Mémoire sur le Projet de loi 70 présenté à la Commission des relations avec les citoyens

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Je présente ce mémoire en tant que juriste et bioéthicienne spécialisée sur la question des thérapies de conversion. Je suis actuellement doctorante à la Faculté de droit et au centre conjoint de bioéthique à l'Université de Toronto où mes recherches portent sur le droit des approches cliniques envers les jeunes trans. J'ai complété une thèse de maîtrise en droit et bioéthique de l'Université McGill sur la règlementation des thérapies de conversion sous la supervision du doyen de la Faculté de droit, Robert Leckey. Je suis diplômée en droit de l'Université McGill et ai été l'auxiliaire juridique de l'honorable juge Sheilah Martin de la Cour suprême du Canada en 2019-2020. J'ai publié à ce jour plus de 13 articles avec évaluation par pairs en droit, médecine, psychologie, sexologie, et études LGBT. Mon manuscrit sur la règlementation des thérapies de conversion, intitulé *Torture Isn't Therapy: Banning Conversion Practices Targeting Transgender People*, est en processus de révision à la suite de l'évaluation par pairs, auprès de la University of British Columbia Press. Mes travaux sur les thérapies de conversion ont été cités par l'expert indépendant de l'Organisme des Nations Unies, Victor Madrigal-Borloz, dans son rapport sur le sujet.

En tant qu'experte sur le sujet des thérapies de conversion, je suis d'avis que le Projet de loi 70 est d'une grande importance et devrait être adopté. Ces supposées 'thérapies' ont un impact ravageur sur la santé mentale des personnes y étant assujetties et sont contraire aux valeurs d'égalité et de dignité qui sont au cœur des valeurs Québécoises. Personne ne devrait tenter de changer l'identité de genre, l'expression de genre ou l'orientation sexuelle d'une personne. Il n'y a rien à guérir : les personnes LGBTQ+ font partie de la diversité humaine et enrichissent nos communautés.

Ayant lu attentivement le projet de loi, je suis d'avis certaines améliorations sont de mise et contribueraient de façon décisive à la lutte contre les thérapies de conversion au Québec, établissant la province comme un véritable leader mondial dans la lutte contre les thérapies de conversion.

J'offre les neuf recommandations suivantes :

(1) **Définition détaillée.** La définition des thérapies de conversion sous la loi doit être plus détaillée. Il est important de penser de façon pédagogique et règlementaire, le but étant de prévenir les thérapies de conversion plutôt que d'y remédier après le fait. Les détails aident aussi les professions en clarifiant ce qui est accepté, ce qui peut éviter les effets négatifs liés à l'incertitude. Une copie d'une loi modèle et notes explicatives se trouvent en annexe.

(2) **Prise en charge santé.** On doit assurer la prise en charge des personnes trans dans le système public de santé. En ce moment, les personnes trans doivent se tourner vers le privé, où les thérapies de conversion se passent très souvent. En assurant la prise en charge en santé mentale et pour les lettres de référence pour hormonothérapie et chirurgies, on s'attaque à l'exposition des personnes trans aux thérapies de conversion.

(3) **Aide juridique.** Le projet de loi devrait être modifié pour que les poursuites contre les personnes pratiquant des thérapies de conversion soient couvertes par l'aide juridique. Compte tenu du haut taux de pauvreté dans la population LGBTQ+, de telles mesures sont nécessaires à l'application de la loi.

(4) **Éducation professionnelle.** Les critères d'obtention des permis de pratique des professions cliniques (comme la médecine, travail social, psychothérapie et psychologie) devraient être révisés pour inclure une base de connaissance en santé LGBTQ+ et sur les thérapies de conversion.

(5) **Santé mentale survivant·e·s.** Le gouvernement devrait assurer la couverture financière des services en santé mentale et les services de support par pairs d'organisations communautaires pour les personnes ayant vécu des thérapies de conversion.

(6) **Protection de la jeunesse.** La Loi de la protection de la jeunesse devrait être révisée pour prendre en compte l'orientation sexuelle, l'identité de genre, et l'expression de genre de l'enfant lors des interventions sociales. L'éducation sur les réalités LGBTQ+ devraient être offertes sur une base obligatoire aux personnes œuvrant en protection de le jeunesse, tant sur le plan des interventions qu'en lien avec l'administration des foyers de groupe.

(7) **Publicités, statut fiscal, et entreprises.** Le projet de loi devrait être modifié pour créer des avenues judiciaires et administratives pour le retrait de publicités faisant la promotion de thérapies de conversion, pour le retrait de statut

d'organisme caritatif d'organismes facilitant les thérapies de conversion, et pour la dissolution d'entreprises offrant des thérapies de conversion.

(8) **Réputée/présumée.** Le mot « présumée » devrait être remplacé par le mot « réputée » à l'article 2 du projet de loi. Aux termes de l'article 2847 du Code civil, une présomption « est simple et peut être repoussée par une preuve contraire ». Le mot « réputée » s'assure que les thérapies de conversion sont une atteinte irréfragable au droit à l'intégrité et à la dignité de la personne.

(9) **Emmener hors-province.** Le projet de loi devrait inclure la prohibition du fait d'emmener une personne hors-province dans le but de lui faire suivre une thérapie de conversion. Sans une telle disposition, il serait possible de contourner l'application de la loi en emmenant un enfant dans une province adjacente ou aux États-Unis pour suivre une thérapie de conversion—ce qui est d'autant plus un grand risque que plusieurs camps de thérapies de conversion se situent aux États-Unis.

Annexe A: Loi modèle

Cette loi modèle, ainsi que ses notes explicatives en annexe B, est tirée du manuscrit de livre Torture Isn't Therapy: Banning Conversion Practices Targeting Transgender People. *Le manuscrit est en processus de révision à la suite de l'évaluation par pairs, auprès de la University of British Columbia Press.*

1. (1) Conversion practices are any treatment, practice, or sustained effort that aims to repress, discourage or change a person's sexual orientation, gender identity, gender modality, gender expression, or any behaviours associated with a gender other than the person's sex assigned at birth.

(2) Conversion practices include:

a. Treatments, practices, and sustained efforts that proceed from the assumption that certain sexual orientations, gender identities, gender modalities, or gender expressions are pathological or less desirable than others;

b. Treatments, practices, and sustained efforts that seek to reduce cross-gender identification or intimate or sexual relations with people of a given gender identity or sex assigned at birth;

c. Treatments, practices, and sustained efforts that have for primary aim the identification of factors that may have caused the person's sexual orientation, gender identity, gender modality, gender expression or behaviours associated with a gender other than the person's sex assigned at birth, unless in the context of research which has been approved by an institutional review board;

d. Treatments, practices, and sustained efforts that direct parents or tutors to set limits on their dependents' gender non-conforming behaviour, impose peers of the same sex assigned at birth, or otherwise intervene in the naturalistic environment with the aim of repressing, discouraging, or changing the dependent's sexual orientation, gender identity, gender modality, gender expression or any behaviours associated with a gender other than the person's sex assigned at birth;

e. Treatments, practices, and sustained efforts that proceed from the assumption that social or medical transition are undesirable;

f. Treatments, practices, and sustained efforts that delay or impede a person's desired social or medical transition without reasonable and non-judgemental clinical justification;

g. Treatments, practices, and sustained efforts that knowingly use names, pronouns, gendered terms, and sexual orientation terms other than those chosen or accepted by the person, except as required by law.

(3) Unless otherwise provided under subsection 1(2), conversion practices do not include:

a. Necessary or desired assessments and diagnoses of gender dysphoria or other comparable diagnostic category under the latest version of the DSM or ICD;

b. Treatments, practices, or sustained efforts that provide non-judgemental acceptance and support of the person's expressed sexual orientation, gender identity, gender modality, gender expression, and behaviours associated with a gender other than the person's sex assigned at birth;

c. Treatments, practices, or sustained efforts that teach individuals coping strategies to help resolve, endure, or diminish stressful life experiences while taking all reasonable steps to avoid repressing, discouraging or changing the person's sexual orientation, gender identity, gender modality, gender expression or any behaviours associated with a gender other than the person's sex assigned at birth;

d. Treatments, practices, or sustained efforts that aim at the development of an integrated personal identity by facilitating the exploration and self-assessment of components of personal identity while taking all reasonable steps to avoid repressing, discouraging or changing the person's sexual orientation, gender identity, gender

modality, gender expression or any behaviours associated with a gender other than the person's sex assigned at birth.

(4) "Sexual orientation" refers to a person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of the same gender, of a different gender, or of more than one gender. Sexual orientation may be expressed by self-identification with sexual orientation terms such as straight, gay, lesbian, bisexual, pansexual, asexual, or queer. Terms and understandings of sexual orientation vary by culture.

(5) "Gender identity" refers to a person's deeply felt internal and individual experience of gender including the personal sense of the body. Gender identity may be completely male or female or may lie outside the male/female binary. Gender identity may be expressed by self-identification with gender identity terms such as man, woman, non-binary, or genderqueer. Terms and understandings of gender identity vary by culture.

(6) "Gender modality" refers to how a person's gender identity stands in relation to their sex assigned at birth including whether they are transgender or cisgender.

(7) "Sex assigned at birth" refers to the classification of a person as male, female, intersex, or another gender or sex based on their anatomy, karyotyping, or other biological traits present at birth. It is typically the gender or sex listed on the person's declaration of birth or original birth certificate.

(9) "Gender expression" refers to a person's desired external appearance as it relates to social expectations and norms of femininity and masculinity. Gender expression may include a person's behaviour, name, pronouns, clothing, haircut, voice, tattoos, piercings, and anatomical features.

(10) "Social transition" refers to the voluntary alteration of a person's gender expression to align it with their gender identity that differs from the one they were assigned at birth, other than through medical interventions. Social transition is personal and may not reflect others' understanding of which gender expressions correspond to a given gender identity.

(11) "Medical transition" refers to the voluntary alteration of a person's gender expression to align it with their gender identity that differs from the one they

were assigned at birth, through medical interventions such as puberty blockers, hormone replacement therapy, voice therapy, surgical procedures. Medical transition is personal and may not reflect others' understanding of which gender expressions correspond to a given gender identity.

(12) Sexual orientation, gender identity, gender modality, gender expression, and behaviours associated with a gender other than the person's sex assigned at birth may be proven by self-report.

[…]

Annexe B: Notes explicatives

Section 1: Defining conversion practices

Subsection 1(1): Basic definition

Subsection 1(1) provides a definition of conversion practices, defining them as "any treatment, practice, or sustained effort that aims to repress, discourage or change a person's sexual orientation, gender identity, gender modality, gender expression, intersex traits, or any behaviours associated with a gender other than the person's sex assigned at birth."

Conversion practices

Conversion practices, conversion therapy, reparative therapy, corrective therapy, the corrective approach, the (psycho)therapeutic approach, ex-gay therapy, reorientation therapy, reintegrative therapy, gay cure therapy, sexual attraction fluidity exploration in therapy, the pathological response approach, and sexual orientation (and/or gender identity) change efforts are all terms that have been used to refer to conversion practices.[1] The model law opts for the terminology of conversion practices for reasons of recognizability, intelligibility, and coherence and to avoid the positive connotations associated with therapy (and other terms such as 'reparative'), which may be inappropriate in the context of unethical and harmful practices. The expression 'conversion practices' can be found in the Maltese ban.[2]

The term 'conversion' is readily recognisable and identified with the practices targeted by the model law. It captures the underlying *animus* of the practices, namely

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[1] Jack Drescher, "I'm Your Handyman: A History of Reparative Therapies" (1998) 36:1 Journal of Homosexuality 19–42 at 20; 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 246–250; Arlene I Lev, "Approaches to the Treatment of Gender Nonconforming Children and Transgender Youth" in Arlene I Lev & Andrew R Gottlieb, eds, *Families in Transition: Parenting Gender Diverse Children, Adolescents, and Young Adults* (New York: Harrington Park Press, 2019); Florence Ashley, "Homophobia, Conversion Therapy, and Care Models for Trans Youth: Defending the Gender-Affirmative Model" (2019) Journal of LGBT Youth; American Psychological Association, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (Washington, DC: American Psychological Association, 2009); Jake Pyne, "The governance of gender non-conforming children: A dangerous enclosure" (2014) 11 Annual Review of Critical Psychology 79–96; Amie Bishop, *Harmful Treatment: The Global Reach of So-Called Conversion Therapy* (New York: OutRight Action International, 2019) at 7, 11.

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

converting patients into gender normative subjects.[3] Clinicians using conversion practices often claim that their patients' targeted characteristics do not reflect an underlying true, fixed identity or disposition but rather a pathological confusion about their true gender or position in the sexual schema.[4] In the context of trans and gender creative youth, [5] the presence of the subjective experience of gender dysphoria[6] or its diagnostic codification under the *Diagnostic and Statistical Manual Of Mental Disorders* ('DSM')[7] is seen as evidence that trans people's gender identity constitutes a mental illness that must be cured or repaired.[8]

The label 'therapy' for these clinical practices has been criticized by clinicians along such lines and may falsely communicate legitimacy.[9] Therapy may also suggest that these practices only occur within a therapeutic relationship, whereas faith-based reparative practices often occur in non-therapeutic relationships. The terminology of 'practices' in lieu of 'therapy' avoids these undesirable connotations.

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[3] In the conversion literature, being LGBQ is often recast as a failure of masculinity/femininity or a "gender role" problem: Ashley, "Homophobia, Conversion Therapy, and Care Models for Trans Youth", *supra* note 1 at 10.

[4] Victor Madrigal-Borloz, *Practices of so-called "conversion therapy"* (A/HRC/44/53, 2020) at 12; 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 533–555 at 544, 549; Kenneth J Zucker et al, "A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder" (2012) 59:3 Journal of Homosexuality 369–397 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 477–486 at 478.

[5] Gender creative people exhibit ongoing patterns of behaviour associated with a gender other than that they were assigned at birth but might not be transgender: 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 at 27.

[6] 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 165–232 at 166.

[7] American Psychiatric Association, *Diagnostic and statistical manual of mental disorders: DSM-5* (Washington, D.C: American Psychiatric Association, 2013).

[8] Zucker et al, *supra* note 4 at 382.

[9] Jonathan Foiles, "Conversion 'Therapy' Isn't Therapy At All", *Psychology Today* (31 January 2018), online: <https://www.psychologytoday.com/ca/blog/the-thing-feathers/201801/conversion-therapy-isnt-therapy-all>; Lara Embry, "'Conversion therapy': Therapy that isn't", *Los Angeles Times* (27 August 2012), online: <https://www.latimes.com/opinion/la-xpm-2012-aug-27-la-oe-embry-gay-conversion-20120827-story.html>.

The definition applies to people of all ages. While youth are most vulnerable to conversion practices, adults are also at risk of being harmed by conversion practices. Social pressures, internalised negative attitudes towards their target characteristic(s), and lack of knowledge of available trans health practices or of those employed by the individual provider may motivate them to seek out or accept conversion practices.

In some jurisdictions, prohibiting conversion practices for putatively consenting adults may be politically unfeasible. While extending the ban to adults regardless of consent is strongly recommended especially given evidentiary difficulties surrounding consent, a provision excluding inappropriately-obtained consent may offer a politically-viable alternative while reducing the risks and harm associated with allowing conversion practices for consenting adults. While reiterating that a ban should extend to all conversion practices regardless of consent, Canadian scholars and activists have suggested the following legal provision as an alternative:[10]

> For the purposes of the law no consent is obtained if:
>
> (a) the agreement is expressed by the words or conduct of a person other than the one who was caused to undergo conversion practices;
>
> (b) the person is incapable of consenting to conversion practices for any reason;
>
> (c) the person was not adequately informed of inefficacy and risks of conversion practices;
>
> (d) the defendant induces the person to consent by abusing a position nof trust, power or authority;
>
> (e) the person is vulnerable to coercion, manipulation, or social pressure taking into consideration their age, maturity, physical and mental health, psychological and emotional

[10] See appendix of Erika Muse, "Open Letter: Bill C-8 excludes conversion therapy practices that target trans people", (25 June 2020), online: *Centre for Gender & Sexual Health Equity* <http://cgshe.ca/open-letter-bill-c-8-excludes-conversion-therapy-practices-that-target-trans-people/>. I have tweaked the punctuation and language to make it read more naturally outside of its context (e.g. I replaced the word "accused" by "defendant" and "subsection (1)" by "the law").

> state, and any other relevant condition including any situation of dependence;
>
> (f) the complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or
>
> (g) the complainant, having consented, expresses, by words or conduct, a lack of agreement to continue to engage in the practice, treatment, or sustained effort;
>
> (h) consent cannot be given to conversion practices given as a prerequisite to social or medical transitioning.

The proposed text, which I have helped write, was inspired by the sexual consent provisions of the Canadian *Criminal Code* and the Maltese law's provisions on vulnerable adults. Circumscribing consent rather than banning all conversion practices will make recourse difficult if not impossible for many adults harmed by them because it fails to account for the social, clinical, and interpersonal pressures that lead people to express consent to conversion practices. It is an acutely substandard option and should only be resorted to if a wholesale ban is not within the realm of possibility.

Treatment, practice, or sustained effort that aims to repress, discourage or change targeted characteristics

Conversion practices may include any "treatment, practice, or sustained effort". The three notions connote a degree of systematicity to distinguish conversion practices from isolated actions on the part of family members or strangers while remaining sufficiently broad to capture conversion practices adopted by individuals who are not licensed professionals and do not have a clinical or therapeutic relationship to the person. Since conversion practices are often undertaken by members of religious organisations,[11] including practices that are not predicated on a professional-patient relationship is necessary to capture all conversion practices.

The aims of conversion practices are to "repress, discourage or change" targeted characteristics. This language is broader than the narrow focus on change

[11] *The Report of the 2015 U.S. Transgender Survey*, by Sandy E James et al (Washington, DC: National Center for Transgender Equality, 2016) at 109; *National LGBT Survey: Research Report*, by Government Equalities Office (Manchester: U.K. Government Equalities Office, 2018) at 93; *Conversion Therapy and LGBT Youth*, by Christy Mallory, Taylor NT Brown & Kerith J Conron (Los Angeles: The Williams Institute, 2018); Tracy N Hipp et al, "From conversion toward affirmation: Psychology, civil rights, and experiences of gender-diverse communities in Memphis." (2019) 74:8 American Psychologist 882–897.

found in many existing laws, and better depicts the goals and theoretical assumptions of conversion practices. As previously described, claims of gender identity ('I am a girl') or sexual orientation ('I am gay') are understood by some clinicians as a form of cognitive confusion that may not reflect an underlying 'true' gender identity or sexual orientation.[12] In the case of gender creative youth, practitioners may deny any attempt at changing gender identity, instead couching their goals as seeking to prevent a child whose gender identity isn't yet established from growing up to be transgender. The addition of 'repress or discourage' broadens the prohibition to accommodate different theoretical views of conversion practices and the psychology of sexual orientation, gender identity, gender modality, gender expression, and gendered behaviour.

Gender expression or any behaviours associated with a gender other than the person's sex assigned at birth

Practices which target gender expression or behaviours associated with a gender other than the person's sex assigned at birth fall within the scope of conversion practices. Historically, conversion practices have targeted gender creative children not only because they may grow up to be transgender or gay, but because their gender non-conformity is seen as indicative or constitutive of psychological disorder.[13] The defunct UCLA Gender Identity Research Clinic, which is now associated with conversion practices,[14] focused its work on feminine youth assigned male at birth, whom clinicians of the clinic described in terms of "deviant sex-role

[12] Bradley & Zucker, *supra* note 4; Tey Meadow, *Trans kids: being gendered in the twenty-first century* (Oakland, California: University of California Press, 2018) at 73; 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) at 325.

[13] Karl Bryant, "Making gender identity disorder of childhood: Historical lessons for contemporary debates" (2006) 3:3 Sexuality Research and Social Policy 23–39; Lev, *supra* note 1; 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]; Karl Bryant, "In Defence of Gay Children? 'Progay' Homophobia and the Production of Homonormativity" (2008) 11:4 Sexualities 455–475; Damien W Riggs et al, "Transnormativity in the psy disciplines: Constructing pathology in the Diagnostic and Statistical Manual of Mental Disorders and Standards of Care." (2019) 74:8 American Psychologist 912–924.

[14] Sonali Kohli, "Gender behavior therapy and gay conversion: UCLA's past, California's future", *Daily Bruin* (15 November 2012), online: <http://dailybruin.com/features/conversion-therapy/>.

behaviors"[15] or "Sissy Boy Syndrome."[16] George Alan Rekers, of the UCLA clinic, justified his approach as an attempt to discourage sex-role rigidity, deeming gender creative children's behaviours narrow and obsessive.[17] Clinical approaches which seek to discourage youth from growing up trans have continued to target gender expression and gendered behaviours for intervention, despite a shift in clinical focus from classical behavioural therapy to mixed approaches which, according to these practitioners, can "fully alter internal gender schemas."[18]

Subsection 1(2): Disallowed practices

Subsection 1(2) provides a list of practices which are non-exhaustively included in the notion of conversion practices.

Psychopathologizing practices: 1(2)(a)

Conversion practices include treatments, practices, and sustained efforts "that proceed from the assumption that certain" targeted characteristics "are pathological or less desirable than others." Conversion practices are typically underpinned by the view that being lesbian, gay, bisexual, or transgender is a mental illness or mental disorder or otherwise undesirable.

In the case of transgender and gender creative people, practitioners may engage in conversion practices even if the person does not demonstrate discomfort, distress, or impaired functioning due to their gender.[19] In some cases, distress is argued to be present insofar as the fact of being trans is a valid marker of distress or impairment, or insofar as the distress caused by misrecognition and social marginalisation is sufficient for trans people to be considered inherently mentally ill.[20] The 'extremeness' of medical transition is often used to justify the claim that being trans is a marker of distress or impairment in and of itself.[21]

In the case of sexual orientation, conversion practices may be justified by the belief that ego-dystonic sexual orientation is a mental illness or condition, or that same-gender sexual urges or behaviour deemed reckless or unsafe by practitioners or

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[15] George A Rekers & O Ivar Lovaas, "Behavioral treatment of deviant sex-role behaviors in a male child" (1974) 7:2 Journal of Applied Behavior Analysis 173–190.

[16] Richard Green, *The "Sissy Boy Syndrome" and the Development of Homosexuality* (New Haven: Yale University Press, 1987).

[17] Bryant, "Making gender identity disorder of childhood", *supra* note 13 at 30–31.

[18] Zucker et al, *supra* note 4 at 388–389; Kenneth J Zucker & Susan J Bradley, *Gender identity disorder and psychosexual problems in children and adolescents* (New York: Guilford Press, 1995) at 270–271, 273; Madrigal-Borloz, *supra* note 4 at 11.

[19] Zucker et al, *supra* note 4 at 382.

[20] Zucker, *supra* note 4 at 543–544.

[21] *Ibid* at 543.

patients are constitutive of impaired functioning.[22] Ego-dystonic sexual orientation refers to sexual orientation which is not desired by the patient and causes them clinically significant distress. This distress can be due to internalised homophobia or external factors such as fear of HIV.[23] While homosexuality was removed from the DSM-III in 1973, the DSM-III retained ego-dystonic homosexuality as a diagnosis,[24] while the DSM-III-R and DSM-IV retained a diagnosis of Sexual Disorder Not Otherwise Specified ('NOS') in the case of "persistent and marked distress about sexual orientation," legitimating continued conversion practices.[25] Conversion practices were presented as one of two choices for patients presenting with ego-dystonic homosexuality, with the other choice being interventions aimed at self-acceptance. However, patients with high levels of internalised homophobia are unlikely to opt for interventions aiming at self-acceptance despite its clinical indicability.[26] A similar problem also arises with trans patients with high levels of internalised transphobia.

Reduction of cross-gender identification & same-sex intimacy: 1(2)(b)

Conversion practices include treatments, practices, and sustained efforts "that seek to reduce cross-gender identification or intimate or sexual relations with people of a given gender identity or sex assigned at birth."

The notion of cross-gender identification accommodates theoretical disagreements over the nature of gender identity and how it ought to be conceptualised. 'Cross-gender identification' is a common term in the scholarly literature,[27] and was mentioned in the Gender Identity in Childhood Diagnosis in the

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[22] Same-gender sexual acts are disproportionately labelled reckless or unsafe among men, unlike sexual acts within other gender configurations.

[23] Edwin V Valdiserri, "Fear of AIDS: Implications for mental health practice with reference to ego-dystonic homosexuality." (1986) 56:4 American Journal of Orthopsychiatry 634–638.

[24] Harold I Lief & Helen S Kaplan, "Ego-dystonic homosexuality" (1986) 12:4 Journal of Sex & Marital Therapy 259–266.

[25] Warren Throckmorton, "Efforts to Modify Sexual Orientation: A Review of Outcome Literature and Ethical Issues" (1998) 20:4 Journal of Mental Health Counseling 283–304.

[26] Ilan H Meyer & Laura Dean, "Internalized Homophobia, Intimacy, and Sexual Behavior among Gay and Bisexual Men" in *Stigma and Sexual Orientation: Understanding Prejudice against Lesbians, Gay Men, and Bisexuals* (2455 Teller Road, Thousand Oaks California 91320 United States: SAGE Publications, Inc., 1998) 160; American Psychological Association, *supra* note 1.

[27] 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 369; 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 7–11 at 8; Zucker

DSM-IV and IV-TR.[28] The term bears a broader connotation than gender identity insofar as it does not imply the presence of an underlying gender identity, referring to the fact of psychologically identifying with another (binary) gender rather than the fact of having a certain gender identity. The term is most common in the literature on trans and gender creative youth, whose expressions of gender identification may be taken as evidence of gender confusion rather than expression of gender identity by practitioners engaging in conversion practices.[29]

Conversion practices include attempts to reduce romantic and sexual involvement with people of a given gender identity or sex assigned at birth.[30] A common form of conversion practices involves counselling absention from romantic and sexual relationships with people of the same gender, regardless of and sometimes in spite of one's continuing sexual attraction to them. In recent years, these efforts have increased as part of a rebranding by conversion organisations, following the motto of "hate the sin, not the sinner."[31] These understandings are muddied when the target of the conversion practices is trans, and abstention might be counselled towards either or both people of same gender and of different genders. For instance, people who engage in conversion practices may oppose intimacy between trans women and men because they believe trans women are men and that it constitutes same-gender intimacy; they may oppose intimacy between trans women and women because, as women, it is inappropriate for them to pursue same-gender intimacy; or

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& Bradley, *supra* note 18 at 266; Bryant, "Making gender identity disorder of childhood", *supra* note 13 at 29; 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 5–23 at 11.

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

[29] Bradley & Zucker, *supra* note 4; Meadow, *supra* note 12 at 73; Zucker, *supra* note 12 at 325.

[30] Jessica Horner, "Undoing the Damage: Working with LGBT Clients in Post-Conversion Therapy" (2019) Columbia Social Work Review 8–16 at 8; Douglas C Haldeman, "The Practice and Ethics of Sexual Orientation Conversion Therapy" in Linda Garnets & Douglas C Kimmel, eds, *Psychological Perspectives on Lesbian, Gay, and Bisexual Experiences*, 2d ed (New York: Columbia University Press, 2003) 681 at 689; American Psychological Association, *supra* note 1 at 35, 61. The APA recommends against promoting celibacy even among patients who wish to resolve tensions between their religious commitments and sexual orientation through sexual abstinence.

[31] American Psychological Association, *supra* note 1 at 35; Brandon Ambrosino, "Gay Celibacy Is the New Ex-Gay Therapy", *Daily Beast* (14 April 2017), online: <https://www.thedailybeast.com/gay-celibacy-is-the-new-ex-gay-therapy>; Gabriel Arana, "My So-Called Ex-Gay Life", *The American Prospect* (11 April 2012), online: <https://prospect.org/civil-rights/so-called-ex-gay-life/>.

they may oppose all intimacy fot trans women due to their perceived gender deviance. These scenarios all manifest conversion practices. Both gender identity and sex assigned at birth are mentioned in paragraph 1(2)(b) due to the different understandings of gender that those engaging in conversion practices may have.

Etiological lens: 1(2)(c)

Conversion practices include treatments, practices, and sustained efforts "that have for primary aim the identification of factors that may have caused the person's" targeted characteristics "unless in the context of research which has been approved by an institutional review board." The identification of factors which have led to targeted characteristics in clinical settings serves no legitimate purpose other selecting interventions to repress, discourage or change the targeted characteristics, and is predicated on the view that the targeted characteristics are abnormalities that are caused, in part or in whole, by external factors.[32] Posited causes include family encouragement or lack of discouragement of gender non-conformity, cognitive developmental level, belief that being a certain gender is advantageous, family functioning, trauma, unresolved conflict, and psychopathology.[33] Some practitioners have also suggested that "limited cognitive abilities and immaturity may make [a child assigned male at birth] no match for other boys," leading them to play with girls and feminine-coded toys.[34] Oftentimes and increasingly, conversion practices are defended under pretext that the person's gender identity reflects internalized misogyny, internalized homophobia, unwanted sexual attention, and/or sexual trauma.[35]

The etiological lens, which seeks to identify causes for the targeted characteristics, is closely connected to psychopathologizing views of sexual and gender minorities.[36] As Robert Wallace & Hershel Russell explain, "if gender variant

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[32] Madrigal-Borloz, *supra* note 4 at 10.

[33] Zucker et al, *supra* note 4 at 376–381; Lisa Marchiano, "Outbreak: On Transgender Teens and Psychic Epidemics" (2017) 60:3 Psychological Perspectives 345–366; Lisa Littman, "Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria" (2018) 13:8 PLoS ONE e0202330; Peggy T Cohen-Kettenis & Friedemann Pfäfflin, *Transgenderism and Intersexuality in Childhood and Adolescence: Making Choices* (Thousand Oaks: SAGE Publications, 2003).

[34] Cohen-Kettenis & Pfäfflin, *supra* note 33.

[35] Jules Sherred, "I underwent conversion therapy. It stopped me from transitioning for decades", *Daily Xtra* (26 October 2020), online: <https://www.dailyxtra.com/conversion-therapy-trans-canada-bill-c-6-183403>; Florence Ashley, "A Critical Commentary on 'Rapid-Onset Gender Dysphoria'" (2020) The Sociological Review; Ashley, "Homophobia, Conversion Therapy, and Care Models for Trans Youth", *supra* note 1.

[36] Robert Wallace & Hershel Russell, "Attachment and Shame in Gender-Nonconforming Children and Their Families: Toward a Theoretical Framework for Evaluating Clinical

behavior is pathological, then we must inquire into its etiology and do what can be done to prevent and to treat it."[37] Inquiries into etiology are an indicator of psychopathologizing practices. Etiological inquiries undertaken pursuant to ethically-conducted scientific research are not conversion practices. However, institutional review boards should be mindful of the possibility that research into the etiology of targeted characteristics could be used for eugenic or otherwise detrimental purposes, and that the integration of research and clinical teams may undermine the validity of informed consent due to patients' belief that refusing to participate in research could jeopardise their access to desired healthcare services.[38]

Interventions in the naturalistic environment: 1(2)(d)

Conversion practices include treatments, practices, and sustained efforts "that direct parents or tutors to set limits on their dependents' gender non-conforming behaviour, impose peers of the same sex assigned at birth, or otherwise intervene in the naturalistic environment" for conversion purposes. The explicit inclusion of such interventions is crucial since they are carried on by parents or tutors at the direction of practitioners rather than by the practitioners themselves.

Parents or tutors are frequently enlisted in conversion practices in the belief that interventions set in everyday life play an important role in discouraging, repressing, or changing targeted characteristics.[39] These interventions are known as 'interventions in the naturalistic environment' and proceed from the assumption that targeted characteristics may be caused by a failure to identify with models and peers of the same sex assigned at birth, and by parental encouragement or failure to discourage non-conforming behaviour.[40] Interventions in the naturalistic environment includes directing parents to prevent or set limits on their child's gender non-conforming behaviours, make their child participate in differently gendered

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Interventions" (2013) 14:3 International Journal of Transgenderism 113–126 at 120; Zucker et al, *supra* note 4 at 389.

[37] Wallace & Russell, *supra* note 36 at 120.

[38] 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 165–175 at 170; Ben Vincent, "Studying trans: recommendations for ethical recruitment and collaboration with transgender participants in academic research" (2018) 9:2 Psychology & Sexuality 102–116.

[39] Turban, de Vries & Zucker, *supra* note 27 at 639; Zucker, *supra* note 12; Zucker et al, *supra* note 4 at 382, 388.

[40] Zucker et al, *supra* note 4; 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.

activities and/or with peers of a different gender, or otherwise alter their everyday environment in the hope that they will cease to display the targeted characteristic.

Presuming the undesirability of transition: 1(2)(e)

Conversion practices include treatments, practices, and sustained efforts that "proceed from the assumption that social or medical transition are undesirable or less desirable." Instead of being directly motivated by a negative view of transitude, the fact of being transgender, conversion practices may instead be motivated by the view that social or medical transition is undesirable or less desirable than its absence.

The focus of negativity is often placed on medical transition,[41] and with the language of 'mutilation' being used to describe the interventions in some cases.[42] The assumption that transition is undesirable may also relate to specific bodily configurations, such as when desired medical interventions would lead to a body that "fall outside of the [rigidly binary] cisnormative view of the body"[43] or when people desire to medically transition without socially transitioning.[44] Practices may also be motivated by negative judgements of social transition, frequently due to the belief that social transition inevitably leads to medical transition or an otherwise more difficult life.[45] This view is notably contrary to emerging evidence that pre-pubertal trans youth who socially transition have mental health comparable to the general population.[46]

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[41] Marchiano, *supra* note 33; Michael Laidlaw, Michelle Cretella & Kevin Donovan, "The Right to Best Care for Children Does Not Include the Right to Medical Transition" (2019) 19:2 The American Journal of Bioethics 75–77.

[42] Carol Lloyd, "Is a sex change operation liberating or mutilating?", *Salon* (3 August 2007), online: <https://www.salon.com/2007/08/02/sex_change/>.

[43] Florence Ashley, "Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth" (2019) 24:2 Clinical Child Psychology and Psychiatry 223–236 at 230.

[44] Katherine Rachlin, "Medical Transition without Social Transition" (2018) 5:2 TSQ: Transgender Studies Quarterly 228–244.

[45] Richard Green, "To Transition or Not to Transition? That Is the Question" (2017) 9:2 Current Sexual Health Reports 79–83 at 82; Zucker & Bradley, *supra* note 18 at 266; Langer & Martin, *supra* note 27 at 14.

[46] Kristina R Olson et al, "Mental Health of Transgender Children Who Are Supported in Their Identities" (2016) 137:3 Pediatrics e20153223; Lily Durwood, Katie A McLaughlin & Kristina R Olson, "Mental Health and Self-Worth in Socially Transitioned Transgender Youth" (2017) 56:2 J Am Acad Child Adolesc Psychiatry 116-123.e2.

The view of trans people as a mentally ill may flow from a view of transition as being "drastic" or as "simply too radical" for transitude to reflect normal human diversity.[47]

Unduly delaying or impeding transition: 1(2)(f)

Conversion practices include treatments, practices, and sustained efforts "that delay or impede a person's desired social or medical transition without reasonable and non-judgemental clinical justification."

Delays or impediments to transition may be used to indirectly discourage individuals from transitioning and minimise the number of people who transition.[48] Because older adolescents and adults cannot as readily be forced to attend clinical sessions motivated by conversion goals, the promise of medical transition under condition of respecting delays and impediments serves to keep patients in the clinical relationship. Expressions of doubts or observations which do not match the provider's understanding of transitude are then used to justify further delays and impediments. Approach which impose undue delays may discourage subsequent transitioning and pose risks of psychological harm to patients.[49]

Undue delays and impediments to transition may also be used to support other conversion practices and reflect a desire to minimise the likelihood of trans outcomes. They may be rationalised by the belief that a longer assessment period is needed to ascertain whether the person is truly transgender or truly gender dysphoric, despite

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[47] Zucker, *supra* note 4 at 543; Marchiano, *supra* note 33 at 346.

[48] 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>.

[49] Olson et al, *supra* note 46; 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 251–268; Winters et al, *supra* note 1 at 248; 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 212–224 at 218–219; Diane Ehrensaft, "Found in Transition: Our Littlest Transgender People" (2014) 50:4 Contemporary Psychoanalysis 571–592 at 579; Williams, *supra* note 48; Ruth Pearce, *Understanding Trans Health: Discourse, Power and Possibility* (Bristol: Policy Press, 2018) at 157; 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; 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 17.

evidence that regret is rare for all age groups.[50] Some practitioners seek to justify delaying or impeding transition by arguig that youth are being pushed into transitioning to avoid being gay or lesbian and that allowing transition may even be a form of conversion therapy.[51] However, these arguments do not accord with empirical and theoretical reality, as few trans people are straight after transition and transphobia is more pervasive and intense than homophobia.[52] It is also worth noting that these arguments often mistake the label used by the person for their sexual orientation ('gay', 'lesbian', 'bisexual', etc.) for the sexual orientation itself (who they are romantically and sexually attracted to). These arguments weaponise pro-LGBQ sentiment in an attempt to legitimate conversion practices towards trans people.

Not all delays or impediments to transition are tantamount to conversion practices. Delays and impediments which are both reasonable and non-judgmental in nature are acceptable. Reasonability is a common concept in the law of negligence and civil liability. The 'reasonable person test' may be used to evaluate whether a

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[50] Ashley, "Thinking an Ethics of Gender Exploration", *supra* note 43; A L C de Vries et al, "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment" (2014) 134:4 PEDIATRICS 696–704; 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 155-156.e3; Florence Ashley, "Gender (De)Transitioning Before Puberty? A Response to Steensma and Cohen-Kettenis (2011)" (2019) 48:3 Arch Sex Behav; Chantal M Wiepjes et al, "The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets" (2018) 15:4 The Journal of Sexual Medicine 582–590; Anne A Lawrence, "Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery" (2003) 32:4 Archives of Sexual Behavior 299–315; Gaines Blasdel et al, *Description and Outcomes of a Hormone Therapy Informed Consent Model for Minors* (Buenos Aires, Argentina, 2018); Madeline B Deutsch, "Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics" (2012) 13:3 International Journal of Transgenderism 140–146; Tim C van de Grift et al, "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study" (2018) 44:2 Journal of Sex & Marital Therapy 138–148.

[51] Susan Bewley, Lucy Griffin & Richard Byng, "Safeguarding adolescents from premature, permanent medicalisation", (11 February 2019), online: *BMJ Rapid Responses* <https://www.bmj.com/content/364/bmj.l245/rr-1>; Marchiano, *supra* note 33; Littman, *supra* note 33; Debra Soh, "The Unspoken Homophobia Propelling the Transgender Movement in Children", *Quillette* (23 October 2018), online: <https://quillette.com/2018/10/23/the-unspoken-homophobia-propelling-the-transgender-movement-in-children/>; Kathleen Stock, "Stonewall's new definition of 'conversion therapy' raises a few questions", *The Article* (15 November 2018), online: <https://www.thearticle.com/stonewalls-new-definition-of-conversion-therapy-raises-a-few-questions/>.

[52] Ashley, "Homophobia, Conversion Therapy, and Care Models for Trans Youth", *supra* note 1; Ashley, "A Critical Commentary on 'Rapid-Onset Gender Dysphoria'", *supra* note 35; James et al, *supra* note 11 at 59.

delay or impediment is reasonable. The test asks that decisionmakers imagine how a reasonable person would have acted in the context at hand.[53]

Delays and impediments must be non-judgemental, reflecting the view that the reasonable person should not hold homophobic or transphobic beliefs.[54] Non-judgemental care in the context of LGBTQIA+ populations is predicated on the view that practitioners should avoid making value or moral judgements regarding targeted characteristics on the patients.[55] This entails that their practices shouldn't betray heteronormative or cisnormative views.[56] Non-judgement is added as an explicit requirement because not all legal systems incorporate such a criterion in their equivalent of the reasonable person test.

Reasonable and non-judgemental delays and impediments may arise for various reasons. Requiring blood testing prior to prescribing hormone replacement therapy is legitimate despite added delay. Requiring an assessment of gender dysphoria pursuant to the latest WPATH Standards of Care[57] isn't a conversion practice unless the intensity and chronology of the assessment process are excessive. Delays that are not due to clinical practice but are a by-product of resource scarcity in the healthcare system cannot be deemed unreasonable or judgemental on the part of the practitioner, although it could be discriminatory on the part of the government

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[53] Alan D Miller & Ronen Perry, "The Reasonable Person" (2012) 87:2 New York University Law Review 323–392; Elizabeth L Shoenfelt, Allison E Maue & JoAnn Nelson, "Reasonable Person versus Reasonable Woman: Does It Matter" (2002) 10:3 American University Journal of Gender, Social Policy & the Law 633–672.

[54] *R v Tran*, 2010 SCC 58, [2010] 3 SCR 350 (Supreme Court of Canada) at para 34.

[55] Mark Hayter, "Is non-judgemental care possible in the context of nurses' attitudes to patients' sexuality?" (1996) 24:4 Journal of Advanced Nursing 662–666; M Johnston, "On becoming non-judgmental: some difficulties for an ethics of counselling." (1999) 25:6 Journal of Medical Ethics 487–490.

[56] Y Gavriel Ansara & Peter Hegarty, "Cisgenderism in psychology: pathologising and misgendering children from 1999 to 2008" (2012) 3:2 Psychology and Sexuality 137–160; Y Gavriel Ansara & Peter Hegarty, "Methodologies of misgendering: Recommendations for reducing cisgenderism in psychological research" (2014) 24:2 Feminism & Psychology 259–270; Alexandre Baril & Kathrym Trevenen, "Exploring Ableism and Cisnormativity in the Conceptualizsation of Identity and Sexuality 'Disorders'" (2014) 11 Annual Review of Critical Psychology 389–416; Nova J Bradford & Moin Syed, "Transnormativity and Transgender Identity Development: A Master Narrative Approach" (2019) 81:5–6 Sex Roles 306–325; Kristen Schilt & Laurel Westbrook, "Doing Gender, Doing Heteronormativity: 'Gender Normals,' Transgender People, and the Social Maintenance of Heterosexuality" (2009) 23:4 Gender & Society 440–464; Brenda A LeFrançois, "Queering Child and Adolescent Mental Health Services: The Subversion of Heteronormativity in Practice: Queering Child and Adolescent Mental Health Services" (2013) 27:1 Children & Society 1–12.

[57] Coleman et al, *supra* note 6.

or healthcare institution.[58] Impediments such as further testing required due to serious physical health concerns may also be reasonable and non-judgemental.

The requirement that delays or impediments be reasonable and non-judgemental shifts the burden of justification onto providers, who must be able to provide rationales for their practices. Such a requirement fosters greater thoughtfulness and introspection in clinical work and alleviates the evidentiary burden on complainants by recognising that practitioners have greater access to relevant facts relating to their work.[59] Healthcare institutions should consider adopting formal policies and review mechanisms aimed at ensuring the absence of undue delays or impediments to transition.

Misgendering & misattributing orientation: 1(2)(g)

Conversion practices include treatments, practices, and sustained efforts "that that knowingly fail to respect the name, pronouns, gendered terms, and sexual orientation terms chosen or accepted by the person, except as required by law."

Respect for a person's chosen or accepted name, pronouns, and gendered terminology communicates acceptance of their gender identity and deserving of respect. Gendered terms include gender labels such as 'girl', 'boy', 'non-binary', which may be denied through questions and affirmations such as: "But you know you're really a boy, right?" Gendered terms may also include words like 'babe' or 'sweetheart', the grammatical gender of nouns, adjectives, etc. in many languages,[60] and gender markers on documents and records.[61] Sexual orientation terms should also be respected and imposing a terminology inconsistent with a patient's self-labelling ('You're gay, not bisexual' or 'You can't say you're a lesbian if you are non-binary') is equally inappropriate.

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[58] Nicola Davis, "Trans patients in England face 'soul destroying' wait for treatment", *The Guardian* (26 February 2019), online: <https://www.theguardian.com/society/2019/feb/26/trans-patients-in-england-face-soul-destroying-wait-for-treatment>; *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 (Supreme Court of Canada) ; *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 SCR 657 (Supreme Court of Canada).

[59] *Snell v Farrell*, [1990] 2 SCR 311 (Supreme Court of Canada) ; *McGhee v National Coal Board*, [1972] 3 All ER 1008, [1972] UKHL 7 (United Kingdom House of Lords).

[60] Florence Ashley, "Qui est-ille ? Le respect langagier des élèves non-binaires, aux limites du droit" (2017) 63:2 Service social 35.

[61] Heath Fogg Davis, *Beyond Trans: Does Gender Matter?* (New York: New York University Press, 2017).

Failure to respect the person's gender, known as misgendering, is associated with substantially poorer mental health.[62] Misgendering is integral to conversion practices and communicates that the person's gender identity should not be taken seriously or is not a true reflection of who they are.[63]

Misgendering may be required by law. A person's legal name and gender marker may be required on documents used for insurance coverage.[64] Legal requirements should not be overstated. Gender markers are not a reliable identity-verification measure[65] and shadow files may be used in cases where legal name and gender marker must be used for some purposes but not others.[66]

Misgendering and misattributing orientation terms must be done knowingly and must fall under the model law's notions of treatments, practices, or sustained efforts. Treatments, practices, and sustained efforts require a degree of systematicity which is not met by occasional accidental misgendering or misattributing orientation terms, or misgendering or misattributing orientation terms which is due to the person's innocent ignorance of the person's chosen or accepted name, pronouns, gendered terms, and sexual orientation terms. The degree of systematicity requires also excludes misgendering and misattributing orientation terms in everyday settings which do not rise to the level of practices, though misgendering and misattributing orientation terms may nevertheless be contrary to human rights protections against harassment based on protected characteristics.[67]

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[62] Kevin A McLemore, "A minority stress perspective on transgender individuals' experiences with misgendering." (2018) 3:1 Stigma and Health 53–64; Kevin A McLemore, "Experiences with Misgendering: Identity Misclassification of Transgender Spectrum Individuals" (2015) 14:1 Self and Identity 51–74; Stephanie Julia Kapusta, "Misgendering and Its Moral Contestability" (2016) 31:3 Hypatia 502–519; Stephen T Russell et al, "Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth" (2018) 63:4 Journal of Adolescent Health 503–505; Bauer et al, *supra* note 49.

[63] *AB v CD and EF*, 2019 BCSC 604 (British Columbia Supreme Court) .

[64] Madeline B Deutsch & David Buchholz, "Electronic Health Records and Transgender Patients—Practical Recommendations for the Collection of Gender Identity Data" (2015) 30:6 Journal of General Internal Medicine 843–847 at 844; Lauren Freeman & Saray Ayala López, "Sex Categorization in Medical Contexts: A Cautionary Tale" (2018) 28:3 Kennedy Institute of Ethics Journal 243–280 at 258; Hale M Thompson, "Patient Perspectives on Gender Identity Data Collection in Electronic Health Records: An Analysis of Disclosure, Privacy, and Access to Care" (2016) 1:1 Transgender Health 205–215 at 212.

[65] Davis, *supra* note 70 at 39.

[66] Commission scolaire de Montréal, *Guidelines Regarding Transgender Students at the Commission Scolaire de Montréal* (2017) at 11–12.

[67] Ashley, "Qui est-ille ?", *supra* note 69.

Subsection 1(3): Permitted practices

Subsection 1(3) provides a list of practices which are non-exhaustively excluded from the notion of conversion practices. The subsection provides that they are not included in the notion of conversion practices unless otherwise included pursuant to subsection 1(2). In other words, practices falling under subsection 1(3) cannot become conversion practices by the sole operation of the general definition under subsection 1(1) and only become conversion practices if subsection 1(2) is applicable.

Diagnosis and assessment: 1(3)(a)

Conversion practices do not include "necessary or desired assessments and diagnoses of gender dysphoria or other comparable diagnostic category under the latest version of the DSM or ICD."

Assessments and diagnoses of gender dysphoria[68] or gender incongruence[69] are often required to access trans healthcare services, insurance coverage, or change legal gender marker. These requirements vary across jurisdictions, service providers, and insurance providers. Mandatory assessments and diagnoses are opposed by a large subset of trans healthcare professionals and trans communities and may be considered dehumanising or psychopathologizing.[70] However, including these assessments and diagnoses under the definition of conversion practices even when necessary and/or desired by the patient could severely impede access to healthcare in trans communities.

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[68] American Psychiatric Association, *supra* note 7.

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

[70] 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 1605–1614; Amets Suess Schwend et al, "Depathologising gender diversity in childhood in the process of ICD revision and reform" (2018) 13:11 Global Public Health 1585–1598; Zowie Davy & Michael Toze, "What Is Gender Dysphoria? A Critical Systematic Narrative Review" (2018) 3:1 Transgender Health 159–169; Jack Drescher, Peggy Cohen-Kettenis & Sam Winter, "Minding the body: Situating gender identity diagnoses in the ICD-11" (2012) 24:6 International Review of Psychiatry 568–577; Françoise Askevis-Leherpeux et al, "Why and how to support depsychiatrisation of adult transidentity in ICD-11: A French study" (2019) 59 European Psychiatry 8–14; Zowie Davy, "The DSM-5 and the Politics of Diagnosing Transpeople" (2015) 44:5 Archives of Sexual Behavior 1165–1176; Florence Ashley, "Gatekeeping Hormone Replacement Therapy for Transgender Patients is Dehumanising" (2019) 45:7 Journal of Medical Ethics 480–482.

The exclusion of assessments and diagnoses of gender dysphoria or comparable diagnostic category does not reflect the belief that these diagnostic categories should continue to exist or that it is legitimate to require assessments or diagnoses for access to healthcare, insurance, or legal gender marker changes. The exclusion of assessment and diagnoses from the definition of conversion practices does not preclude a finding that the practitioner was otherwise engaging in conversion practices and will notably constitute conversion practices if the assessments or diagnoses lead to unreasonable delays in social or medical transition.

In jurisdictions that use a modified or older version of the DSM or ICD, the words "latest version" should be substituted for the appropriate reference.

Acceptance and support: 1(3)(b)

Conversion practices do not include treatments, practices, or sustained efforts "that provide non-judgemental acceptance and support of the person's expressed" targeted characteristics.

Accepting and supporting the person's expressed target characteristics is not included in the notion of conversion practices.[71] Acceptance and support are grounded in a client-centred approach to therapeutic care, and 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."[72] This may involve addressing factors impeding the patient's psychosocial adaptation, such as drug addiction. In the context of patients who wish to alter their targeted characteristics, acceptance and support aims at reducing distress brought on by stigma, isolation, and internalised shame, which may involve exploring why the patient wishes to change their targeted characteristics without negatively judging them for struggling with self-acceptance.

Specifying the expressed nature of characteristics clarifies the temporal nature of conversion practices and complements the proof of targeted characteristics by self-reporting set out in section 1(10). Acceptance and support will not amount to conversion practices even if the practitioner believes in good faith that the patient is misrepresenting these characteristics. For instance, practitioners who believe for good reasons that a patient of theirs is a trans woman but continues to represent themselves as a cis man would not be committing a wrong by continuing to refer to them using masculine terminology, even if they were to later self-identify as a

[71] American Psychological Association, *supra* note 1.
[72] *Ibid* at 55.

woman. The same would be true of the converse. Non-judgemental and unconditional acceptance and support of a person is appropriate and would not be tantamount to conversion practices regardless of the outcome of this exploration process, and even if the patient retrospectively estimates having always known.

The requirement that acceptance and support be non-judgemental—without preference of targeted characteristic—indicates that foreclosing future identity development may nevertheless fall under the umbrella of conversion practices. Suggesting that one is accepted and supported as is but would not be accepted or supported if their targeted characteristics were different (e.g. "I accept you as long as you're straight.") would not fall under the notion of acceptance and support since it would be judgemental.

Coping strategies: 1(3)(c)

Conversion practices do not include treatments, practices, or sustained efforts "that teach individuals coping strategies to help resolve, endure, or diminish stressful life experiences while taking all reasonable steps to avoid repressing, discouraging or changing the person's" targeted characteristics.

Empowering patients by teaching them coping strategies in dealing with negative experiences, notably linked with gender or sexuality-related marginalisation, may be an appropriate therapeutic practice.[73] These strategies may include common therapeutic interventions such as psychoeducation, cognitive-behavioural therapy, mindfulness-based therapy, and narrative therapy.

The motivational underpinning and context of practices are crucial to distinguishing between conversion practices and legitimate therapeutic practices. For instance, reading religious texts is often associated with faith-based conversion practices but may also be used to reduce "the salience of negative messages about homosexuality and increasing self-authority or understanding" over religious texts through active engagement.[74] Helping patients navigate strategic reductions in gender non-conforming behaviour in severely hostile and dangerous environments should also be properly contextualised since it may reflect a coping strategy motivated by reasonable self-preservation rather than a disavowal of gender non-conformity amounting to a conversion practice. However, some professionals engaging in conversion practices seek to justify their work by framing them as merely teaching helpful coping strategies to patients who wish to avoid transitioning or

[73] *Ibid* at 57.
[74] *Ibid* at 59.

engaging in sexual acts with people of a certain gender.[75] Oftentimes, the desire to avoid transitioning or engaging in sexual acts with people of a certain gender is underwrit by internalised transphobia and/or homophobia and outsized fears of ostracization and rejection (e.g. "I should not transition because being trans is unnatural and wrong" or "if I come out everyone will reject me and I will never be loved or happy"), and conversion practices agree with and reinforce these feelings instead of addressing, disrupting, and undermining them. Proposed treatments of ego-dystonic sexual orientation, mentioned in the explanatory notes to paragraph 1(2)(a), were often framed as teaching coping strategies. Appropriate therapeutic practices towards such patients involve helping them work through their internalised transphobia and/or homophobia and fears while respecting and supporting the patient's targeted characteristics.

Given the dangers of practitioners seeking to justify conversion practices under this paragraph, it specifies that practitioners must take all reasonable steps to avoid repressing, discouraging, or changing targeted characteristics. Reasonability may be evaluated using the reasonable person test, which is common throughout law.[76] The type of precautions to be taken is left open-ended to avoid further restricting practices where flexibility and sensitivity to context is needed. The steps that should be taken must be evaluated on a case-by-case basis based on the person's vulnerability, perspectives, and relationship to the practitioner. Patients should benefit from a clear understanding that coping strategies are not about delaying or avoiding transitioning or engaging in same-sex acts, but about managing in a healthy and sustainable manner the social, emotional, and psychological difficulties associated with stigma and marginalisation. Research on conversion practices shows that denying or downplaying one's sexual desire or desire to transition is neither healthy or sustainable.

Integrated personal identity: 1(3)(d)

Conversion practices do not include treatments, practices, or sustained efforts "that aim at the development of an integrated personal identity by facilitating the exploration and self-assessment of components of personal identity while taking all reasonable steps to avoid repressing, discouraging or changing the person's" targeted characteristics.

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[75] Madrigal-Borloz, *supra* note 4 at 9, 13.

[76] The language of "all reasonable steps" is inspired by the language of "all reasonable steps to ascertain the age of the complainant," which circumscribes the use of the mistake of age defence in sexual offences involving minors. See e.g. *Criminal Code*, RSC 1985, c C-46, ss. 150.1(4)-(6)

Enabling identity exploration and development is predicated on the idea that "conflicts among disparate elements of identity appear to play a major role in the distress of those seeking" conversion practices.[77] People whose religion or culture are hostile to their targeted characteristic, in particular, may struggle to integrate and harmonise the various elements of their personal identity. Personal dentity is understood holistically, comprising "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."[78] Identity development refers to the active exploration and self-assessments of personal identity and its various components with the goal of attaining an integrated personal identity which is free from major tension or conflict between components.[79]

Conversion practices have justified the repression and discouragement of targeted characteristics via the goal of reducing the tension between the person's religious commitments and these characteristics.[80] Those practices, however, place religious commitment above the targeted characteristics in the hierarchy instead of attempting to make them compatible for the individual. As such, it is not truly aiming at the development of an integrated personal identity. In this context as everywhere else, practitioners must always consider target characteristics "to be absolutely as valid and legitimate an outcome as any other identity or practice."[81]

Given the dangers of practitioners seeking to justify conversion practices under this paragraph, it specifies that practitioners must take all reasonable steps to avoid repressing, discouraging, or changing targeted characteristics. Patients should clearly understand that free exploration is about improving one's self-understanding and reducing tensions within one's personal identity by reconciling aspects of it, not about denying aspects of one's identity or conforming to societal or religious expectations. The reference to reasonability invokes here again the reasonable person test. The question is: what steps would a reasonable practitioner take in the

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[77] American Psychological Association, *supra* note 1 at 60.

[78] *Ibid*.

[79] *Ibid*; British Psychological Society, "Guidelines for Psychologists Working with Gender, Sexuality and Relationship Diversity", (4 July 2019), online: <https://www.bps.org.uk/news-and-policy/guidelines-psychologists-working-gender-sexuality-and-relationship-diversity> at 6.

[80] Madrigal-Borloz, *supra* note 4 at 17; Mark A Yarhouse & Warren Throckmorton, "Ethical issues in attempts to ban reorientation therapies." (2002) 39:1 Psychotherapy: Theory, Research, Practice, Training 66–75; Throckmorton, *supra* note 25. See also the previous discussion of the diagnostic category of ego-dystonic sexual orientation.

[81] British Psychological Society, *supra* note 88 at 6.

circumstances to avoid, intentionally or unintentionally, repressing, discouraging, or changing the person's targeted characteristics. The type of precautions to be taken is left open-ended to avoid further restricting practices where flexibility and sensitivity to context is needed but may involve establishing therapeutic strategies that highlight the compatibility of the religion and its associated texts with the targeted characteristics.[82] Development of an integrated personal identity is predicated in retaining both the religious commitment and the targeted characteristic of a person, and bringing them into harmony.

Subsections 1(4) to 1(11): Definitions

Sexual orientation: 1(4)

Sexual orientation is defined as "a person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of the same gender, of a different gender, or of more than one gender. Sexual orientation may be expressed by self-identification with sexual orientation terms such as straight, gay, lesbian, bisexual, pansexual, asexual, or queer." The definition further acknowledges that "[t]erms and understandings of sexual orientation vary by culture."

This definition of sexual orientation is inspired by the one provided in the Yogyakarta Principles.[83] The importance of self-labelling and the culturally-specific nature of terms and understanding of sexual orientation were added to the Yogyakarta definition.[84] Judging whether a practitioner is engaging in conversion

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[82] Victoria Kolakowski, "Toward a Christian Ethical Response to Transsexual Persons" (1997) 1997:6 Theology & Sexuality 10–31; Chris Glaser, ed, *Gender Identity & Our Faith Communities: A Congregational Guide for Transgender Advocacy* (Washington, D.C: Human Right Campaign Foundation, 2008); Susannah Cornwall, "Healthcare Chaplaincy and Spiritual Care for Trans People: Envisaging the Future" (2019) 7:1 Health and Social Care Chaplaincy 8–27; Aiyyana Maracle, "A Journey in Gender" (2000) 2 torquere: Journal of the Canadian Lesbian and Gay Studies Association 36–57; delfin bautista, Quince Mountain & Heath Mackenzie Reynolds, "Religion and Spirituality" in Laura Erickson-Schroth, ed, *Trans Bodies, Trans Selves: A Resource for the Transgender Community* (Oxford: Oxford University Press, 2014) 62. See also the Human Rights Campaign Foundation's Coming Home series, which includes guides specific to Catholicism, Islam, Judaism, Mormonism and Evangelicalism: Human Rights Campaign Foundation, "Coming Home: To Faith, To Spirit, To Self", (2014), online: *Human Rights Campaign* <https://www.hrc.org/resources/coming-home-to-faith-to-spirit-to-self>.

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

[84] Andrew Park, *Comment on the Definition of Sexual Orientation and Gender Identity Submitted to The Drafting Committee, Yogyakarta Principles on the Application of*

practices requires cultural sensitivity and it would be inappropriate for a practitioner to impose a Western understanding of sexuality and sexual orientation onto their patients. The proposed definition acknowledges that terms used to express sexual orientation are often gender-specific but does not define sexual orientation by reference to the person's own gender. [85]

The choice to define sexual orientation solely by reference to the targets of attraction seeks to avoid the potential interpretive difficulties arising when transgender people change their self-elected gender labels. In the past, the claim that a shift in self-elected gender labels (for instance from 'butch lesbian' to 'straight man') entails a change in sexual orientation was used to falsely accuse gender-affirmative practices of being conversion practices based on sexual orientation, despite the targets of attraction not having changed. [86]

Gender identity: 1(5)

Gender identity is defined as "a person's deeply felt internal and individual experience of gender including the personal sense of the body. Gender identity may be completely male or female or may lie outside the male/female binary. Gender identity may be expressed by self-identification with gender identity terms such as man, woman, non-binary, or genderqueer." The definition further acknowledges that "[t]erms and understandings of sexual orientation vary by culture."

As with sexual orientation, this definition substantively builds upon the definition provided in the Yogyakarta Principles.[87] The definition explicitly recognises non-binary gender identities, as well as gender identities which otherwise lie outside of the male/female binary but may not recognise themselves in the umbrella notion of non-binary. This recognition closes a potential gap in the law and precludes attempts to justify conversion practices by arguing that non-binary identities are not validly included in the notion of gender identity. Accessing transition-related care remains difficult for non-binary individuals, and some countries do not offer them any medical transition services. As with sexual orientation, the definition was supplemented by an understanding of the importance

International Human Rights Law to Sexual Orientation and Gender Identity (The Williams Institute on the Study of Sexual Orientation and Gender Identity, 2017).

[85] Talia Mae Bettcher, "When Selves Have Sex: What the Phenomenology of Trans Sexuality Can Teach About Sexual Orientation" (2014) 61:5 Journal of Homosexuality 605–620.

[86] Ashley, "Homophobia, Conversion Therapy, and Care Models for Trans Youth", *supra* note 1.

[87] *The Yogyakarta Principles*, *supra* note 92.

of self-labelling and culturally-sensitivity.[88] The definition of gender identity in the Yogyakarta Principles includes components corresponding to gender expression. These were not included, as gender expression bears its own definition under the model law. The merging of gender identity and gender expression under the Yogyakarta Principles reflects the historical context of the document. The 2017 Yogyakarta Principles plus 10 provided separate definitions for gender identity and gender expression.[89]

Gender modality: 1(6)

Gender modality is defined as "how a person's gender identity stands in relation to their sex assigned at birth including whether they are transgender or cisgender."

The term gender modality was coined in 2019 and serves, in relationship to cisgender and transgender, a role analogous to sexual orientation vis-à-vis the labels gay, lesbian, bisexual, pansexual, and queer. Gender modality is:

> [A]n open-ended category which includes being trans and being cis and welcomes the elaboration of further terms which speak to the diverse experiences people may have of the relationship between their gender identity and sex assigned at birth: the cis-trans binary is challenged by some non-binary people—especially agender people—some intersex people, some gender creative youth, and some people who were raised in a fully gender neutral manner.[90]

The inclusion of gender modality serves to ensure and reinforce the prohibition of conversion practices in instances where gender identity is unclear, as may be the case for some gender creative youth. It also serves to recognise that conversion practices are often motivated by a negative judgement of the non-correspondence between gender identity and sex assigned at birth among transgender people, rather than a negative assessment of the gender identity itself.

Sex assigned at birth: 1(7)

Sex assigned at birth is defined as "the classification of a person as male, female, intersex, or another gender or sex based on their anatomy, karyotyping, or

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[88] G Nic Rider et al, "The gender affirmative lifespan approach (GALA): A framework for competent clinical care with nonbinary clients" (2019) 20:2–3 International Journal of Transgenderism 275–288.

[89] *The Yogyakarta Principles plus 10*, *supra* note 66 at 10.

[90] Florence Ashley, "'Trans' is my gender modality: a modest terminological proposal" in Laura Erickson-Schroth, ed, *Trans Bodies, Trans Selves*, 2d ed (Oxford: Oxford University Press, 2021).

other biological traits present at birth. It is typically the gender or sex listed on the person's declaration of birth or original birth certificate."

Sex assigned at birth is most commonly based on the presence or absence of a penis at birth. However, the assignment of gender at birth is often based on a more complicated process when it comes to intersex people, who do not correspond to the binary socio-medical conceptions of male or female bodies. Original declarations of birth and birth certificates typically reflect this classification; however, errors of notation may occur, and the documents of intersex youth drafted shortly after their birth do not always reflect the process of gender assignment imposed upon them. While sex assigned at birth may not be male or female, it is extremely rare for gender or sex to be classified otherwise on declarations of birth and birth certificates.

Gender expression: 1(8)

Gender expression is defined as "a person's desired external appearance as it relates to social expectations and norms of femininity and masculinity. Gender expression may include a person's behaviour, name, pronouns, clothing, haircut, voice, tattoos, piercings, and anatomical features."

This definition is offered *de novo* for the purposes of the model law and does not substantively reflect definitions such as the one provided in the Yogyakarta Principles plus 10.[91] Gender expression is defined in relation to gendered social expectations and norms, must be desired, and includes anatomical features. References to gendered social expectations and norms serve to exclude minor or non-gendered changes to external appearances from the scope of conversion practices; though such changes may be unethical, they do not form conversion practices. Framing the gendered nature of gender expression by reference to gendered social expectations and norms avoids implying that appearances are inherently gendered. External appearance must be desired. To define gender expression without reference to desire might prevent practitioners from encouraging patients to adopt a desired appearance, but which they are hesitant to embrace. Lastly, gender expression includes anatomical features. The inclusion of anatomical features in the definition of gender expression facilitates the labelling as conversion of practices which seek to discourage desired anatomical changes, notably through transition-related interventions.

Gender expression is occasionally defined as how a person chooses to express their gender. For the purposes of the model law, this definition if inadequate. Components of external appearance that are socially perceived as masculine or

[91] *The Yogyakarta Principles plus 10*, *supra* note 66 at 10.

feminine may not reflect a choice to express gender and may instead reflect non-gender-related desires. For instance, many people find clothing coded as masculine more comfortable. Discouraging gender non-conforming may be conversion independently of whether the patient's external appearance is desired for gender-related reasons.

Social and medical transition: 1(9) & 1(10)

Social transition is defined as "the voluntary alteration of a person's gender expression to align it with their gender identity that differs from the one they were assigned at birth, other than through medical interventions." Medical transition is defined as voluntary alterations of the same kind, but for operating "through medical interventions such as puberty blockers, hormone replacement therapy, voice therapy, surgical procedures." The definitions acknowledge that social and medical transition are "personal and may not reflect others' understanding of which gender expressions correspond to a given gender identity." Social and medical transition may include changes to behaviour, name, pronouns, clothing, haircut, voice, tattoos, piercings, and anatomical features, by reference to gender expression.

Social and medical transition must be voluntary. Involuntary alterations of gender expression are not social transition, as they do not emanate from the person's free choice. This precludes an understanding of medical transition as including surgical procedures on intersex newborn and children who did not personally provide free and enlightened consent or assent. These procedures are harmful and unethical and are not comparable to medical transition for transgender people, which are beneficial and ethical.[92] Surgeries and interventions relating to intersex traits fall under the notion of medical transition for the purposes of the model law if they emanate from the person's free choice. As provided by paragraph 1(2)(g), free and enlightened consent or assent must be present. These surgeries and interventions may or may not be understood as part of medical transition by intersex individuals.

Social and medical transition are personal, individual processes. The person's chosen social and/or medical transition may not reflect conventional understandings of the traits associated with manhood, womanhood, or other genders. For instance, it is frequently assumed that women do not have penises, and therefore that medical transition for trans women should, must, or always does include vaginoplasty. A person's social and/or medical transition may even be directly contrary to lay

[92] Malta Declaration, *supra* note 66; Agius, *supra* note 66; Bastien-Charlebois, *supra* note 63; Chase, *supra* note 63; Holmes, *supra* note 63; Ittelson, Fraser & Levasseur, *supra* note 60; Elders, Satcher & Carmona, *supra* note 63; Office of the United Nations High Commissioner for Human Rights, *supra* note 66.

expectations. For instance, a non-binary person assigned female at birth but whose given name is unisex may wish to change their name for a typically feminine name as part of their social transition. To discourage uncommon or unconventional social and/or medical transitions would be included within the prohibition set out in paragraph 1(2)(f), as the adequacy of social and/or medical alterations is based on the individual's desire rather than conformity to an external norm.

Voluntary alterations of gender expression solely motivated by reasons other than the person's gender identity or by a gender identity aligned with their sex assigned at birth are not included within the notions of social and medical transition. This reference to underlying motives reflects the common understanding that gender non-conformity alone does not constitute social and/or medical transition. Although this definitional feature restricts the application of paragraph 1(2)(f), seeking to repress, discourage, or change gender expression is prohibited under section 1(1). Practices targeting voluntary alterations of gender expression for non-gender-identity-related reasons may also fall within the scope of paragraph 1(2)(e), which prohibits treatments, practices, and sustained efforts that "proceed from the assumption that social or medical transition are undesirable or less desirable."

It is unnecessary to define the term "medical interventions", since social and medical transition cover the entire field of transition: all interventions are either medical or non-medical. Common transition-related medical interventions are nevertheless provided in the definition for greater clarity.

Subsection 1(11): Proof by self-report

Sexual orientation, gender identity, gender modality, gender expression, and behaviours associated with a gender other than the person's sex assigned at birth "may be proven by self-report."

Providing for proof of targeted characteristics by testimony significantly curtails evidentiary difficulties involved in proving that someone engaged in conversion practices, as evidence of the targeted characteristic at the time of the practices may be difficult to prove later. This difficulty is lessened by allowing people to self-report the targeted characteristic they had at the time of the offense, including by testimony at trial. This section limits practitioners' capacity to raise as a defence that the patient's self-reported targeted characteristic did not represent their true targeted characteristic, but rather was a lie or form of false-consciousness. Since conversion practices often label self-reported gender identities and sexual orientations as mere confusion, proof by testimony is essential to effectively prohibiting conversion practices.

[…]

Florence Ashley, *Loi modèle : version française*

(1) Les pratiques de conversion incluent tout traitement, pratique ou effort soutenu qui vise à réprimer, décourager ou changer l'orientation sexuelle, l'identité de genre, la modalité de genre ou l'expression de genre de la personne ou ses comportements associé à un genre autre que celui qui lui fut assigné à la naissance.

(2) Les pratiques de conversion incluent:

a. Les traitements, pratiques et efforts soutenus qui présument que certaines orientations sexuelles, identités de genre, modalités de genre, ou expressions de genre sont pathologiques ou moins désirables que d'autres;

b. Les traitements, pratiques et efforts soutenus qui tentent de réduire l'identification aux genres autre que celui assigné à la naissance ou les rapports intimes et sexuels avec des personnes d'une certaine identité de genre ou sexe assigné à la naissance;

c. Les traitements, pratiques et efforts soutenus qui ont pour premier but l'identification de facteurs ayant pu causer l'orientation sexuelle, l'identité de genre, la modalité de genre ou l'expression de genre de la personne ou ses comportements associés à un genre autre que celui qui lui fut assigné à la naissance, sauf dans un contexte de recherche approuvé par comité d'éthique à la recherche;

d. Les traitements, pratiques et efforts soutenus qui dirigent les parents ou tuteurs de limiter les comportements non-conformes dans le genre, d'imposer des pairs du même sexe assigné à la naissance, ou d'intervenir autrement dans l'environnement journalier du dépendant dans le but de réprimer, décourager ou changer l'orientation sexuelle, l'identité de genre, la modalité de genre ou l'expression de genre de la personne ou ses comportements associés à un genre autre que celui qui lui fut assigné à la naissance;

e. Les traitements, pratiques et efforts soutenus qui présument que les transitions sociales ou médicales sont indésirables;

f. Les traitements, pratiques et efforts soutenus qui délaient ou entravent la transition sociale ou médicale désirée par la personne sans justification clinique raisonnable et libre de jugement;

g. Les traitements, pratiques et efforts soutenus qui utilisent délibérément des noms, pronoms, termes genrés, et termes d'orientation sexuelle autre que ceux utilisés ou acceptés par la personne hormis lorsque requis par la loi.

(3) Sauf dans les cas prévus au paragraphe 1(2), les pratiques de conversion n'incluent pas :

a. Les évaluations et diagnostics nécessaires ou désirés de dysphorie de genre ou autre catégorie diagnostique comparable sous la dernière version du DSM ou du CIM;

b. Les traitements, pratiques et efforts soutenus qui dispensent de l'acceptation et du support libre de jugement envers l'orientation sexuelle, l'identité de genre, la modalité de genre ou l'expression de genre exprimée par la personne ou ses comportements associés à un genre autre que celui qui lui fut assigné à la naissance;

c. Les traitements, pratiques et efforts soutenus visant à enseigner des stratégies d'adaptation pour aider à résoudre, endurer ou diminuer des expériences de vies stressantes tout en prenant toutes les mesures raisonnables pour éviter de réprimer, décourager ou changer l'orientation sexuelle, l'identité de genre, la modalité de genre ou l'expression de genre de la personne ou ses comportements associés à un genre autre que celui qui lui fut assigné à la naissance;

d. Les traitements, pratiques et efforts soutenus qui visent à développer une identité personnelle intégrée en facilitant l'exploration et l'autoévaluation des composantes de l'identité personnelle tout en prenant toutes les mesures raisonnables pour éviter de réprimer, décourager ou changer l'orientation sexuelle, l'identité de genre, la modalité de genre ou l'expression de genre de la personne ou ses comportements associés à un genre autre que celui qui lui fut assigné à la naissance.

(4) « Orientation sexuelle » se réfère à la capacité qu'à la personne d'avoir une profonde attirante émotionnelle, affective, et sexuelle, et des relations intimes et sexuelle avec des individus de même genre, d'un autre genre, ou de plus d'un genre. L'orientation sexuelle peut être exprimée par auto-identification avec des termes

d'orientation sexuelle tels qu'hétérosexuel, gai, lesbienne, bisexuel, pansexuel, asexuel et queer. Les termes et compréhensions de l'orientation sexuelle varient par culture.

(5) « Identité de genre » se réfère à l'expérience profonde, interne et individuelle qu'a une personne par rapport au genre, ce qui inclut son sens personnel du corps. L'identité de genre peut être complètement homme ou femme ou peut être en dehors du binaire homme/femme. L'identité de genre peut être exprimée par auto-identification avec des termes d'identité de genre comme homme, femme, personne non-binaire ou personne genderqueer. Les termes et compréhensions de l'identité de genre varient par culture.

(6) « Modalité de genre » se réfère à la relation qu'entretient l'identité de genre d'une personne à son sexe assigné à la naissance, incluant notamment le fait d'être transgenre ou cisgenre.

(7) « Sexe assigné à la naissance » se réfère à la classification d'une personne comme homme, femme, intersexe ou comme un autre genre ou sexe sur la base de leur anatomie, caryotype ou autre traits biologiques présents à la naissance. Le sexe assigné à la naissance correspond habituellement au genre ou sexe inscrit sur la déclaration de naissance ou sur le certificat de naissance original de la personne.

(8) « Expression de genre » se réfère à l'apparence externe désirée par la personne, conçu sous l'angle de sa relation aux attentes et normes sociales de masculinité et féminité. L'expression de genre peut inclure le comportement, nom, pronoms, accords grammaticaux, vêtements, coiffure, voix, tatouages, piercings et trait anatomiques de la personne.

(9) « Transition sociale » se réfère l'altération volontaire de l'expression de genre de la personne pour l'aligner à son identité de genre qui diffère de l'identité de genre qui lui fut assigné à la naissance autrement que par interventions médicales. La transition sociale est personnelle et ne reflète pas nécessairement la compréhension qu'ont les autres des expressions de genre correspondant à une identité de genre donnée.

(10) « Transition médicale » se réfère l'altération volontaire de l'expression de genre de la personne pour l'aligner à son identité de genre qui diffère de l'identité de genre qui lui fut assigné à la naissance à l'aide d'interventions médicales comme les bloqueurs de puberté, l'hormonothérapie, l'électrolyse ou épilation au laser du visage,

la thérapie de la voix et les procédures chirurgicales. La transition médicale est personnelle et ne reflète pas nécessairement la compréhension qu'ont les autres des expressions de genre correspondant à une identité de genre donnée.

(11) L'orientation sexuelle, l'identité de genre, la modalité de genre, l'expression de genre, et les comportements associés à un genre autre que celui assigné a la naissance peuvent être prouvés par déclaration de la personne.