Dr. Oren Amitay, Ph.D., C. Psych.
Registered Psychologist (Registration No. 4497)

3335 Yonge Street, Suite 404 Toronto, ON, M4N 2M1 **(416) 666-7763**
oa@docamitay.com **Fax: (416) 440-0848**

July 12, 2021

To Whom It May Concern:

As a clinical psychologist, I have an ethical duty not only to the individuals I treat, but also to society. As a result, when I see decisions being made that could harm both individuals and society, I have an ethical obligation to speak up.

I have taught about gender-related issues for nearly 20 years, as they comprise a substantial component of my ***Psychology of Human Sexuality*** course, which I have taught almost 100 times; these phenomena are also covered to some degree in my ***Psychology of Gender***, ***Clinical Psychology*** and other relevant courses I have taught many dozens of times over the years. I have also worked with many patients who present with questions, concerns, confusion, distress, etc. with respect to their gender and other related constructs such as sex, sexuality, sexual orientation, personal identity, and so forth.

In order to perform my academic and clinical duties effectively, I have immersed myself in the preceding topics over the past two decades. I therefore believe that I can speak to the issues at hand from the perspective of a well-informed and highly invested university lecturer and practising clinical psychologist.

The following points represent only a few of the many concerns I could raise with respect to your proposed bylaw; I am obviously limited by the pre-determined time restrictions. I would be happy to discuss these and any other relevant issues further, after my allotted five minutes.

Existing Scientific Studies Can Be Misleading

It is well known that Alcoholics Anonymous cannot proclaim much success, with drop-out rates within the first month reaching over 80%; that number rises to about 90% over three months and 95% after one year. Yet, if I were to speak to people who still attend AA meetings after one or two years, I would find that the program is extremely effective – for them. I could likely report abstinence rates of 90%-100% based on the experiences of such individuals, especially those who last in AA even longer. Of course, such claims would fly in the face of the aforementioned statistics demonstrating discouragingly low rates of success.

The preceding analogy applies to much of the research claiming that "gender affirming" hormonal and surgical interventions are highly effective in reducing gender dysphoria, suicidality and other serious mental health issues of individuals identifying as Transgender. That is, the subjects reporting such positive experiences are typically those with whom the researchers were able to follow up after treatment at whichever clinic was treating them when the data were first collected.

If patients stop attending a gender-related clinic after receiving some form of care, we do not know whether they committed suicide, experienced serious mental health setbacks that prevent them from continuing treatment, were upset with the treatment they received, or desisted/detransitioned. Activists typically avoid this issue when proclaiming a) that certain treatments for which they are advocating are successful – including claiming that they are more successful than ***watchful waiting***, or b) that desistence/detransitioning rates are extremely low – usually claiming 1-2%, with 4% being the highest number some are willing to concede.

Another issue is that a number of follow-up studies look at how the patients are doing relatively soon after their social or medical transitioning. This is the "honeymoon phase," during which they are most likely to report positive outcomes. For some people, they will continue to benefit from their transitioning. Others, however, will realize afterward that hormones or surgery did not alleviate their issues – either in a meaningful manner or to the degree they had hoped – and/or caused many other issues they had not anticipated.

However, it is well known that the process of cognitive dissonance reduction will cause most people to frame – or to distort – their decisions and experiences in ways that reduce negative perceptions of or beliefs about themselves. In the present context, patients have a) spent a long time believing that they will benefit from, e.g., hormonal or surgical treatment – possibly believing that it is the only thing that will literally save them, or at least is the only thing that will finally bring them peace of mind, improved mental health and more adaptive social/interpersonal functioning; b) invested very much of their time, mental/physical energy and resources in planning for the transition; and c) told everyone about their plan and the extreme importance of it. Very few people would have the mental, psychological and emotional wherewithal to admit afterward that their long-awaited treatment plan was not the panacea they had believed or hoped it would be. We must therefore question the veracity of their self-report following such interventions.

Potential Impact of Legislation on Vulnerable Children and Teens

Even the strongest proponents of gender affirming care, including the ***World Professional Association for Transgender Health*** (***WPATH***), in their ***Standards of Care*** (***SOC***) ***Version 7***, acknowledge that there is no way to know which children who present as "Trans" or gender non-conforming will continue to do so once they commence puberty. The aforementioned SOC Version 7 even cites research showing that up to 94% of such children will no longer consider themselves "Trans," or will no longer report any confusion or distress regarding their sex or gender identity. Other studies have placed this number at between 63% and 88%. (Please see page 11 of the SOC Version 7 [https://wpath.org/publications/soc] for the preceding data.) Although WPATH and others have cautioned that such high rates are likely due to methodological issues of the relevant studies – particularly the inclusion of children who would not be considered Transgender through modern assessment – a review of the literature reveals that the most conservative interpretation of the data still indicates that over half (i.e., 54%) of such children will not persist in their cross-sex identification following puberty. (Please see http://www.sexologytoday.org/search/label/Transgender?updated-max=2018-10-17T20:57:00-04:00&max-results=20&start=1&by-date=false for an analysis of the relevant data.)

Yet, recent investigations have shown that between 98% and 100% of individuals who take hormone suppressors/puberty blockers such as ***Lupron*** will continue on to cross-sex hormones. Advocates for earlier and earlier transitioning claim that these extremely high numbers "prove" that the patients are indeed Transgender and know what is best for them. Critical thinkers, conversely, are concerned that the aforementioned cognitive dissonance reduction is ensuring that even those who might have otherwise desisted or detransitioned will continue on the path toward further medical transitioning.

Please consider the preceding points: 1) There is no way to know which children identifying as "Trans" will continue to feel that way after puberty; 2) legislation such as the one in question will prevent most therapists from being able to properly discuss potentially important issues that might help explain why perhaps 54% to 94% of children described as "Trans" or gender non-conforming – but who are not in fact Transgender – are experiencing confusion, distress, gender dysphoria or other related symptoms; 3) recent changes in our approach to working with and trying to help such children and teens – i.e., gender affirming care – significantly increase the risk that non-Transgender individuals will continue on the path toward transitioning, even though they would not have done so if the previously agreed upon best practice – i.e., "***watchful waiting***" – were employed; and 4) as is finally being acknowledged by numerous health care professionals and legislators around the world, not only cross-sex hormones but also the supposedly "safe" and "entirely reversible" puberty blockers can cause many serious medical and psychological complications, thereby currently preventing ethical care providers from being able to claim that the potential benefits of these interventions outweigh the risks of severe harm.

Which Science Should We Follow?

There are many misconceptions about gender affirming care, most notable of which is the false belief that there is consensus among the relevant (mental) health professionals regarding how best to treat gender dysphoria and other associated issues. In my many discussions and consultations with experts in the field, it has become clear that a relatively small number of activists, academics and "specialists" have driven the agenda that has resulted in gender affirming care replacing watchful waiting. Most (mental) health professionals are not specialists in the field of gender, hence they rely on their colleagues who ostensibly have the relevant expertise and/or on their respective professional body's guidance in such matters.

The problem is that those with sufficient expertise or experience in the field of gender who can provide contradictory evidence are typically shut down. I am in constant communication with many endocrinologists, pediatricians, psychiatrists, psychologists, psychotherapists, counsellors and others who have experienced personal and professional attacks – to the point of (almost) losing their license to practice or, at the very least, being ostracized by colleagues who are simply taking their cues from others who they believe are basing their claims on "science." This happened to me with the ***Ontario Psychological Association*** (to be clear, I am not proclaiming myself an "expert" in this area due to professional and ethical restrictions), which ended up banning me for life due to my persistent efforts a) to reveal to my colleagues the kinds of concerning developments alluded to and cited above, and b) to collaborate with appropriate individuals in order to address these concerns.

One pertinent and critical example of "science" being manipulated in what I believe to be a clearly unethical manner is a policy statement produced by The American Academy of Pediatrics (AAP) in 2018. Dr. James Cantor, who addressed a Senate Hearing with respect to Bill C6 this year – along with another colleague, Dr. Kenneth Zucker – analyzed this document, concluding that "AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide *extraordinary* evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence." (Please see: http://www.sexologytoday.org/2018/10/american-academy-of-pediatrics-policy.html.)

What Can (Mental) Health Professionals Do?

During the aforementioned Senate hearing, Drs. Cantor and Zucker expressed clearly that the proposed legislation is worded in such a way that someone working with an individual presenting with gender-related issues would literally have no way of knowing whether his or her professional decisions would be deemed illegal or, at the very least, an ethical transgression. To be clear, they were referring to simply asking a patient why he or she believed (s)he was Transgender, or trying to determine whether factors other than gender identity/expression could be contributing to the patient's distress or other symptomology.

Perhaps the greatest problem with the proposed legislation is that it conflates conversion/reparative therapy for sexual orientation with talk therapy or psychotherapy for gender-related issues. It is almost inconceivable that any (mental) health professional with relevant knowledge or experience would fail to recognize this conflation or, even worse, to promulgate it. Yet, that is exactly what Bill C6 and the bylaw in question does, e.g., "Conversion Therapy 'Conversion Therapy' means the following when used for the purpose of changing a person's sexual orientation, gender identity or gender expression, or for the purpose of repressing or reducing non-heterosexual attraction or non-heterosexual sexual behaviour:" and "The Canadian Psychological Association endorses this national guide and opposes any therapy with the goal of repairing, changing, suppressing, or converting an individual's sexual orientation, gender identity, or gender expression, regardless of age."

You might believe that the wording of your bylaw is precise enough to ensure that simply discussing such issues would never be misconstrued as "repairing, changing, suppressing, or converting" a patient's sense of gender (identity). However, those of us who have been dealing with the relevant matters are well aware of the extreme ease with which someone with dubious or malevolent motives – or someone who is confused, feeling vulnerable and/or being manipulated and misled by individuals and organizations who are intent on preventing any form of treatment other than gender affirming ones – could falsely accuse a (mental) health

professional who was acting with good and ethical intentions. The potential professional and/or legal ramifications of such false allegations is guaranteed to prevent most (mental) health care providers from helping individuals presenting with gender-related concerns. Only those who practise gender affirming care will deal with these cases. Unfortunately, more and more people are coming forward and exposing the fact that they were subjected to such approaches, despite the clear evidence that they were experiencing other serious mental health conditions that should have precluded the radical hormonal and/or surgical interventions that they regret and that they insist have caused them irreparable damage.

On a final note, one reason for the increase in people expressing extreme regret at having transitioned medically is that our definitions of the relevant concepts have been corrupted. Terms such as "Trans" or "Transgender" no longer mean what they used to mean. It appears that a significantly large proportion of children and teens are using these terms to refer to feelings, beliefs, perceptions, experiences, needs and desires that have little or nothing to do with the phenomena that have led a tiny proportion of the population a) to require hormonal and/or surgical remedies when no other approaches have worked to alleviate their distress or dysphoria, or b) to choose such radical interventions as ***adults*** – usually after receiving proper assessments, treatments and support in order to ensure that they are not making a terrible mistake.

Concluding Statements

In general, "politics" should not be influencing science, especially when the science is far from settled, as is the case with treatment for gender dysphoria and other associated mental health concerns for those identifying as Trans(gender). Although the proposed bylaw has undoubtedly been drafted with the best of intentions, I believe the issues presented above will inevitably lead to unintended harm toward highly vulnerable individuals.

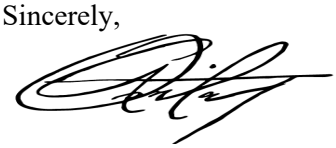
On the one hand, there is sufficient evidence demonstrating the serious harm that conversion/reparative therapy for sexual orientation can cause, thus there should be no question about banning its use. On the other hand, the evidence with respect to gender identity and gender expression is far from unequivocal, as is the evidence concerning what constitutes ***best practices*** to help people struggling with such issues.

In order not to contribute to the aforementioned uncertainty and to the risk of harm to the relevant parties, I believe the wording of the bylaw should be changed so that:

1) Any references to a) sexual orientation, sexual behaviour, sexual attraction or similar such constructs are kept distinct from b) gender identity and gender expression.
2) Any references to problematic aspects of treatment are made more explicit and more precise in order to eliminate any confusion or potential for confusion with respect to what exactly constitutes "conversion/reparative therapy." In other words, competent, experienced and ethical (mental) health professionals should be able to discuss and explore any issues germane to the individual's presenting concerns with respect to his or her personal identity, gender identity, gender expression or other relevant factors without any fear of being falsely accused of performing conversion/reparative therapy; to be clear, the presumption is that there would be no attempts to force, to shame, to manipulate or to harm patients in any manner with regard to their gender identity or gender expression.

Thank you for your attention to this matter. Should you require or desire any further information, please do not hesitate to contact me.

Sincerely,



Dr. Oren Amitay, Ph.D., C. Psych