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PSYNOOPSIS

CANADA'S PSYCHOLOGY MAGAZINE

GENDER DIVERSITY

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DISMANTLING
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PSYCHOLOGY AND OTHER
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PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE

Psynopsis is the official magazine of the Canadian Psychological Association. Its purpose is to bring the practice, study and science of psychology to bear upon topics of concern and interest to the Canadian public. Each issue is themed and most often guest edited by a psychologist member of the CPA with expertise in the issue's theme. The magazine's goal isn't so much the transfer of knowledge from one psychologist to another, but the mobilization of psychological knowledge to partners, stakeholders, funders, decision-makers and the public at large, all of whom have interest in the topical focus of the issue. Psychology is the study, practice and science of how people think, feel and behave. Be it human rights, healthcare innovation, climate change, or medical assistance in dying, how people think, feel and behave is directly relevant to almost any issue, policy, funding decision, or regulation facing individuals, families, workplaces and society. Through *Psynopsis*, our hope is to inform discussion, decisions and policies that affect the people of Canada. Each issue is shared openly with the public and specifically with government departments, funders, partners and decision-makers whose work and interests, in a particular issue's focus, might be informed by psychologists' work. The CPA's organizational vision is a society where understanding of diverse human needs, behaviours and aspirations drive legislation, policies and programs for individuals, organizations and communities. *Psynopsis* is one important way that the CPA endeavours to realize this vision.



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MESSAGE FROM THE GUEST EDITOR



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According to EGALE's April 2023 report, the human rights of 2SLGBTQIA+ people are being systematically violated in Canada, with there being over 4000 hate crimes from January 1 to March 30, 2023.¹ Additionally, "On June 5, 2023, the Human Rights Campaign declared a state of emergency for all 2SLGBTQIA+ Americans, citing 525 state-level bills targeting LGBTQ+ populations in the USA."² The campaign has declared that there is a state of emergency in the US for 2SLGBTQIA+ people. In Canada, there are similar trends, with five provinces passing legislation or policies while others are in debate, that are aimed at and hurtful to trans and gender-diverse populations, in some cases specifically youth. The Canadian Conservative Party has followed suit, "at the federal Conservative Party's policy convention in Quebec City, where 69 percent of delegates voted to bar trans children from receiving gender-affirming care, while 87 percent of delegates voted to define "woman" as a "female person" and to demand that trans women be barred from women-only spaces."² In recent months, there has been a rise in protests against gender-affirming education in schools and drag queen story hours. The positions and policies being circulated are extremely misinformed and have in some cases resulted in violence toward trans and gender-diverse individuals.

Over the course of history, the landscape for trans and gender-diverse people has evolved from Eldorado (a LGBT+ club in Berlin in the 1920s and 30s) to the Stonewall Uprising in New York City in 1969, and the gay and trans liberation movements that followed. These movements resulted in changes in discriminatory laws that existed in Canada and the United States.³ The current protests, changes in legislation and attempted changes,⁴ along with the Conservative Party's position serve to claw back the many advances made in the protection of the human and legal rights of trans and gender-diverse people. The Canadian Psychological Association has taken a strong stand to support the rights of trans and gender-diverse people (2STNBDG) as evidenced by the position statement entitled [Promotion of Gender Diversity and Expression and Prevention of Gender-Related Hate and Harm](#).⁵ This issue of *Psynopsis* is particularly timely, as the authors highlight psychology's role in promoting human rights, health, and wellness for trans and gender-diverse people and communities.

To begin, in the article entitled *Recognizing and Dismantling Cisnormativity in Psychology and Other Health Care Disciplines*, Jesse Bossé highlights the challenges faced by trans and gender-diverse people and the related negative outcomes resulting from cisnormative discrimination. Next, in the article entitled *Plot Twist: Cisnormativity Is the Fad, not the Historical Norm*, Françoise Susset and Jesse Bossé deconstruct cisnormativity from a historical perspective and remind the reader that hundreds of cultures throughout history honoured, respected, and even celebrated gender fluidity, and how that can be contrasted with the medicalizing and pathologizing positions held today. This article is followed by Françoise Susset's article entitled *Detransitioning: Welcoming Uncertainty, Change of Course, and the Possibility of Regret in a Gender-Affirming Journey*. Here, the author gives a snapshot of a client's transition journey and offers important information about integrating gender-affirming care into practice. Next, in *Gender Diversity and Eating Disorders: Where Do We Stand?*, Chloe White and colleagues present a discussion about eating disorders among trans and gender-diverse individuals and clients. They make recommendations for research and gender-affirming care for 2STNBDG clients.

Given the importance of gender-affirming care and education, these papers deliver important information so that the reader can begin to understand the skills and competencies necessary when working with trans and gender-diverse populations. I encourage you to read them and seek out additional information and resources.

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FROM THE PRESIDENT'S DESK

ELEANOR GITTENS, Ph.D.
CPA President

As the President of the Canadian Psychological Association (CPA), I stand at the forefront of a critical and timely discussion – the imperative for gender diversity within the realm of psychology across our nation. This issue is not only pertinent to our profession; it is a fundamental matter of social justice, equity, and inclusivity that requires our individual attention and steadfast commitment.

Gender diversity is a multifaceted concept that encompasses a spectrum of gender identities beyond the traditional binary understanding of male and female. It includes transgender, non-binary, genderqueer, Two-Spirit, genderfluid, and other identities that deserve recognition, respect, and validation. In the field of psychology, acknowledging and embracing gender diversity is essential to fostering a truly inclusive and representative discipline.

Our association must lead the charge in challenging outdated norms and promoting an environment where all gender identities are not only recognized but also celebrated. Earlier this year, we celebrated the release of our position statement on the [Promotion of Gender Diversity and Expression and Prevention of Gender-Related Hate and Harm](#). However, we recognize that we need to update our policy statement on *Gender Identity in Adolescents and Adults* as well as to create a policy statement specific to gender identity in children and youth. Representation matters; it empowers individuals, dispels stereotypes, and fosters a sense of belonging and acceptance within our professional community and society at large.

First and foremost, we must advocate for the inclusion of gender diversity in psychology curricula and training programs. This integration ensures that future psychologists are well-equipped to serve a diverse clientele and understand the unique experiences and challenges faced by individuals of various gender identities. By fostering educational environments that celebrate diversity, we prepare our students to be compassionate and informed professionals.

Additionally, our association must prioritize research that delves into gender-related issues, experiences, and mental health disparities. The nuances of gender identity and its intersections with other aspects of identity, such as race, ethnicity, and socioeconomic status, warrant dedicated research efforts. This research will shed light on the specific needs of diverse gender groups, enabling the development of tailored interventions and policies that promote equality and equity.

Furthermore, we must strive to create safe spaces within our profession where individuals of all gender identities feel welcomed and supported. This can be achieved through mentorship programs, support networks, and open dialogues that address the unique concerns faced by gender-diverse psychologists and individuals navigating the mental health system.

Advocacy is a crucial component of our mission. The CPA must leverage its influence to work with governments, institutions, and organizations to enact policies that protect the rights and well-being of individuals of diverse gender identities. We need to encourage the implementation of policies that facilitate gender-affirming health care, remove discriminatory practices, and ensure equal opportunities in education and employment.

As Canadians, we pride ourselves on our commitment to diversity and inclusivity. Embracing and promoting gender diversity in psychology is not just a professional obligation but a societal responsibility. Together, let us work tirelessly to eradicate discrimination, promote understanding, and create a society where individuals of all gender identities can thrive and contribute their unique perspectives to the rich tapestry of our profession and our nation. In closing, the pursuit of gender diversity within psychology is a call to action for us all. Let us unite with a shared vision of inclusivity and equity and work steadfastly towards a Canada where every individual's gender identity is respected and celebrated.



RECOGNIZING AND DISMANTLING CISNORMATIVITY IN PSYCHOLOGY AND OTHER HEALTH CARE DISCIPLINES

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We are living in a time of increased hostility, hate, and violence towards 2STNBGD¹ individuals, with a concerning upward trend in transphobic violence observed worldwide.¹ Canada is no different, with multiple provinces falling in the “high-risk” category for anti-trans legislation passing within the next two years, and two provinces with active anti-trans policies instated over the past year (e.g., school policies restricting trans youth’s ability to choose name and pronouns via mandatory parental consent).²

Gender minorities in Canada experience cis-sexistⁱⁱ discrimination and systemic barriers and are at increased risk for myriad negative outcomes, including experiencing significantly more physical and sexual violence, intimate partner violence, harassment, and discrimination in education, employment discrimination and economic insecurity, housing discrimination and homelessness, and discrimination in public accommodations.³⁻⁶ Genderqueerⁱⁱⁱ people and those who present in ways that challenge the gender binary experience even higher risks of violence and discrimination.⁷

Because of systemic barriers and structural stigma, 2STNBGD people experience one of the highest rates of suicidality, with a lifetime prevalence of suicide attempt of 40.4%, and 81.7% of gender diverse people having seriously considered suicide at some point in their lives.³ Within the trans^{iv} community, trans youths have the highest rate of suicidality, with two-thirds of suicide attempts taking place before age 20.⁸ Factors linked with an increased likelihood of suicidal ideation and attempts include discrimination, transphobia, family rejection, physical attacks, and lack of access to gender-affirming care.^{3,8} Conversely, protective factors associated with a significant reduction in suicidality include parental and social support, reduced exposure to transphobia, having identity documents that reflect one’s authentic gender designation, and access to gender-affirming care when needed.⁹ Collectively, these

findings point to an issue of social justice; they illustrate how detrimental social factors, endemic to our systems, contribute to increased rates of suicidality and mental health issues within the 2STNBGD population.⁸

Further, cisnormative^v discrimination and stigma create excess stress for 2STNBGD individuals that limits opportunities and access to important societal resources, creating significant mental health disparities between 2STNBGD and cisgender people.¹⁰ For example, there are higher prevalence rates of anxiety, depression, trauma, and substance use in gender diverse individuals compared to their cisgender counterparts. 2STNBGD people of all ages also experience significant health disparities and barriers in accessing health care. Among the most cited obstacles to accessing health care reported by trans individuals are difficulty accessing competent health care providers due to lack of knowledgeable practitioners and lack of cultural competency, financial barriers, and discrimination.¹¹ As a result, 2STNBGD individuals often refrain from seeking healthcare services out of distrust towards healthcare professionals and the healthcare system in general and out of fear of experiencing discrimination, trans-specific negative interactions, conversion therapy-type practices or other traumatic experiences.¹²⁻¹³ It is crucial to recognize that health professionals, inclusive of psychologists, have a history of pathologizing people with diverse gender identities (e.g., Gender Identity Disorder) and playing a “gatekeeping” role in controlling access to gender-affirming care.

Taken altogether, this illustrates how the poor health outcomes of 2STNBGD people are direct consequences of cis-sexist discrimination. The way society and systems, in particular healthcare systems, treat trans and gender diverse people creates psychological distress and harm. We must work to make legal and policy changes that eliminate cis-sexist discrimination, decrease social exclusion, and increase access to safer and gender-affirming health care for 2STNBGD people.⁹ Psychologists and other

health professionals must take on this work. We must take responsibility for dismantling cis-sexism within the field, but also dismantling the cis-sexism to which we have heavily contributed (e.g., pathologizing normal gender diversity via mental health disorders and diagnoses), and which echoes in legislation, policy, and health and social services. It is in recognition of this responsibility that the CPA has developed a position statement titled “[Promotion of Gender Diversity and Expression and Prevention of Gender-Related Hate and Harm](#).” It is the hope that other health professionals, legislators, and policymakers, and those who deliver health and human services will join the CPA in amplifying the voices of 2STNBGD individuals and communities and their lived experiences, advocate for and contribute to social, legal, and policy changes that will eliminate cis-sexist discrimination, mitigate negative social determinants of health, and protect 2STNBGD people’s rights.

i The initialism 2STNBGD stands for Two-Spirit, Trans, Non-binary, and other Gender Diverse. Other Gender Diverse includes, but is not limited to, genderfluid, agender, genderqueer, and questioning individuals. We represent Two-Spirit individuals first out of respect for Indigenous ancestry and ancestral homelands and acknowledgement of past violence and human rights violations.

ii Cis refers to cisgender - someone whose gender identity aligns with their sex assigned at birth; the term cis-sexist is used to refer to the assumption that cis identities are more legitimate and valid than trans identities, as well as the system of oppression that causes harm to 2STNBGD people.

iii Genderqueer is an umbrella term that includes gender identities outside of the gender binary (i.e., man and woman) and may include, but is not limited to, moving between genders (genderfluid), a combination of genders, other-gender, agender, or those who do not and/or cannot name their gender.

iv Trans (transgender) is an umbrella term that refers to people whose gender identity differs from their sex assigned a birth; this includes trans women, trans men, and may also include non-binary people as well.

v Cisnormativity refers to the assumption that everyone is cisgender and privileges cisgender identities above other gender identities.

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PLOT TWIST: CISNORMATIVITY IS THE FAD, NOT THE HISTORICAL NORM

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They were, and still are referred to as Nádleehí,¹ Muxe,² Calalai,³ Kathoey,⁴ (see cover photo of article: Kathoey on the stage of a cabaret show in Pattaya), Mähū,⁵ and a multitude of other designations specific to their languages and cultures. Today, when referring to North American Indigenous cultures, we refer to them as Two-Spirit, a relatively recent term that some say was coined by Dr. Myra Laramee, Ph.D., an Anishinaabe Elder: “Your gift is to see the world always in two sights, with two feelings of the heart; it’s neither male nor female, but it’s both; it’s neither up nor down, but in the middle. It’s complex.”⁶

Throughout millennia, in hundreds of cultures across the globe, they were the leaders and the healers, the wise ones consulted on all relevant community matters. They could be fluid in their social roles, at times caretakers, at times fierce warriors. Because they embodied both the male and female spirit, they were believed to possess a deeper understanding of human experiences and the relationship between humans and their Gods. One such individual was We’Wha, a Zuni Ihamana⁷ of the American South-West who was sent by their community to negotiate land claims with then President of the United States, Grover Cleveland.

FIGURE 1

We-Wa [sic], a Zuni Ihamana, weaving.⁸



In many cultures, gender was determined by observing the child growing, by analyzing their dreams, by consulting the elders, not by an observation of their genitals at birth. Their gender

was consecrated by means of a coming-of-age ceremony at puberty during which they were offered a wardrobe that corresponded to their gender.⁹ Families felt honoured to have a Two-Spirit or Gender Diverse (2SGD) child.

This perspective on 2SGD people stands in sharp contrast to the medicalized, pathologized vision that has almost entirely replaced it. A dramatic shift occurred when Europeans began their journeys to various continents. Few Peoples were spared their destructiveness. They were colonizers or missionaries who came in the name of their king or queen. Everywhere they journeyed, they were confronted by the many cultures whose paradigms in regard to gender and sexual diversity challenged their religious beliefs. In many cases, 2SGD people were the first to be put to death and every attempt was made to erase the fact of their existence.

From this significant but largely ignored history emerges two important observations. First, the place of respect occupied by 2SGD people across time and geography is remarkably similar; a dramatic contrast to our current paradigm that views them as ill and deficient or indiscriminately following some new social trend. Second, non-binary identities have always existed and are the historic norm. These 2SGD people belonged to a third, fourth, fifth, or sixth gender within complex cultural and spiritual systems; these cultures understood gender to be anything but binary.

The destructive forces of European colonization are still embedded in the way society and systems treat 2SGD individuals. Until recently, many Canadian provinces still offered government-funded conversionⁱ therapies aimed at coercing 2SGD individuals into taking on a cisgender identity, presentation, and social role. In fact, conversion “therapy” was only criminalized in Canada in 2022. Despite this, some conversion practices such as unnecessarily delaying, discouraging, or withholding necessary medical care like puberty blockers or hormone therapy still take place in healthcare settings.¹⁰⁻¹²

The pathologizing view of gender diversity that followed colonization is still well-ensconced in our disciplines. We are still operating within a cisnormative framework. We’ve moved from a “gender-affirming care for a chosen few” model to a “gender-affirming care for those who fit a narrow and specific narrative of transness” model. We have created and perpetuated a “transnormative”ⁱⁱ understanding of gender diversity, recognizing only trans identities that adhere to specific, generally binary, gender tropes.¹³ Under this transnormative understanding of gender diversity, the validity of trans identities is determined by how closely they mirror heterocisgender identities.

Gender diversity is not a fad. It is anchored in a rich and complex history. This knowledge serves as a call to correct our trajectory, to return to 2SGD individuals the fundamental right to be believed, and the dignity and respect that is their legacy.

i The Canadian Criminal Code defines Conversion therapy as: “a practice, treatment or service designed to: change a person’s sexual orientation to heterosexual; change a person’s gender identity to cisgender; change a person’s gender expression so that it conforms to the sex assigned to the person at birth; repress or reduce non-heterosexual attraction or sexual behaviour; repress a person’s non-cisgender gender identity; or repress or reduce a person’s gender expression that does not conform to the sex assigned to the person at birth.” (An Act to Amend the Criminal Code (conversion therapy), SC 2021, c 24, art 5).¹³ While this is how the Canadian law currently defines conversion therapy, the reality of conversion practices exists on a broader spectrum of efforts aiming to change or repress non-cisgender identities. This spectrum of conversion-type practices includes “any form of efforts, explicit or implicit, which pressure someone to deny, suppress, or change their sexual orientation, gender identity, or gender expression to heterosexual and/or cisgender.”¹⁴

ii The term transnormative as defined by Riggs, et al.¹³ refers to “the ways in which dominant narratives about what it means to be transgender emphasize a particular and narrow set of tropes to which all transgender people are expected to adhere,” and includes “expectation that all trans people conform to a “wrong body narrative” when describing their gender, all transgender people require medical treatment, and all transgender people should seek to present and be perceived as cisgender.”

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DETRANSITION: WELCOMING UNCERTAINTY, CHANGE OF COURSE, AND THE POSSIBILITY OF REGRET IN A GENDER-AFFIRMING JOURNEY

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(This article is taken from an opening address given in November 2022 at a York University Symposium on Detransition).

Despite what the media would have us believe,¹ very few individuals will detransition¹ and return to a permanent cisgender identity. Even fewer of those will experience ongoing regret about their transition choices.^{2,3}

Years ago, I followed a 16-year-old as they navigated social, legal, and medical options of embodying a gender different than the one theyⁱⁱ were assigned at birth. During this time, we had identified and addressed many issues. This was someone who presented no significant mental health concerns but needed support as they came out in various spheres of their life, including to key family members. *Our work together spanned eight months.*

A few years later they came back, requesting my support to reverse the effects of a gender-affirming surgery they'd obtained. During this new phase of our work, I asked if there was anything I could have done differently to prevent this outcome.

They answered: "At first, I was angry with you for letting me go through with it. Then I realized that the best thing you ever did was to give me the entire responsibility for my decision."

Then they said: "As I was lying on the operating table, I became filled with doubt but figured it was too late to turn back...". My heart sank.

My heart sank because once again I was confronted with the profound inadequacies of the system we have created. A system which puts pressure on our clients to provide a convincing and unwavering narrative of gender dysphoria to obtain the coveted referral letter; and on ourselves to somehow know and predict people's destination on their gender journey. My heart sank because this young person did not know they could walk out of that operating room without losing any future access to it. We had failed to consider that whatever certainty they felt at one point

in their journey could change over even a short amount of time.

This is the nature of any significant decision we make. Why should decisions surrounding identity and/or gender-affirming care be any different?

As health professionals, we are not trained to make the big decisions for our clients. I have supported people through very painful decision-making processes, sometimes over years, about whether they should leave their spouse, change careers, move to another part of the world, have children, or come out as gay. We are trained to journey with our clients, to address whatever stands in the way of arriving at their own truths. Never, in over 30 years of practice, have I made the decision for them.

There may be a temptation to use our clients' mental health as a kind of divining rod to enable us to predict regret. We seek to comfort ourselves in our belief that given enough time, psychological testing, and questionnaire administration, we will know "The Truth" about an individual's gender identity, embodiment needs, and gender journey. The only fact that currently stands is that we have absolutely no way of predicting who is likely to change course and detransition.

We are tempted to equate the presence of any mental health challenge, let alone serious mental illness, as a useful indicator. It isn't. This is not to say that trans, non-binary, gender-diverse individuals as well as those who will eventually question and choose to return to a cisgender identity, can't experience mild-to-severe mental health challenges. They can. And that's the point: They all can; studies going all the way back to the middle of the last century have confirmed a higher rate of mental health challenges in LGBTQ+ communities as well as in any other marginalized groups experiencing Minority Stress.⁴ We must be clear that there is no mental health diagnosis that excludes a person, given the appropriate support, from journeying successfully towards gender-related embodiment goals.⁵

Furthermore, what we do know from numerous studies and reports over the years leaves little doubt as to the significant improvement in mental health associated with access to gender-affirming care.⁶⁻⁸

For a more gender-affirming practice, consider the following:

- Welcome uncertainty, doubt, and questioning without supplanting your clients' decision-making power with your own.
- Shift the paradigm to one that recognizes gender fluidity: Current models fail to account for the dynamic nature, the temporality, or the complexity of identities and embodiment needs. Detransition or change of course rarely equals regret.
- Move away from an approach that aims to prevent detransition, towards an approach that aims to support the complexities of any gender journey, including the decision to change course or detransition.⁹
- Your informed consent process should systematically and explicitly communicate to clients that they can access your services and obtain your support if they discontinue any dimension of their transition or detransition.
- Recognize that a cisgender identity is not necessarily the default setting. A good portion of the individuals who detransition will retransition.¹⁰
- Make services accessible and affordable: Voicing uncertainty, questioning, and doubt is a challenge when the meter is running.
- Value the importance of peer support and community services as they create spaces for exploration of gender identity and embodiment.

ⁱ "Detransition" is the term used by many of those who experience this change of course. It is a problematic term when used to describe a monolithic phenomenon. It serves here as an umbrella term encompassing many varied and nuanced journeys.

ⁱⁱ "They" is used here not as an indication of this client's gender identity but to protect their privacy.

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GENDER DIVERSITY AND EATING DISORDERS: WHERE DO WE STAND?

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Eating disorders affect nearly 1,000,000 Canadians at any given time, and have the highest mortality rate of any mental illness.¹ Importantly, eating disorders affect gender diverse and transgender people at greater rates than cisgender individuals.²⁻³ Research has suggested that some of the central symptoms of eating disorders, including disliking one's body, body checking, and an overemphasis on importance of shape and weight, are reported by 90% of transgender and non-binary youth.⁴

These statistics are less surprising when contextualized by the link between societal appearance pressures and eating disorders. Western society places significant importance and pressures on appearance. However, one's gender has a large influence on the appearance ideals and sociocultural pressures that matter most to different people.⁵ For instance, women have classically been pressured to conform to the "thin ideal" body that often has an underweight body mass index (BMI).⁶ Alternatively, men are faced with sociocultural pressures to conform to an increasingly muscular and lean ideal which may result in appearance concerns for both muscularity and leanness.⁷ However, experiencing these ideals as a cisgender individual is likely different from experiencing these ideals as a non-binary or transgender individual. Body image is likely to be influenced by a transgender individual's experience of "passing" as cisgender (e.g., the ability to be identified as their gender identity based on their outward appearance), or their interactions with a largely cisgender and heteronormative society that spews transphobia. Research has shown that nearly nine in 10 transgender and non-binary youth who experience body dissatisfaction report that their dissatisfaction is related to the difference between their gender identity and their sex assigned at birth.⁴ Thus, transgender and non-binary youth are not just worried about achieving a body ideal to fit in with their peers, they are also concerned about fitting into a cisgender and heteronormative mold.

While body dissatisfaction is a major intervention target for treatments meant to decrease eating disorder risk and symptoms, there are gender-specific differences that should be considered within treatment administration. In this same vein, when working with non-binary and transgender youth, it is important for practitioners to consider the specific reasons for why non-binary and transgender youth engage in eating disorder behaviours. For instance, many transgender and non-binary youth report engaging in eating disorder behaviours in attempts to change their body to be more in-line with their gender identity.⁸

The use of eating disorder behaviours may be the result of a lack of gender-affirming care in the individual's life, leading them to pursue potentially harmful behaviours to achieve their body ideals. However, even when some non-binary and transgender individuals seek treatment for eating disorder behaviours, many report difficulty finding a clinician who can incorporate gender-affirming care into their treatment.⁹ This may be the result of conflicts between traditional eating disorder treatment and gender-affirming practice as there is concern that traditional treatment could further add to feelings of gender dysphoria. Common eating disorder treatment practices such as "body acceptance" or "body positivity" often contrast the practices that transgender and non-binary youth feel would work best for them.¹⁰ More specifically, a positive body image approach, such as learning to love and accept one's body, may worsen dysphoria by invalidating and ignoring transgender and gender diverse body discomfort.⁹ In contrast, the concept of "body neutrality", which focuses on the functions of the body instead of appearance, has been recommended as being a more helpful concept to use in the treatment of eating disorders for transgender and gender diverse individuals.¹⁰⁻¹¹

Overall, while gender non-binary and transgender individuals are more likely than cisgender individuals to experience eating disorder symptoms, little research currently focuses on these populations. Moving forward, research should examine whether the specific strategies or concepts within existing treatments are acceptable for gender diverse individuals. Additionally, research should seek to develop and test new forms of treatment and eating disorder screening tools to help with diagnosis for transgender and gender diverse individuals.

As research focuses on these developments, clinicians should aim to better integrate gender-affirming care into existing treatments through consideration of gender-specific concerns and increased provider education. For example, some recommendations include providing gender-neutral bathrooms in treatment centres, using proper pronouns and chosen names, considering an individual's gender identity throughout the process of eating disorder treatment, as well as hiring individuals with lived experience to help with inclusive treatment programs.¹⁰ Eating disorder treatment providers should also seek learning opportunities that educate on the strengths and resilience of transgender and gender diverse individuals and communities, as well as potential challenges such as gender dysphoria and discrimination.¹⁰

**FOR A COMPLETE LIST OF REFERENCES,
PLEASE GO TO [CPA.CA/PSYNOPSIS](https://cpa.ca/psynopsis)**

CPA HIGHLIGHTS

A list of our top activities since the last issue of *Psynopsis*.

Be sure to contact membership@cpa.ca to sign up for our monthly *Psynature* e-newsletter to stay abreast of all the things we are doing for you!

CONGRATULATIONS TO THE 2023 RECIPIENTS OF CPA CERTIFICATES OF ACADEMIC EXCELLENCE!

In 2023, more than 100 students were awarded CPA Certificates of Academic Excellence for their outstanding achievements at all levels of study (Honours, Master's, Ph.D.) in each Canadian Department of Psychology.

CPA RELEASES RECOMMENDATIONS FOR THE DECRIMINALIZATION OF ILLEGAL SUBSTANCES IN CANADA (SEPTEMBER 2023)

Led by Co-Chairs, Dr. Andrew Kim, Dr. Keira Stockdale, and the late Dr. Peter Hoaken, the CPA Board of Directors approved a position paper – *The Decriminalization of Illegal Substances in Canada* – developed by the Working Group on Decriminalization. In addition to seven actionable recommendations for governments and relevant stakeholders, the report calls for criminal penalties associated with simple possession of illegal substances to be removed from the Controlled Drugs and Substances Act, and strongly recommends that the determination of the quantity of “personal use” should be made in consultation with all relevant stakeholders, including people with lived and living experience with substance use.

FEDERAL GOVERNMENT 2024 PRE-BUDGET CONSULTATIONS (AUGUST, 2023)

In the lead-up to the federal government's 2024 Budget, the CPA submitted its Brief to the House of Commons Standing Committee on Finance which contains three financial asks that focus on improved access to care across the public and private sectors, creating more training positions for psychology, and increasing research funding to the Tri-Councils and funding for students and post-doctoral fellows. The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) and the Canadian Consortium of Research (CCR), both of which the CPA is a founding member, also submitted a Brief.

CPA HIGHLIGHTS

CPA RELEASES TELEPSYCHOLOGY GUIDELINES (SEPTEMBER 2023)

The CPA Board of Directors approved the release of new Guidelines on Telepsychology. The intent of the guidelines is to provide direction and support to Canadian psychologists in order to enable them to practice ethically, competently, and reflectively while engaging in a virtual environment. The guidelines replace the Interim Ethical Guidelines for Psychologists Providing Psychological Services via Electronic Media, approved in 2020.

NEW “PSYCHOLOGY WORKS” FACT SHEETS

The CPA has created three new “Psychology Works” Fact Sheets, dealing with Food Insecurity, Homelessness, and Poverty. These fact sheets were created by the Canadian Poverty Institute at Ambrose University, and were published in September.

ACCREDITATION STANDARDS RELEASED

The Sixth Revision of the CPA’s Accreditation Standards for Doctoral and Residency Programs in Professional Psychology has been approved by the CPA Board of Directors and was presented at the CPA’s 84th Annual National Convention in June. This revision is the result of a six-year process led by the CPA’s Accreditation Panel and Standards Review Committee, including representation from Clinical, Counselling, School, and Clinical Neuropsychology in both doctoral and residency programs. This included surveys, public consultation, and focused consultations with CPA sections and groups external to the CPA.

NEW EPISODES OF THE CPA PODCAST MIND FULL

Recent episodes of *Mind Full* are available to stream and download on listeners’ preferred podcast platform. Dr. Jiaying Zhao discusses her new study ‘Cash Transfers Reduce Homelessness’, Dr. Andrew Kim talks about the CPA’s Position Paper on decriminalization, and Dr. Alex DiGiacomo makes two appearances as she cycles across Canada to raise awareness and money for youth mental health.



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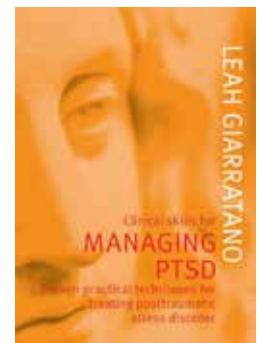
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[Watch Leah present an overview of Day 1-4.](#)

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