
>
> (3) Subsection (1) does not apply if the person is capable with respect to the treatment and consents to the provision of the treatment.
>
> (4) Despite the *Health Care Consent Act, 1996*, a substitute decision-maker may not give consent on a person' s behalf to the provision of any treatment described in subsection (1).
>
> (5) Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations,
>
> (a) clarifying the meaning of "sexual orientation", "gender identity" or "seek to change" for the purposes of subsection (1);
>
> (b) exempting any person or treatment from the application of subsection (1).

NOVA SCOTIA, *SEXUAL ORIENTATION AND GENDER IDENTITY PROTECTION ACT*[298]:

> **2** The purpose of this Act is to protect Nova Scotia youth from damaging efforts to change their sexual orientation or gender identity.
>
> **3** In this Act,
>
> (a) "change effort" means any counselling, behaviour modification techniques, administration or prescription of medication or any other

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[297] *Regulated Health Professions Act, 1991*, *supra* note 88.
[298] *Sexual Orientation and Gender Identity Protection Act*, *supra* note 175.

purported treatment, service or tactic used with the objective of changing a person' s sexual orientation or gender identity;

4 Notwithstanding the Health Services and Insurance Act, the Insured Health Services Act or the regulations made thereunder, or any other Act, any hospital or professional services that seek to change the sexual orientation or gender identity of a resident are not insured services under those Acts.

5 The expenditure of public funds of the Province to cover the costs of any change effort with the objective to change the sexual orientation or gender identity of a person is hereby prohibited and declared unlawful.

6 (1) No member of a regulated health profession shall, in the course of the member' s scope of practice, provide any hospital or professional services with the objective to change the sexual orientation or gender identity of a person under the age of nineteen years.

(2) Subsection (1) does not apply where the person receiving the services is over the age of sixteen years, capable of consenting to the services and consents to the services.

(3) Notwithstanding any other Act, a parent, guardian, substitute decision-maker or representative decision-maker may not give consent on a person' s behalf to the provision of any services described in subsection (1).

7 (1) No person in a position of trust or authority towards a young person under the age of nineteen years shall make any change effort with respect to the young person.

(2) Subsection (1) does not apply where the young person is over the age of sixteen years, capable of consenting to the change effort and consents to the change effort.

(3) Notwithstanding any other Act, a parent, guardian, substitute decision-maker or representative decision-maker may not give consent on a person' s behalf to the provision of any efforts described in subsection (1).

8 For greater certainty, the services and change efforts referred to in Sections 4 and 5, subsection 6(1) and subsection 7(1) do not include

(a) services that provide acceptance, support or understanding of a resident or the facilitation of a resident' s coping, social support or identity exploration or development; and

(b) gender-confirming surgery or any services related to gender-confirming surgery.

UNITED STATES[299]:

COLORADO, COLO. REV. STAT.[300]:

> **§ 12-36-102.5.** (5.5) (a) "Conversion therapy" means any practice or treatment by a licensed physician specializing in the practice of psychiatry that attempts or purports to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attraction or feelings towards individuals of the same sex.
>
> (b) "Conversion therapy" does not include practices or treatments that provide:
>
> > (I) Acceptance, support, and understanding for the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change sexual orientation or gender identity; or
> >
> > (II) Assistance to a person undergoing gender transition.
>
> **§ 12-36-117.** (1) "Unprofessional conduct" as used in this article 36 means:
>
> > (nn) Engaging in conversion therapy with a patient who is under eighteen years of age.

CONNECTICUT, CONN. GEN. STAT. § 19A-907–19A-907C:

> **§ 19a-907.** As used in this section and sections 19a-907a to 19a-907c, inclusive:
>
> (1) "Conversion therapy" means any practice or treatment administered to a person under eighteen years of age that seeks to change the person' s sexual orientation or gender identity, including, but not limited to, any effort to change gender expression or to eliminate or reduce sexual or romantic attraction or feelings toward persons of the same gender.
>
> "Conversion therapy" does not include counseling intended to
>
> > (A) assist a person undergoing gender transition,
> >
> > (B) provide acceptance, support and understanding to the person, or

[299] Does not include proposed bills: HF 93 (Iowa),HB 5550 (Michigan), HF 2246 (Minnesota), SB 126 (Ohio), and HB 1177 (Pennsylvania).

[300] Identical provisions also appear in the chap on mental healthcare.

(C) facilitate the person' s coping, social support or identity exploration and development, including, but not limited to, any therapeutic intervention that is neutral with regard to sexual orientation and seeks to prevent or address unlawful conduct or unsafe sexual practices, provided such counseling does not seek to change the person's sexual orientation or gender identity.

§ 19a-907a. (a) No health care provider shall engage in conversion therapy.

(b) Any conversion therapy practiced by a health care provider shall be considered unprofessional conduct and shall be grounds for disciplinary action under section 19a-17, 21a-7 or 21a-8 of the general statutes, including, but not limited to, suspension or revocation of the professional's license, certification or registration to practice his or her profession.

(c) Nothing in sections 1 to 4, inclusive, of this act shall prevent a national certifying body that certifies any licensed, certified or registered professional from acting in response to a complaint that a licensed, certified or registered professional has engaged in conversion therapy.

§ 19a-907b. (a) It shall be unlawful for any person who practices or administers conversion therapy to practice or administer such therapy while in the conduct of trade or commerce.

(b) A violation of subsection (a) of this section shall be considered an unfair or deceptive trade practice pursuant to section 42-110b of the general statutes and shall be subject to the same enforcement, liabilities and penalties as set forth in sections 42-110a to 42-110q, inclusive, of the general statutes.

§ 19a-907c. No public funds, as defined in section 9-601 of the general statutes, shall be expended for the purpose of (1) practicing conversion therapy, (2) referring a person to a health care provider for conversion therapy, (3) referring any individual to any person engaged in trade or commerce for conversion therapy, (4) health benefits coverage for conversion therapy, or (5) a grant or contract with any entity to conduct conversion therapy or refer any person to a health care provider for conversion therapy or to a person engaged in trade or commerce to provide conversion therapy.

DELAWARE:

Del. Code tit. 19, § 710. For the purposes of this subchapter:

(10) "Gender identity" means a gender-related identity, appearance, expression or behavior of a person, regardless of the person's assigned sex at birth. Gender identity may be demonstrated by consistent and uniform assertion of the gender

identity or any other evidence that the gender identity is sincerely held as part of a person's core identity; provided, however, that gender identity shall not be asserted for any improper purpose.

Del. Code tit. 24, § 1702[301]**.** The following definitions apply to this chapter **[**Medical Practice Act**]** unless otherwise expressly stated or implied by the context:

(3) "Conversion therapy" means any practice or treatment that seeks to change an individual' s sexual orientation or gender identity, as "sexual orientation" and "gender identity" are defined in § 710 of Title 19, including any effort to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. "Conversion therapy" does not mean any of the following:

a. Counseling that provides assistance to an individual who is seeking to undergo a gender transition or who is in the process of undergoing gender transition.

b. Counseling that provides an individual with acceptance, support, and understanding without seeking to change an individual' s sexual orientation or gender identity.

c. Counseling that facilitates an individual' s coping, social support, and identity exploration and development, including counseling in the form of sexual orientation-neutral interventions or gender identity-neutral interventions provided for the purpose of preventing or addressing unlawful conduct or unsafe sexual practices, without seeking to change an individual' s sexual orientation or gender identity.

§ 1731. (a) A person to whom a certificate to practice medicine in this State has been issued may be disciplined by the Board for unprofessional conduct, as defined in subsection (b) of this section, by means of levying a fine, or by the restriction, suspension, or revocation, either permanent or temporary, of that person' s certificate to practice medicine, or by other appropriate action, which may include a requirement that a person who is disciplined must complete specified continuing education courses. The Board shall permanently revoke the certificate to practice medicine in this State of a person who is convicted of a felony sexual offense.

(b) "Unprofessional conduct" includes any of the following acts or omissions:

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[301] Although only code sections for medicine were included, near-identical provisions also exist for nursing, psychology, and clinical social work.

(24) Engaging in conversion therapy with a child

DISTRICT OF COLUMBIA, D.C. CODE § 7-1231.02, 7-1231.14A:

> **§ 7–1231.02** (25A) "Sexual orientation change efforts" means a practice by a provider that seeks to change a consumer' s sexual orientation, including efforts to change behaviors, gender identity or expression, or to reduce or eliminate sexual or romantic attractions or feelings toward a person of the same sex or gender; provided, that the term " sexual orientation change efforts " shall not include counseling for a consumer seeking to transition from one gender to another, or counseling that provides acceptance, support, and understanding of a consumer or facilitates a consumer' s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices in a manner that does not seek to change a consumer's sexual orientation.
>
> **§ 7–1231.14a** (a) A provider shall not engage in sexual orientation change efforts with a consumer who is a minor.
>
> (b) A violation of subsection (a) of this section shall be considered a failure to conform to acceptable conduct within the mental health profession under § 3-1205.14(a)(26) and shall subject a provider to discipline and penalties under § 3-1205.14(c).

HAWAII, SENATE BILL 270[302]:

> §**1.** (a) No person who is licensed to provide professional counseling shall:
>
> (1) Engage in or attempt to engage in sexual orientation change efforts on a person under eighteen years of age; or
>
> (2) Advertise the offering of sexual orientation change efforts on a person under eighteen years of age.
>
> (b) Any person who is licensed to provide professional counseling who engages in or attempts to engage in the offering of sexual orientation change efforts on a person under eighteen years of age shall be subject to disciplinary action by the appropriate professional licensing authority.
>
> (c) For purposes of this section:

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[302] *Sexual Orientation Change Efforts*, 2018, SB 270 (Hawaii).

"Advertise" means a communication made by or on behalf of a person who is licensed to provide professional counseling, made for the purpose of inducing or promoting a professional counseling relationship in which sexual orientation change efforts will be undertaken on a person under the age of eighteen. "Advertise" includes oral, written, graphic, or pictorial statements or representations, including those made through any electronic or print medium.

"Sexual orientation change efforts" means the practice of attempting to change a person's sexual orientation, including but not limited to efforts to change gender identity or gender expressions and behaviors; or to reduce or eliminate sexual or romantic attractions or feelings toward a person of the same gender.

"Sexual orientation change efforts" shall not include counseling supporting a person seeking to transition from one gender to another or counseling that:

(1) Provides acceptance, support, and understanding of a person or facilitates a person' s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and

(2) Does not seek to change sexual orientation, gender identity, or gender expression.

MAINE, ME. REV. STAT. ANN. TIT. 32:

§ 59-C. As used in this Title, unless the context otherwise indicates, the following terms have the following meanings.

1. Conversion therapy. "Conversion therapy" means any practice or treatment that seeks or purports to change an individual's sexual orientation or gender identity, including, but not limited to, any effort to change gender expression or to eliminate or reduce sexual or romantic attractions, feelings or behavior toward individuals of the same gender. "Conversion therapy" does not include the following:

A. Any practice or treatment that assists an individual undergoing a gender transition;

B. Any practice or treatment that provides acceptance, support and understanding to an individual; and

C. Any practice or treatment that facilitates an individual's coping, social support or identity exploration and development, including any therapeutic treatment such as talk therapy that is neutral with regard to sexual orientation and gender identity and that seeks to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change the individual's sexual orientation or gender identity.

§ 2112.[303] An individual licensed or certified under this chapter may not advertise, offer or administer conversion therapy to a minor.

MARYLAND, MD. CODE ANN., HEALTH OCC. § 1-212.1:

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Conversion therapy" means a practice or treatment by a mental health or child care practitioner that seeks to change an individual' s sexual orientation or gender identity.

(ii) "Conversion therapy" includes any effort to change the behavioral expression of an individual's sexual orientation, change gender expression, or eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender.

(iii) "Conversion therapy" does not include a practice by a mental health or child care practitioner that:

1. Provides acceptance, support, and understanding, or the facilitation of coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and

2. Does not seek to change sexual orientation or gender identity.

(3) "Mental health or child care practitioner" means:

(i) A practitioner licensed or certified under Title 14, Title 17, Title 18, Title 19, or Title 20 of this article; or

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[303] Although only the provision for nurses was included, identical provisions also exist for osteopathic physicians, medical doctors, psychologists, alcohol and drug counselors, social workers, pharmacists, counseling professionals, and members of the board of speech, audiology, and hearing.

(ii) Any other practitioner licensed or certified under this article who is authorized to provide counseling by the practitioner' s licensing or certifying board.

(b) A mental health or child care practitioner may not engage in conversion therapy with an individual who is a minor.

(c) A mental health or child care practitioner who engaged in conversion therapy with an individual who is a minor shall be considered to have engaged in unprofessional conduct and shall be subject to discipline by the mental health or child care practitioner's licensing or certifying board.

(d) No State funds may be used for the purpose of:

(1) Conducting, or referring an individual to receive, conversion therapy;

(2) Providing health coverage for conversion therapy; or

(3) Providing a grant to or contracting with any entity that conducts or refers an individual to receive conversion therapy.

MASSACHUSETTS, MASS. GEN. LAWS CH. 112, § 275:

(a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Gender identity", a person's gender-related identity, appearance or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person's physiology or assigned sex at birth. Gender-related identity may be shown by providing evidence including, but not limited to, medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the gender-related identity or any other evidence that the gender-related identity is sincerely held as part of a person's core identity; provided, however, that gender-related identity shall not be asserted for any improper purpose.

"Health care provider", any health care professional licensed under this chapter, including but not limited to, any physician, psychologist, social worker, nurse, or allied mental health and human services professional, including marriage and family therapist, rehabilitation counselor, mental health counselor, or educational psychologist.

"Sexual orientation", having an orientation for or being identified as having an orientation for heterosexuality, bisexuality, or homosexuality.

"Sexual orientation and gender identity change efforts", any practice by a health care provider that attempts or purports to impose change of an individual's sexual orientation or gender identity, including but not limited to efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

"Sexual orientation and gender identity change efforts" shall not include practices that:

(1) (i) provide acceptance, support, and understanding of an individual's sexual orientation, gender identity, or gender expression; (ii) facilitate an individual's coping, social support, and identity exploration and development; or (iii) are sexual orientation-neutral or gender identity-neutral including interventions to prevent or address unlawful conduct or unsafe sexual practices; and

(2) do not attempt or purport to impose change of an individual's sexual orientation or gender identity.

(b) A health care provider shall not advertise for or engage in sexual orientation and gender identity change efforts with a patient less than 18 years of age.

(c) Any health care provider who violates this section shall be such subject to discipline by the appropriate licensing board, which may include suspension or revocation of license.

(d) Any health care provider who violates this section shall be considered to have violated section 2 of chapter 93A. Any such claim brought under this section shall be subject to sections 5A and 7 of chapter 260.

NEVADA, NEV. REV. STAT. §629.600:

1. A psychotherapist shall not provide any conversion therapy to a person who is under 18 years of age regardless of the willingness of the person or his or her parent or legal guardian to authorize such therapy.

2. Any violation of subsection 1 is a ground for disciplinary action by a state board that licenses a psychotherapist as defined in subsection 3.

3. As used in this section:

(a) "Conversion therapy" means any practice or treatment that seeks to change the sexual orientation or gender identity of a person, including, without limitation, a practice or treatment that seeks to change behaviors or

gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward persons of the same gender. The term does not include counseling that:

(1) Provides assistance to a person undergoing gender transition; or

(2) Provides acceptance, support and understanding of a person or facilitates a person' s ability to cope, social support and identity exploration and development, including, without limitation, an intervention to prevent or address unlawful conduct or unsafe sexual practices that is neutral as to the sexual-orientation of the person receiving the intervention and does not seek to change the sexual orientation or gender identity of the person receiving the intervention.

NEW HAMPSHIRE, N.H. REV. STAT. ANN. § 332-L: 1–3:

1. In this chapter, "conversion therapy" means practices or treatments that seek to change an individual' s sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. Conversion therapy shall not include counseling that provides assistance to a person undergoing gender transition, or counseling that provides acceptance, support, and understanding of a person or facilitates a person' s coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual' s sexual orientation or gender identity.

2. I. A person who is licensed to provide professional counseling under RSA 326-B, RSA 328-D, RSA 329, RSA 329-B, RSA 330-A:16, RSA 330-A:18, RSA 330-A:19, RSA 330-A:20, RSA 330-A:21, or RSA 330-C, including, but not limited to, a nurse, physician assistant, physician, psychologist, clinical social worker, clinical mental health counselor, marriage and family therapist, or licensed alcohol and drug counselor, or a person who performs counseling as part of the person's professional training for any of these professions, shall not engage in conversion therapy with a person under 18 years of age.

II. Any licensed professional, as listed in paragraph I, who proposes to engage or engages in conversion therapy on a patient under 18 years of age shall be considered to have engaged in unprofessional conduct and shall be subject to such discipline as the relevant licensing authority deems appropriate.

3. Nothing in this chapter shall be construed to infringe on any constitutional right, including the free exercise of religion.

NEW JERSEY, N.J. REV. STAT. § 45:1-55:

2. a. A person who is licensed to provide professional counseling under Title 45 of the Revised Statutes, including, but not limited to, a psychiatrist, licensed practicing psychologist, certified social worker, licensed clinical social worker, licensed social worker, licensed marriage and family therapist, certified psychoanalyst, or a person who performs counseling as part of the person's professional training for any of these professions, shall not engage in sexual orientation change efforts with a person under 18 years of age.

b. As used in this section, "sexual orientation change efforts" means the practice of seeking to change a person's sexual orientation, including, but not limited to, efforts to change behaviors, gender identity, or gender expressions, or to reduce or eliminate sexual or romantic attractions or feelings toward a person of the same gender; except that sexual orientation change efforts shall not include counseling for a person seeking to transition from one gender to another, or counseling that:

(1) provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices; and

(2) does not seek to change sexual orientation.

NEW MEXICO, N.M. STAT. § 61-1-3.3[304]:

A. A person licensed pursuant to provisions of Chapter 61 NMSA 1978 shall not provide conversion therapy to any person under eighteen years of age. The provision of conversion therapy in violation of the provisions of this subsection shall be grounds for disciplinary action by a board in accordance with the provisions of the Uniform Licensing Act.

B. As used in this section:

(1) "conversion therapy" means any practice or treatment that seeks to change a person's sexual orientation or gender identity, including any effort

[304] Although only code sections applicable to all professionals was included, separate near-identical provisions also exist for nursing, medicine, psychology, counselling and therapy, osteopathic medicine, and social work.

to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward persons of the same sex. "Conversion therapy" does not mean:

(a) counseling or mental health services that provide acceptance, support and understanding of a person without seeking to change gender identity or sexual orientation; or

(b) mental health services that facilitate a person's coping, social support, sexual orientation or gender identity exploration and development, including an intervention to prevent or address unlawful conduct or unsafe sexual practices, without seeking to change gender identity or sexual orientation;

(2) "gender identity" means a person's self-perception, or perception of that person by another, of the person's identity as a male or female based upon the person's appearance, behavior or physical characteristics that are in accord with or opposed to the person's physical anatomy, chromosomal sex or sex at birth

NEW YORK, N.Y. EDUC. §6509-1[305]:

1. For the purposes of this section [definitions of misconduct applicable to all regulated professionals]:

a. "Mental health professional" means a person subject to the provisions of article one hundred fifty-three, one hundred fifty-four or one hundred sixty-three of this title; or any other person designated as a mental health professional pursuant to law, rule or regulation.

b. "Sexual orientation change efforts" (i) means any practice by a mental health professional that seeks to change an individual's sexual orientation, including, but not limited to, efforts to change behaviors, gender identity, or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings towards individuals of the same sex and (ii) shall not include counseling for a person seeking to transition from one gender to another, or psychotherapies that:

(A) provide acceptance, support and understanding of patients or the facilitation of patients' coping, social support and identity exploration and development, including sexual orientation-neutral

[305] A similar provision applicable specifically to medicine is found at § 6531-a.

interventions to prevent or address unlawful conduct or unsafe sexual practices; and

(B) do not seek to change sexual orientation.

2. It shall be professional misconduct for a mental health professional to engage in sexual orientation change efforts upon any patient under the age of eighteen years, and any mental health professional found guilty of such misconduct under the procedures prescribed in section sixty-five hundred ten of this subarticle shall be subject to the penalties prescribed in section sixty-five hundred eleven of this subarticle.

OREGON, OR. REV. STAT. §675.850:

(1) A mental health care or social health professional may not practice conversion therapy if the recipient of the conversion therapy is under 18 years of age.

(2) As used in this section:

(a)(A) "Conversion therapy" means providing professional services for the purpose of attempting to change a person's sexual orientation or gender identity, including attempting to change behaviors or expressions of self or to reduce sexual or romantic attractions or feelings toward individuals of the same gender.

(B) "Conversion therapy" does not mean:

(i) Counseling that assists a client who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition; or

(ii) Counseling that provides a client with acceptance, support and understanding, or counseling that facilitates a client's coping, social support and identity exploration or development, including counseling in the form of sexual orientation-neutral or gender identity-neutral interventions provided for the purpose of preventing or addressing unlawful conduct or unsafe sexual practices, as long as the counseling is not provided for the purpose of attempting to change the client's sexual orientation or gender identity.

(3) Any state board that regulates licensees described in subsection (2)(b)(B) of this section may impose any form of discipline that the board may impose on a licensee under the laws of this state for violating a law of this state or a rule adopted by the board.

Sección 1ra. Se declara política pública del Gobierno de Puerto Rico la protección de la niñez a través de la prohibición de las terapias de conversión o reparativas para cambiar la orientación sexual o identidad de género de menores de edad. Para propósitos de esta Orden Ejecutiva, "terapias de conversión o reparativas" se definen como aquellas intervenciones realizadas por una entidad o un profesional licenciado para proveer servicios de salud mental en Puerto Rico, que buscan cambiar la orientación sexual o identidad de género de un menor. A los fines de esta Orden Ejecutiva, las terapias de conversión o reparativas no contemplan aquellas orientaciones que se proveen para la aceptación, apoyo y comprensión y desarrollo de la identidad individual, como tampoco alude a aquellas intervenciones dirigidas a prevenir conducta ilegal o prácticas sexuales inseguras que pudieran representar riesgos adversos a la salud física o mental.

Sección 2da. Se ordena al Secretario de Salud a establecer como requisito reglamentario de una solicitud para la concesión o renovación de una licencia emitida por el Departamento de Salud para operar una facilidad de salud al amparo de la Ley Núm. 101 de 26 de junio de 1965, "*Ley de Facilidades de Salud*", según enmendada, la necesidad de presentar una certificación de la cual surja que, durante la vigencia del permiso solicitado, no se brindarán terapias de conversión o reparativas, según definidas en esta Orden Ejecutiva, en las instalaciones para cual se solicita la concesión o renovación de la licencia.

Sección 3ra. Se ordena a la Administradora de ASSMCA a establecer como requisito reglamentario de una solicitud para la concesión o renovación de una licencia emitida por ASSMCA para la operación de facilidades e instituciones, tanto públicas como privadas, dedicadas a la prevención, tratamiento no medicado y rehabilitación de personas con desórdenes mentales, adicción o dependencia a sustancias narcóticas, deprimentes o estimulantes, incluyendo el alcohol al amparo de la Ley 67-1993, "*Ley de la Administración de Servicios de Salud Mental y Contra la Adicción*", según enmendada, y la Ley 408-200, "*Ley de Salud Mental de Puerto Rico*", según enmendada, la necesidad de presentar una certificación de la cual surja que, durante la vigencia del permiso solicitado, no se brindarán terapias de conversión o reparativas, según definidas en esta Orden Ejecutiva, en las instalaciones para cual se solicita la concesión o renovación de la licencia.

Sección 4ta. Se ordena al Secretario de Desarrollo Económico y Comercio a que incluya como requisito reglamentario para la concesión de decretos de incentivos

económicos para promover actividades, servicios e inversiones en el campo científico, hospitalario y/o médico al amparo de la Ley 20-2012; Ley 22-2012 y Ley 14-2017, una prohibición al ofrecimiento, directo y indirecto, de servicios de terapias de conversión o reparativas, según definidas en esta Orden Ejecutiva. El secretario deberá asegurarse que la prohibición se incluya textualmente en todo decreto de incentivos económicos que se emita para solicitudes presentadas con posterioridad a la feche de efectividad de esta Orden Ejecutiva, como una condición esencial para la vigencia del miso.

Sección 5ta. Se ordena a las agencias mencionadas en esta Orden Ejecutiva la creación de aquellos mecanismos que permitan la corroboración del cumplimiento con las disposiciones reglamentarias que se adopten, según lo dispuesto en esta Orden Ejecutiva. Esos mecanismos deberán proveer para la suspensión o revocación de una licencia o decreto de incentivo económico por el incumplimiento con la condición de no brindar terapias de conversión o reparativas.

Sección 7ma. Se exhorta a la Junta Examinadora de Psicólogos y a la Junta Examinadora de Consejeros Profesionales, como entes reguladores del ejercicio de la psicología y consejería profesional en Puerto Rico, a prohibir el ofrecimiento de servicios de terapias de conversión o reparativas para cambiar de la orientación sexual o identidad de género en personas menores de edad.

Sección 8va. NO CREACIÓN DE DERECHOS EXIGIBLES. Esta Orden Ejecutiva no tiene como propósito crear derechos substantivos o procesales a favor de terceros, exigibles ante foros judiciales, administrativos o de cualquier otra índole, contra el Gobierno de Puerto Rico o sus agencias, sus oficiales, empleados o cualquier otra persona.

RHODE ISLAND, 23 R.I. GEN. LAWS § 23-94-2–23-94-5:

§ 23-94-2. As used in this chapter:

(1) "Conversion therapy" means any practices or treatments that seek to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. Conversion therapy shall not include counseling that provides assistance to a person undergoing gender transition, or counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or

address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual's sexual orientation or gender identity.

(i) "Conversion therapy" shall include any practice by any licensed professional that seeks or purports to impose change of an individual's sexual orientation or gender identity, practices that attempt or purport to change behavioral expression of an individual's sexual orientation or gender identity or attempt or purport to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex;

(ii) "Conversion therapy" shall not include practices that:

(A) Provide acceptance, support, and understanding of an individual's sexual orientation, gender identity, or gender expression and the facilitation of an individual's coping, social support, and identity exploration and development, including interventions to prevent or address unlawful conduct or unsafe sexual practices; or

(B) Provide acceptance, support, or understanding of an individual's gender expression or the facilitation of an individual's coping, social support, and identity exploration and development.

§ 23-94-3. (a) No licensed professional shall advertise for or engage in conversion therapy efforts with or relating to a patient(s) under the age of eighteen (18).

(b) Any conversion therapy practiced by a licensed professional, as defined in § 23-94-2, on a patient under the age of eighteen (18) shall be considered unprofessional conduct and shall subject them to discipline by the department, which discipline may include suspension and revocation of the professional's license.

§ 23-94-4. No state funds, nor any funds belonging to a municipality, agency, or political subdivision of this state, shall be expended for the purpose of conducting conversion therapy; referring a person for conversion therapy; health benefits coverage for conversion therapy; or a grant or contract with any entity that conducts conversion therapy or refers individuals for conversion therapy.

VERMONT, VT. STAT. ANN. TIT. 18 § 8351-8353[306]:

[306] Although only code sections applicable to all professionals was included, separate provisions referring back to those sections can be found in the respective chapters of medicine, osteopathy, psychology, clinical social work, clinical mental health counselling, marriage and family therapy, psychoanalysis, and naturopathic medicine.

§ 8351. A s used in this chapter:

(1) "Conversion therapy" means any practice by a mental health care provider that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to change sexual or romantic attractions or feelings toward individuals of the same sex or gender. "Conversion therapy" does not include psychotherapies that:

(A) provide support to an individual undergoing gender transition; or

(B) provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development, including sexual-orientation-neutral or gender-identity-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices without seeking to change an individual's sexual orientation or gender identity.

§ 8352. A mental health care provider shall not use conversion therapy with a client younger than 18 years of age.

§ 8353. Any conversion therapy used on a client younger than 18 years of age by a mental health care provider shall constitute unprofessional conduct as provided in the relevant provisions of Title 26 and shall subject the mental health care provider to discipline pursuant to the applicable provisions of that title and of 3 V.S.A. chapter 5.

WASHINGTON, WASH. REV. CODE § 18-130-020, 18-130-180:

§ 18-130-020. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(4)(a) "Conversion therapy" means a regime that seeks to change an individual's sexual orientation or gender identity. The term includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. The term includes, but is not limited to, practices commonly referred to as "reparative therapy."

(b) "Conversion therapy" does not include counseling or psychotherapies that provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support, and identity exploration and development that do not seek to change sexual orientation or gender identity.

§ 18-130-180. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(27) Performing conversion therapy on a patient under age eighteen.

OTHER COUNTRIES:
IRELAND, *PROHIBITION OF CONVERSION THERAPIES BILL 2018*[307] (UNDER CONSIDERATION):

1. In this Act—

"conversion therapy"—

(a) means any practice or treatment by any person that seeks to change, suppress and, or eliminate a person' s sexual orientation, gender identity and, or gender expression; and

(b) does not include any practice or treatment, which does not seek to change a person' s sexual orientation, gender identity and, or gender expression, or which—

(i) provides assistance to an individual undergoing a gender transition; or

(ii) provides acceptance, support and understanding of a person, or a facilitation of a person' s coping, social support and identity exploration and development, including sexual orientation-neutral interventions;

"gender identity" refers to each person' s internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance and, or functions by medical, surgical or other means) and other expressions of gender, including name, dress, speech and mannerisms;

2. It shall be unlawful for—

(a) any person to—

(i) perform or offer to perform conversion therapy on a person, or

(ii) advertise conversion therapy,

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[307] Seanad Éireann (Senate of Ireland), *An Act to prohibit conversion therapy, as a deceptive and harmful act or practice against a person's sexual orientation, gender identity and, or gender expression*, Bill No 39 of 2018 (Ireland).

(b) any person to remove a person from the State for the purposes of conversion therapy, or

(c) a professional to—

(i) perform or offer to perform conversion therapy on a person, irrespective of whether monetary compensation is received in exchange, or

(ii) refer a person to other professionals and, or to any other person to perform conversion therapy

3. (1) A person found guilty of an offence under either section 2(a) of this Act shall on conviction be liable to a fine of not less than one thousand Euros (€1,000) and not exceeding five thousand Euros (€5,000) or to imprisonment for a maximum period of 6 months, or both such fine and imprisonment.

(2) A person found guilty of an offence under section 2(b) of this Act shall on conviction be liable to a fine of not less than two thousand (€2,000) and not more than ten thousand Euros (€10,000) or to a maximum term of imprisonment of 12 months, or both such fine and imprisonment.

(3) A person found guilty of an offence under section 2(c) of this Act shall on conviction be liable to a fine of not less than two thousand (€2,000) and not more than ten thousand Euros (€10,000) or to a maximum term of imprisonment of 12 months, or both such fine and imprisonment.

(4) In determining the sentence to be imposed following conviction under this Act the court shall have regard to the circumstances under which the conversion therapy was performed.

(7) If a professional is found guilty of any offence under section 2 of this Act, the Court shall direct that the body regulating that profession, or any other regulatory body as deemed necessary, are notified of the conviction.

MALTA, *AFFIRMATION OF SEXUAL ORIENTATION, GENDER IDENTITY AND GENDER EXPRESSION ACT*[308]:

To affirm that all persons have a sexual orientation, a gender identity and a gender expression, and that no particular combination of these three characteristics constitutes a disorder, disease, illness, deficiency, disability and, or shortcoming;

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[308] *Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act*, *supra* note 160.

and to prohibit conversion practices as a deceptive and harmful act or interventions against a person' s sexual orientation, gender identity and, or gender expression.

2. In this Act, unless the context otherwise requires:

"conversion practices" refers to any treatment, practice or sustained effort that aims to change, repress and, or eliminate a person' s sexual orientation, gender identity and, or gender expression; such practices do not include -

(*a*) any services and, or interventions related to the exploration and, or free development of a person and, or affirmation of one's identity with regard to one or more of the characteristics being affirmed by this Act, through counselling, psychotherapeutic services and, or similar services; or

(*b*) any healthcare service related to the free development and, or affirmation of one' s gender identity and, or gender expression of a person; and, or

(*c*) any healthcare service related to the treatment of a mental disorder;

"gender identity" refers to each person's internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance and, or functions by medical, surgical or other means) and other expressions of gender, including name, dress, speech and mannerisms;

"mental disorder" means a significant mental or behavioural dysfunction, exhibited by signs and, or symptoms indicating a distortion of mental functioning, including disturbances in one or more of the areas of thought, mood, volition, perception, cognition, orientation or memory which are present to such a degree as to be considered pathological in accordance with internationally accepted medical and diagnostic standards, with the exclusion of any form of pathologisation of sexual orientation, gender identity and, or gender expression as may be classified under the International Classification of Diseases or other similar internationally recognised classifications, and "mental illness" shall be construed accordingly, and for the purpose of any matter related to criminal proceedings, it shall include "insanity" as understood for the purpose of the Criminal Code;

"vulnerable person" refers to any person:

(*a*) under the age of sixteen years; or

(*b*) suffering from a mental disorder; or

(*c*) considered by the competent court to be particularly at risk when taking into account the person' s age, maturity, health, mental disability, other conditions including any situation of dependence, the psychological state and, or emotional state of that person.

3. It shall be unlawful –

(*a*) for any person to:

(i) perform conversion practices on a vulnerable person; or

(ii) perform involuntary and, or forced conversion practices on a person; or

(iii) advertise conversion practices; and, or

(*b*) for a professional to:

(i) offer and, or perform conversion practices on any person irrespective of whether compensation is received in exchange; or

(ii) make a referral to any other person to perform conversion practices on any person.

4. (1) Any person found guilty under the provisions of article 3(*a*) shall, upon conviction, be liable to a fine (*multa*) of not less than one thousand euro (€1,000) and not exceeding five thousand euro (€5,000), or to imprisonment for a term of not less than one month and not exceeding five months, or to both such fine and imprisonment:

Provided that the punishment prescribed for under this sub-article shall be increased by one to two degrees in those instances where any person performs conversion practices on a vulnerable person.

(2) Any professional found guilty under the provisions of article 3(*a*) and, or (*b*) shall, upon conviction, be liable to a fine (*multa*) of not less than two thousand euro (€2,000) and not exceeding ten thousand euro (€10,000), or to imprisonment for a term of not less than three months and not exceeding one year, or to both such fine and imprisonment.