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Sexual Orientation and Gender Identity Conversion Therapy: Or, Who Put The 'GI' in 'SOGI'?

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Abstract

In the last few years, many countries have introduced (or are proposing to introduce) legislation on 'conversion therapy', prohibiting attempts to change or suppress sexual orientation and/or gender identity. This legislation covers 'aversion therapy', a form of torture that has already been criminalized in most progressive countries, and also 'talk therapy', involving things like counselling, psychoanalysis, and prayer. Focusing on this latter category of practices, I explain what is at stake in the fact that sexual orientation and gender identity have been paired for the purposes of this legislation. I use a particular law reform institute's approach to this legislation as a case study, and review their literature review in mind to discovering whether they provided sufficient empirical justification for including gender identity in their conversion therapy legislation. I conclude that they did not, and suggest that the pairing of sexual orientation and gender identity may be purely political.

Keywords: Sexual orientation, Gender identity, SOGI, Conversion therapy, Legislation, Evidence-based medicine, Evidence-based law

1. 'SOGI' protections

In May 2020 the United Nations put out its *Report on conversion therapy*. The report opens with the question 'What is conversion therapy?' and answers: '"Conversion therapy" is used as an umbrella term to describe interventions of a wide-ranging nature, all of which have in common the belief that a person's sexual orientation or gender identity (SOGI) can and should be changed. Such practices aim (or claim to aim) at changing people from gay, lesbian or bisexual to heterosexual and from trans or gender diverse to cisgender' (United Nations 2020). Conversion therapy practices, the report says, are 'deeply harmful interventions that rely on the medically false idea that LGBT [lesbian, gay, bisexual, and transgender] and other gender diverse persons are sick' (*ibid*). However, a couple of paragraphs later, we are presented with the following claim: 'in 2016, the World Psychiatric Association found that "there is no sound scientific evidence that *innate sexual orientation* can be changed"' (*ibid*, my emphasis).

Why is evidence about attempts to change sexual orientation—evidence about the 'LGB' part of the 'LGBT and other gender diverse persons' that the report refers to—being used as the basis for conclusions about attempts to change gender identity—the protected attribute transgender and 'other gender diverse persons' are assumed to have? In a context in which sexual orientation and gender identity are bundled together as 'SOGI', and the people who have minority/atypical sexual orientations and gender identities[1] are bundled together as 'LGBT' persons, it is an easy inference from 'innate sexual orientation' not being able to be changed to innate gender identity not being able to be changed. The assumption is that what is true of some members of that group is also true of others. But the 'LGBT' is not a group that carves nature at its joints. It's a coalition of different groups, strategically allied for political purposes. (So too, for that matter, is the LGB). The protected attribute of the LGB is sexual orientation; the protected attribute of the T is gender identity. This same point could be made at greater length for the 'LGBTQIA+' community (adding in the protected attributes, or properties, of being intersex, asexual, or queer—for the latter read being polyamorous or as a euphemism for any of the other letters). There is no reasonable basis for assuming that what is true for sexual orientation is true for gender identity, or any other property or attribute of the community represented by the longer initialism.

Once we see that, we're in a position to ask: *is* gender identity innate, in the same way the World Psychiatric Association takes sexual orientation to be?[2] What if gender identity is *dissimilar* to sexual orientation—perhaps because gender identity is considerably more fluid, changing across people's lifetimes;[3] or because there are many more pathways to atypical gender identity than there are pathways to minority sexual orientation; or because unlike sexual orientation, there is a much higher proportion of people who have false beliefs about their gender identities, or who

[1] For simplicity I'm going along with the assumption of universal gender identity, which is the claim that everyone has a gender identity, where most people's gender identity is 'congruent' with their sex or their 'gender assigned at birth'. (The idea being that all males are 'assigned boy' and all females are 'assigned girl' and that for most people this will be correct, but for trans and gender diverse people it will not.) However, some people, especially radical and gender-critical feminists, reject the assumption of universal gender identity, denying that they have gender identities at all. I am a gender-critical feminist. Because our conception of gender is external, about what is done to a person on the basis of her sex, it is incoherent for us to think of ourselves as having an identity that is either 'congruent' or 'incongruent' with our assignment to femininity. Even those who like and accept femininity wish that it were not imposed on the basis of sex. All such feminists would thus count as 'trans' (in virtue of 'incongruence') on the universal gender identity assumption. However, that would be to interpret us through the conceptual parameters of gender identity ideology, which we reject. Feminists are not trans. We are just women who reject gender norms, and because we reject the ideology of gender identity, deny that we have a gender identity at all.

[2] It might also be that sexual orientation is not innate, and yet is immutable (for example, becoming fixed in early childhood); or is not innate, and not immutable, and yet attempts to change it are harmful. In these cases (and any combination of innateness, immutability, and harmfulness) we can also ask whether gender identity works the same way, or not, and criticize the assumption that it does, if offered without evidence.

[3] Kenneth Zucker and colleagues, reporting on more than 40 years of referrals to their Gender Identity Service, Child, Youth, and Family Program at the Centre for Addiction and Mental Health, Toronto, say 'For children who present clinically with the diagnosis of GID [Gender Identity Disorder], long-term follow-up studies suggest that their gender identity is not necessarily fixed. The majority of children followed longitudinally appear to lose the diagnosis of GID when seen in late adolescence or young adulthood, and appear to have differentiated a gender identity that matches their natal sex' (Zucker et al. 2012, p. 375; see also references in the paragraph of this quote).

self-diagnose specific ways that they feel as gender identity when there is a better explanation available? What if there is no more than a lazy generalization here, and good intentions about protecting LGB people from harm are being used to prevent any challenge to claims about gender identity?[4]

This might strike readers as a perplexing set of questions. Conversion therapy interventions aim to change people from homosexual or bisexual to heterosexual, and from trans or gender diverse to 'cisgender' or gender-conforming. Aren't such interventions bad, and worth prohibiting, *regardless of* the similarity or difference between sexual orientation and gender identity? Indeed, the United Nations report suggested that conversion therapy practices 'violate the prohibition of torture and ill-treatment', that they 'may amount to torture depending on the circumstances, namely the severity of physical and mental pain and suffering inflicted' (*ibid*). Who would argue against a prohibition on *torture*? Isn't it to put dry academic concerns about scientific evidence ahead of reducing harm to real people, to seek to peer further into the science and politics of 'SOGI'?

I believe not, for two reasons. First, the kinds of conversion practices that would rise to the level of torture, when imposed upon an adult without their consent, are already prohibited by criminal law and by professional standards in liberal democracies, including Australia and the United Kingdom. So what federal or state-level conversion therapy legislation is doing is banning those *further* practices which are not already prohibited. It is useful to think of 'conversion therapy' as an umbrella term covering a number of distinct types of practices, and to be clear about which of these practices it may be misguided to prohibit on the basis of what might be a careless or politically-motivated generalization. Let's focus on the conversion practices that aim at changing or suppressing sexual orientation, which are well-documented. (Whether there are conversion practices aimed at suppressing gender identity is the topic of Sec. 3.)

In a systematic review focused on 'organizing the spectrum of practices that could be considered conversion therapy' posted by the Office of the United Nations High Commissioner for Human Rights,[5] four categories of practices were identified: 'psychotherapy, medical, religious, and punitive' (OHCHR *n.d.*, p. 3).[6] Psychotherapy included two very different types of practices, talk-based therapy and behavioural reconditioning. The behavioural subtype, perhaps better described as 'aversion therapy', is what many people think of when they hear the words 'conversion therapy'. This includes electric shock treatment, inducing of nausea, orgasm reconditioning, and inducing of disgust (*ibid*, p. 4). Medical interventions (largely historical: the review describes them as 'archaic in nature' but notes that 'there are countries around the world whose draconian laws may allow for these antiquated and destructive medical practices') included lobotomies, removal of sex organs, medication, and hormone or steroid therapy (ibid). Religious interventions included prayer, conversion camps, 12-step programmes, and exorcisms (*ibid*, p. 5); and punitive interventions included physical abuse and humiliation (*ibid*). (For the full taxonomy and references see their Figure 2, pp. 6-9).

This taxonomy is organized by the motivation (religious, punitive) or profession (medical, therapeutic) of the conversion therapy practitioner, rather than by the type of intervention that is made. Another way to distinguish conversion practices would be by whether they are physical

[4] For a recent survey of the politics surrounding contestation of the affirmation-only approach to gender identity in the context of a UK children's service, see (Barnes 2023).

[5] https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Academics/Conversion-Therapy-Lit-Review.pdf

[6] There are no page numbers on the document, so page numbers used here refer to the PDF.

or non-physical, and further, whether they are consented to or not (and relatedly, whether they are initiated by the LGBT person themselves, or by someone else). The whole category of medical interventions, the whole category of punitive interventions, and much of the behavioural reconditioning subcategory of psychotherapy interventions are physical, and so involve acts that when performed without consent would count as assault.[7] Furthermore, the medical and therapeutic (aversion) interventions would likely violate the professional standards of their practitioners' fields. This leaves two categories that are non-physical: talk-based therapies (from the psychotherapy category), and prayer (from the religious category). Should these practices be prohibited? Further considerations relevant to answering that question might include whether the LGBT person subject to the practices is a child or an adult; whether they initiated the conversion therapy or someone else did; and whether they consent to the conversion therapy (and when they're a child or adolescent, whether they are actually capable of giving informed consent). It also matters, surely, whether conversion therapy works; what the LGBT person stands to gain from it when it works (if it does); and what the LGBT person stands to lose from it when it doesn't work (if it doesn't). Even those who think it's clear cut that physical conversion therapy practices should be prohibited (regardless of consent) should still be open to the question of whether non-physical interventions—initiated by an LGBT adult and fully consented to—should be prohibited by law.[8]

The second reason why I don't think it's inappropriate to look into the science and politics of 'SOGI' is that there are multiple stakeholders to the matter of prohibiting conversion therapies, especially when it comes to prayer and discussion-based therapy. Conversion therapy legislation aims to prohibit the change or suppression of sexual orientation or gender identity. Depending on the exact form of the legislation, it can put third parties—including the parents of children who claim atypical gender identities—at risk of fines, jail time, and potentially even the loss of custody of their children. The *Change or Suppression (Conversion) Practices Prohibition Act 2021*, in place in Victoria, Australia, for example, makes it a crime for third parties (with the exception of some health service providers)[9] to engage in conversion therapy (the Act calls this 'change or suppression practices'), with maximum individual penalties of 10 years in prison or $222,000 in fines.[10] The Tasmanian Law Reform Institute's final report on conversion practices recommended that 'conversion practices directed towards children should be categorised as a form of child abuse' (Tasmanian Law Reform Institute 2022, p. *v*). If children who claim atypical gender identities *are wrong*, and their parents are acting in their best interests by refusing to outright affirm those claims—trying to keep their children's options open for the future, and especially trying to avoid any medical or surgical transition—then those parents *should not* be put at risk of criminal punishment. Neither should any third parties acting in good faith, like teachers or extended family members.

The ethical and political implications of generalizing from sexual orientation to gender identity, if it turns out to not be justified by evidence of relevant similarity, also go further than just the risk to third parties created by conversion therapy legislation. Suppose for a moment that sexual orientation is innate and immutable, and gender identity is neither of these things.[11] On this

[7] In some rare cases where there is consent they may still count as assault, if the harm caused is serious enough. See e.g. discussion in (Bartle 2018).

[8] For several composite case studies of such persons from the perspective from a therapist who believes that change of sexual orientation is possible, see (Nicolosi 1993).

[9] The Act makes exceptions for 'practice or conduct of a health service provider that is, in the health service provider's reasonable professional judgement, necessary—(i) to provide a health service; or (ii) to comply with the legal or professional obligations of the health service provider' (5(2)(b), p. 7).

[10] https://www.legislation.vic.gov.au/as-made/acts/change-or-suppression-conversion-practices-prohibition-act-2021

[11] Or more weakly, suppose that for almost everyone who claims a minority sexual orientation, that orientation is innate and immutable; while for almost

assumption, wrongly taking gender identity to be innate and immutable like sexual orientation causes clinicians to affirm children's and adults' claims about gender identity instead of looking more holistically for problems that the child or adult might be mistakenly self-diagnosing as gender identity. (Not to mention that if attempts to change sexual orientation are harmful, but attempts to change gender identity are not, then in a misguided attempt to avoid harm we might actually be *harming* people who claim to have gender identities, by channelling them toward non-necessary medical and surgical interventions that can result in serious long-term health impacts including sterility and loss of sexual function).

Another risk of generalizing from sexual orientation to gender identity is that the public will be more likely to support laws that make legal sex a matter of statutory declaration ('sex self-identification' laws). Just as gay people 'know who they are', so do trans people; 'gatekeeping' legal sex status appears paternalistic rather than precautionary. Desisters (people who transitioned socially then went back to their original sex/gender) and detransitioners (people who transitioned medically and/or surgically and then went back to their original sex/gender) will be subject to testimonial injustice, because we'll conceptualize them as we do 'ex-gays', believing that they have not *really* ceased to have atypical gender identities, they've only chosen faith or family over 'out' transgender status.[12]

Negative impacts on the safeguarding of women and children, and on women's boundaries, will be harder to conceptualize as such. Although it does not follow logically that having an innate gender identity of 'woman' would make male people more like female people and less like other male people, there does seem to be a popular assumption that this is so. If it is assumed that males with atypical gender identities are more like others of their identity category than their sex category, exceptions are more likely to be made of them when we generalize about their sex category. (For a concrete example, we'd be more likely to believe that statistical generalizations about male physical and sexual violence don't apply to transwomen). Negative impacts on freedom of expression, freedom of opinion, and freedom of speech won't be taken seriously, for the more real a protected attribute, the more likely people will be to settle a 'balance of interests' between the speech of critics and the alleged harm to the minority with that attribute in favour of eliminating harm to the minority.

Finally, if gender identity is wrongly assumed to be innate and immutable like sexual orientation, then schools that socially transition children without their parents' knowledge or consent will appear as heroes protecting vulnerable children from the 'transphobia' of parents who refuse to accept them, rather than as villains overstepping their proper limits to enforce particular decisions about what is in the best interests of the child.

For all these reasons and more, it matters how sexual orientation and gender identity are alike, and how they are different. To fully assess that, one would have to consider the scientific literature on innateness and immutability for both sexual orientation and gender identity.[13] That is not my project here. Instead, I want to ask a more limited question, which is about the evidence base for the prohibition of conversion therapy in particular. Perhaps there isn't one, and the argument is moral or political, rather than empirical. But if there is good empirical evidence that

everyone who claims an atypical gender identity, that gender identity is not innate and not immutable. That leaves open that there is a small proportion of socially constructed sexual orientations, and a small proportion of innate and immutable gender identities.

[12] To be clear, I am reporting what I take to be the folk attitude toward the claims of self-proclaimed 'ex-gays', rather than my own beliefs about whether it is possible to change one's sexual orientation.

[13] This is a project which I have commenced, but not completed, and which will probably require a book-length treatment.

conversion therapy is being done on the basis of gender identity, and that it is similarly harmful, that would provide a strong justification for including gender identity alongside sexual orientation in conversion therapy legislation.[14] I'll focus on the case study of the Tasmanian Law Reform Institute (TLRI), because they are somewhat unique in taking an evidence-based approach to the introduction of conversion therapy legislation in the Australian state of Tasmania. My aim is to seriously consider the evidence cited by the TLRI, not to search out evidence that they may have missed, or that may have been published since their report.[15] Before that, I'll give a brief overview of the existing Australian conversion therapy law, to illustrate the very different forms that such legislation can take.

2. Australian conversion therapy law

Queensland's *Health Legislation Amendment Act 2020* prohibits health service providers from performing conversion therapy on their patients or clients.[16] Conversion therapies are defined as practices that attempt 'to change or suppress a person's sexual orientation or gender identity' (28(5B)(213F), p. 18). 'Health service providers' is understood broadly, to include 'doctors, nurses and psychologists, as well as… counsellors, naturopaths and social workers', and covers both paid and unpaid services offered by these health service providers.[17] But the Act exempts from counting as conversion therapy any 'practice by a health service provider that, in the provider's reasonable professional judgement—(a) is part of the clinically appropriate assessment, diagnosis or treatment of a person, or clinically appropriate support for a person; or (b) enable or facilitates the provision of a health service for a person in a manner that is safe and appropriate; or (c) is necessary to comply with the provider's legal or professional obligations' (28(5B)(213F)(2), p. 19). Assisting a person with a 'gender transition' is noted as an example that would fall under this exception (28(5B)(213F)(3a), p. 19).[18] The maximum penalties for health service providers who perform conversion therapies are 18 months in jail or around a $22,000 fine if the person subjected to conversion therapy was a vulnerable person, otherwise it's 12 months in jail or around a $14,000 fine (28(5B)213H)(1-2), p. 20). (Vulnerable persons are children and those with impaired capacities for understanding or informed consent) (28(5B)(213H)(3), pp. 20-21). What is noteworthy about the Queensland legislation is that it only applies to health service providers.

The Australian Capital Territory (ACT) *Sexuality and Gender Identity Conversion Practices Act 2020* prohibits all adults from performing conversion practices against a 'protected person', which means either a child or a person with impaired decision-making ability as regards their own health or welfare.[19] It defines a conversion practice as 'a treatment or other practice the purpose, or purported purpose, of which is to change a person's sexuality or gender identity' (2(7)(1), p. 4), and like the Queensland Act makes an exception for practices that assist a person with gender transition, and makes an exception from counting as a conversion practice any 'practice by a health service provider that, in the provider's reasonable professional judgement, is necessary

[14] Another issue, outside the scope of this paper but related to its central question, is whether gender identity is a proper object of empirical study. For a discussion of the difficulties with the concept, including whether it can do the work it has been intended to do in feminism and/or trans activism, see e.g. (Stock 2021, Ch. 4); (Bogardus 2022); (Gheaus 2023); and (Byrne 2023, Ch. 5). See also Justin Kalef's thoughtful review of this paper.

[15] On which see e.g. (Blais et al. 2021); (Jones et al. 2022a); (Jones et al. 2022b).

[16] https://www.legislation.qld.gov.au/view/html/asmade/act-2020-031/lh

[17] https://healthlegal.com.au/current-news/conversion-therapy-banned-queensland/ and see also Health Ombudsman Act 2013, Queensland, (2)(8) p. 16.

[18] This exception may have been thought necessary to protect the health service provider from a double-bind: if a patient is lesbian, gay or bisexual and wants to transition, then without this exception they could be accused of conversion therapy whether they chose to assist the transition or not (conversion of sexual orientation for assisting in gender transition; conversion of gender identity for refusing to assist in gender transition). It also has the effect of protecting those providers who affirm as trans children who later desist or detransition, from later charges of change or suppression practices causing physical injury: for medical and surgical interventions aimed at bringing a person's body into line with their gender identity may otherwise be described as having caused disfigurement, substantial pain, and/or impairment of bodily function. See also fn. 20.

[19] https://www.legislation.act.gov.au/a/2020-49/

to— (a) provide a health service in a manner that is safe and appropriate or (b) comply with the provider's legal or professional obligations' (2(7)(3), p. 5). The maximum penalty is 12 months in jail, around $28,000 in fines, or both (2(8)(1), p. 5). What is noteworthy about the ACT's legislation is that it only applies to protected persons.

While the Queensland legislation applies only to health service providers, and the Australian Capital Territory's legislation applies only to the conversion of protected persons, Victoria has conversion therapy legislation that applies to nearly everyone, whether perpetrator or victim of the conversion practice. Victoria's *Change or Suppression (Conversion) Practices Prohibition Act 2021* prohibits 'change or suppression practices', which are practices aimed at changing or suppressing a person's sexual orientation or gender identity. The Act makes it a crime for most adults to engage in change or suppression practices. The exceptions are the 'practice or conduct of a health service provider that is, in the health service provider's reasonable professional judgement, necessary—(i) to provide a health service; or (ii) to comply with the legal or professional obligations of the health service provider' (5(2)(b), p. 7). Intentionally engaging in change or suppression practices that cause serious injury comes with a maximum of 10 years in prison or a maximum fine of around $222,000 (10(1), p. 10); intentionally engaging in change or suppression practices that cause injury comes with a maximum of 5 years imprisonment, or a maximum fine of around $111,000 (11(1)(b), p. 11).[20] The scope of Victoria's Act is broader both in who can perpetrate change or suppression practices and who can be a victim of them, and its penalties are substantially more severe. Even if an LGB person initiates their own non-physical therapy, asking a religious leader or a counsellor for support in resisting same-sex desires in order to, for example, remain faithful in an existing heterosexual marriage, or act according to their faith as they understand it, the religious leader or counsellor would put themselves at risk of criminal punishment by agreeing to support them.

All three Australian states that have conversion therapy legislation in place include both sexual orientation and gender identity together in their legislation (although the ACT uses the term 'sexuality' instead of 'sexual orientation'). Indeed, the Victorian Act uses the phrase 'sexual orientation or gender identity' 6 times, 'sexual orientation and gender identity' 1 time, and 'gender identity and sexual orientation' 1 time: sexual orientation is mentioned alone only in the list of definitions (4, p. 6), the specification of the amendment to the definition of that attribute (5(59)(3), p. 39),[21] and in one example given to explain 'emotional or physical abuse' (6(64), p. 42). Similarly, 'gender identity' shows up alone only in the list of definitions (4, p. 5), specification of the amendment to the definition of that attribute (5(59)(1), p. 39), and once in the exemption from counting as a 'change or suppression practice' any practice undertaken for the purposes of 'assisting a person to express their gender identity' (5(2)(a)(iii), p. 7). There appears to be an insistence throughout existing legislation on pairing sexual orientation with gender identity.

[20] 'Injury' in the Crimes Act 1958 (Victoria) is physical injury (unconsciousness, disfigurement, substantial pain, infection with a disease, or impairment of bodily function) or harm to mental health (psychological harm, but not emotional reactions alone – distress, grief, fear, anger – unless they result in psychological harm). 'Serious injury' is injury that endangers life, or, is 'substantial and protracted'. https://www.legislation.vic.gov.au/in-force/acts/crimes-act-1958/294

[21] The Victorian Act also amended the definitions of both 'sexual orientation' and 'gender identity' as protected attributes in the Equal Opportunity Act 2010, changing the definition of sexual orientation from '*sexual orientation* means homosexuality (including lesbianism), bisexuality or heterosexuality', to '*sexual orientation* means a person's emotional, affectional and sexual attraction to, or intimate or sexual relations with, persons of a different gender or the same gender or more than one gender' (pp. 39-40). This may be another result of generalizing from sexual orientation to gender identity, for if gender identity has the same status as sexual orientation, then it would seem to make sense that sexual orientation itself be reconceptualized in a way that makes space for gender identity. (If sex is the basis of sexual orientation then, because there are two sexes, there are just three sexual orientations: same-sex attracted, opposite-sex attracted, or both. So the Equal Opportunity Act's old definition is correct. But if gender (as identity) is the basis of sexual orientation (or both gender and sex are), then because there are many genders, there are many sexual orientations. So whether or not the Change or Suppression Act gets the new definition right, a new definition would indeed be needed).

Let's now look at a fourth state of Australia, namely Tasmania, whose law reform institute produced a review and recommendations for upcoming legislation (at my time of writing this paper, August 2023, no bill had yet been put forward—Tasmanian Times 2023*a*; at my time of finalising the paper, December 2023, a draft bill had just been put forward for public consultation—Tasmanian Times 2023*b*). To the best of my knowledge, Tasmania is unique in attempting a review of the evidence on conversion therapy in order to justify the legislation. That gives us an opportunity to look at whether conversion therapy is in fact being done on the basis of both sexual orientation and gender identity, and if so, whether it's true for both that it doesn't work and that attempts are harmful.

3. The Tasmanian Law Reform Institute Issues Paper No. 31

In November 2020, the Tasmanian Law Reform Institute (TLRI) released their Issues Paper No. 31, titled 'Sexual Orientation and Gender Identity Conversion Practices'. It was part of the TLRI's terms of reference for this project that they would 'Review and consider peer-reviewed literature about the impacts of SOGI conversion practices on people who are subjected to them and/or who have survived them' (p. xi).[22] In this section I will 'review and consider' *their* review.

The TLRI considered 35 papers in total. I read them and sorted them into 4 categories, depending on whether they had anything to say about gender identity conversion practices (see *Table 1*).

A	B	C	D
Relevant	Borderline/arguable	Relevant terms only	Not relevant
#27 (Salway et al., 2020)	#26 (Ryan et al., 2020)	#1 (Beckstead, 2012)	#4 (Delmas, 2014)
#34 (Wright et al., 2018)		#2 (Bradshaw et al., 2015)	#12 (Haldeman, 1991)
		#3 (Cramer et al., 2008)	#13 (Haldeman, 1994)
		#5 (Drescher et al., 2016)	#20 (Meanley et al., 2020b)
		#6 (Drescher, 2015)	#21 (Morrow and Beckstead, 2004)
		#7 (Dworkin and Pope, 2012)	#22 (Nicolosi et al., 2000)
		#8 (Earp, 2014)	#24 (Rosik, 2013)
		#9 (Flentje et al., 2013)	#25 (Rosik, n.d)
		#10 (Flentje et al., 2014)	#29 (Shidlo and Schroeder, 2002)
		#11 (Frankowski, 2004)	#30 (Sowe et al., 2014)
		#14 (Haldeman, 2002a)	#31 (Sutton, 2015)
		#15 (Haldeman, 2002b)	#32 (Throckmorton, 2002)
		#16 (Haldeman, 2004)	
		#17 (Haldeman, 2012)	
		#18 (Maccio, 2011)	
		#19 (Meanley et al., 2020a)	
		#23 (Olson et al., 2016)	
		#28 (Schneider et al., 2002)	
		#33 (Tozer and Hayes, 2004)	
		#35 (Yarhouse and Burkett, 2002)	

***Table 1*. Peer-reviewed literature considered by the TLRI in their Issues Paper No. 31**

[22] An opponent may object that the population suffering the impacts of SOGI conversion practices is not necessarily the same as the population being subject to SOGI conversion practices: perhaps there are some who are subject to it but not impacted by it, and so who don't opt into studies of impacts. If there is such a difference, it would be relevant to arguments for the pairing that rely on the same or similar harms being caused. See references in fn. 15 for studies speaking more directly to prevalence.

Category A papers are the most relevant: these are papers that explicitly include transgender people or talk about gender identity in relation to conversion therapy. Category B are borderline cases, papers that could be argued to be relevant to gender identity conversion therapy (I'll say more about these soon). Category C papers contain some *terms* relevant to gender identity, but as a matter of content are not in fact relevant to gender identity conversion therapy. Finally, Category D papers are not relevant: they neither discuss gender identity conversion therapy, nor include any terms relating to gender identity.[23]

All the papers in categories C and D were exclusively about conversion therapy for sexual orientation. There were 32 papers in these two categories in total. Let me give an example from each category. Delmas (2014) (paper #4 in category D) is titled 'Three Harms of Conversion Therapy', appearing in the journal *AJOB Neuroscience*. It's a rejoinder to a bioethics paper that argued for sexual orientation conversion biotechnology in limited cases. The paper is exclusively about future biotechnology that might be used to change sexual orientation (i.e. it is philosophical, not empirical), and contains no terms relevant to gender identity. Beckstead (2012) (paper #1 in category C) is titled 'Can we change sexual orientation?' and appears in the journal *Archives of Sexual Behaviour*. It is exclusively about sexual orientation and the possibility of 'reorientation' for people whose sexual orientations/attractions are unwanted. The words 'gender identity' do appear in the paper, but they don't refer to transgender people: the meaning of the words is something close to 'features of a person that relate to his or her sex'. The words appear in the context of talking about how same-sex attraction can disrupt normal relationships between people of the same sex. Someone doing a quick search for papers on gender identity conversion therapy might think this paper is relevant, but anyone who has read it could not.

This leaves 3 papers, 1 in category B and 2 in category A.[24] Ryan et al. (2020) (paper #26 in category B) is titled 'Parent-initiated sexual orientation change efforts with LGB adolescents: Implications for young adult mental health and adjustment', appearing in the *Journal of Homosexuality*. I classified this paper as borderline for the reason that while it is exclusively about the conversion of sexual orientation in young adults initiated by their parents, it surveys 245 participants who *self-identify as LGBT*. It reports that the demographics were 46.5% male, 44.9% female, and 8.6% transgender. The questions asked of participants were about attempts to cure, treat, or change *sexual orientation*. In the notes, the authors say that "all transgender youth in this sample also identified as lesbian/gay, bisexual, homosexual, or queer" (p. 171, n. 1). The authors did not collect data on the sexual orientation labels used by the trans subjects. This is a problem, because many trans people use sexual orientation labels in line with their gender identities rather than their biological sexes. For example, a transwoman who dates only women

[23] It might seem curious that I separated categories C & D when both sets of papers are ultimately irrelevant to gender identity conversion therapy. My intention was simply to be charitable: someone searching for papers by keywords in an initial gathering of literature might have found those keywords and thereby assumed the papers to be relevant to *both* sexual orientation and gender identity.

[24] I had initially categorised paper #2 and paper #8 from category C into category B, but after emailing their authors to discuss the papers' relevance to gender identity conversion therapy, I reclassified the papers. (Bradshaw et al. 2015) is about psychotherapy for same-sex attracted individuals associated with the Mormon church, but it refers to these individuals with the initialism 'LGBQ', and includes 'transgendered' when asking participants when they first labelled themselves. The recruitment and inclusion criteria for the study were explicitly about sexual orientation, but sexual orientation labels were chosen by self-report, and there was a very small number of trans people in the greater subject pool that this study's subjects were a subset of. In the larger pool, there were 6 transwomen, 4 trans men, and 24 individuals who identified outside the binary. This means it is *possible* that a trans subject with a sexual orientation label chosen to fit with their gender identity rather than their biological sex (i.e. a transwoman using the label 'lesbian' when exclusively dating women) may have reported conversion therapy. Still, given the aims of the study, they would presumably still understand this conversion therapy to be aimed at *their sexual orientation* (label), not their *gender identity* (that is to say, to justify participation, the psychotherapy should have been aimed at change of their sexual attractions and behaviours, not change of their gender identification). (Earp 2014) is about future biotechnology that could alter romantic and sexual feelings (paper #4, mentioned already, is a reply to this paper). The authors talk about 'sex or gender' (p. 9); position a person's sexual orientation in relation to her values, which might include 'transhumanism, or gender experimentalism' (p. 10); and talk about people who might want to experience alternative sexual orientations, gay, straight, or 'other possibilities in between' (*ibid*). This inclusive language might suggest the discussion to be relevant to trans people, but the discussion is exclusively about biotechnology for changing sexual orientation, not for changing gender identity (also, the paper is philosophical, not empirical – it is not reporting on conversion therapy, but speculating on its justification).

may self-label as 'lesbian' or 'queer'; a trans man who dates only men may self-label as 'gay' or 'queer'. But both are *heterosexual* relative to their biological sex, meaning that if they experienced conversion therapy for their sexual orientation (labels), this would in fact have been an attempt to turn them *from straight to gay*, not the other way around.[25] Such a process may not work in the same way, or be equally harmful. Trans subjects using the sexual orientation labels 'straight' or 'heterosexual' (e.g. a transwoman dating only men, a trans man dating only women) would in fact be same-sex attracted, and yet would not be likely to opt into the study in the first place. Only trans subjects using the sexual orientation labels 'bisexual' or 'pansexual' might have been subject to conversion therapy for same-sex attraction. Because of this complexity, because the trans subjects were only 8.6% of the sample (about 21 people), and because any conversion therapy experienced was targeting their sexual orientation (labels) not their gender identity, the paper is arguably not relevant to gender identity conversion therapy.

Finally, the most relevant papers, in category A. (Salway et al. 2020) is about efforts to change sexual orientation in 'sexual minority men'. It includes trans men among sexual minority men. But, just like (Ryan et al. 2020) from category B, the study is still about conversion of *sexual orientation*. Out of a total 8,388 respondents, 99 were transgender (less than 1.2%), and of those, 12.1% (about 12 people) said they'd been exposed to sexual orientation change efforts. It's *possible*, of course, that the trans men in the study were understanding sexual orientation change efforts to be about either or both of sexual orientation and gender identity, but the study *doesn't ask them* whether the conversion therapy was done on the basis of their sexual orientation, their gender identity, or both at once.[26] Thus, as with (Ryan et al. 2020), these could be heterosexual females claiming to have experienced conversion therapy from 'straight' to 'gay', on the basis of labelling their sexual orientations in line with their gender identity rather than their biological sex. Despite these small numbers and the complexities involved in intersecting gender identity with sexual orientation labels, the study reports that trans people are 'disproportionately exposed' to conversion therapy—because it's 12.1% of the small number of trans men, compared to 3.5% of the much larger number of non-trans men, who have been subjected to conversion therapy (Salway et al. 2020, p. 506 & Table 1, p. 505).

(Wright et al. 2018) is the only paper that is actually about conversion of gender identity. To emphasise: in a 35-paper literature review of conversion therapy for sexual orientation and gender identity, 34 papers are about sexual orientation, and 1 is about gender identity. The paper is a systematic review of the literature on conversion therapy for transgender people. The authors report finding only 4 papers about conversion therapy for gender identity.[27] They write 'We found limited evidence in the research literature of the use of conversion therapies that aimed solely at suppressing or modifying what was considered by the therapist as abnormal gender identity' (Wright et al. 2018, pp. 9-10).[28] 3 of these 4 papers were case studies involving a single individual. The 3 case studies were described as being 'overall of poor methodological quality' (*ibid*, p. 4).

[25] Other studies simply excluded transgender respondents: see e.g. (Tozer & Hayes 2004, p. 722).

[26] A later paper by two of the same authors (plus other co-authors) does ask whether the conversion therapy targeted the person's sexual orientation or gender identity, and found that 'Among the 910 participants'— out of 9,214, so 9.9%—'who were exposed to CTP [conversion therapy practices], 77.3% reported that CTP exclusively targeted their sexual orientation, 5.9% reported that it exclusively targeted their gender identity, and 16.8% reported that it targeted both' (Salway et al. 2021, p. 9). The total number who said gender identity was targeted exclusively was 43, and the total number who said both their gender identity and sexual orientation were targeted was 123 (p. 11, Table 4).

[27] 12,605 papers were initially identified, most were removed as not relating to conversion therapy or healthcare access (which was a second topic of the paper), which left 117 articles, then these were assessed more closely, resulting in a final pool of 4 articles about conversion therapy and 3 articles about healthcare access (Wright et al. 2018, p. 4).

[28] The authors note that they restricted their search to papers published between 1990 and 2017, because of a historical 'conflation of gender diverse with gay and lesbian people'. They say that they're aware of two papers published prior to 1990 about conversion for gender identity. These are (Bancroft & Marks 1968) and (Marks et al. 1970).

The fourth paper gave a number of case examples from a gender clinic in Toronto, including details of 7 children with gender dysphoria whose parents brought them to a Canadian gender clinic with the aim of working towards desistance. (Note that this would count as conversion therapy in all three states of Australia that have conversion therapy prohibition law in place). They reported 'remission' (desistance) in most cases (*ibid*, p. 8). However, most childhood gender dysphoria resolves itself naturally; desistance is common.[29] For the paper to establish whether 'conversion therapy' worked and whether it was harmful, the authors would have to know whether each of those 7 children were members of the cohort whose gender dysphoria would naturally resolve, or whose gender dysphoria would persist. If they were members of the former, larger, group then interventions aimed at desistance were not 'conversion' at all. This makes the paper of dubious relevance to the matter of conversion therapy.

In summary, of the 35 papers the TLRI considered, 34 are exclusively about sexual orientation. 2 of those 34 include trans people who label as same-sex attracted, and one leaves open that the conversion therapy might have been done on the basis of the person's gender identity rather than their sexual orientation, although does not gather the data to resolve this question. Only 1 of the 35 papers is about conversion therapy for gender identity, and it's a systematic review, including one paper of dubious relevance and three poor quality case studies. That paper's conclusion was that there isn't much evidence—in the research literature, at least—that conversion therapy for gender identity is going on: 'To an extent our findings are reassuring, in that explicit attempts at conversion therapy seem to be less common than was the case in LGB people' (Wright et al. 2018, p. 11).

The TLRI, however, concludes that 'There is no convincing evidence that SOGI conversion practices are 'effective' in achieving their purported aims of suppressing or changing a person's sexual orientation or gender identity', and 'Peer-reviewed empirical studies indicate that SOGI conversion practices have significant and prolonged harmful effects on people subjected to them' (*ibid*, p. 15).

These claims are either false or misleading. With respect to the first, there is *some* evidence that conversion therapy for sexual orientation is successful, including in the literature the TLRI reviewed (Shidlo & Schroeder 2002; Nicolosi et al. 2000; see also Nicolosi 1993). Their phrasing, 'no convincing evidence', also elides the fact that when it comes to gender identity, there is little evidence available. Evidence of a lack of effectiveness is very different from a lack of evidence of effectiveness. With respect to the second claim, they say that SOGI practices have 'significant and prolonged harmful effects on the people subjected to them' (TLRI 2020, p. 15). The literature they surveyed supports this claim for sexual orientation, but not for gender identity.[30] The claim is true, but misleading; these practices do have significant and prolonged harmful effects on the people subjected to them, but the people overwhelmingly subjected to them are sexual orientation minorities, not sexual orientation and gender identity (SOGI) minorities.

The TLRI is therefore committing a fallacy in reasoning, taking evidence for *A* and claiming evidence of *A* and *B*. Perhaps moral and philosophical arguments can be offered to support the adding of *B*—'SOGI' instead of 'SO'—but it is odd for them to have to offered empirical evidence in support of the legislation that does not support the legislation as formulated. (Although to be fair to the TLRI, the Terms of Reference for their inquiry, stated in both their Issues Paper No. 31

[29] See e.g. (Wallien & Cohen-Kettenis 2008), (Ristori & Steensma (2016), & (Steensma & Cohen-Kettenis 2018).
[30] Although cf. (Sullins 2022); & see also (Rosik 2022).

and their Final Report No. 32, and which they are constrained by, used 'SOGI'.)

Their Final Report, released in April 2022, addressed this issue in a dedicated section (TLRI 2022, pp. 18-21). They acknowledged that a number of individual submissions to their inquiry had argued against the inclusion of gender identity, with one of the reasons given being that gender identity is ideological, while sex (and so, presumably, sexual orientation) is biological (*ibid*, p. 18). They gave two responses: first, 'neither contemporary health science nor the law concern themselves with the underlying bases of sexual orientation or gender identity' (*ibid*, p. 19); second, 'There is no conventional medical evidence that suggest a person's experienced or expressed sexual orientation or gender identity have separate or different 'causes' that might support distinction or discrimination under law' (*ibid*).

Their first response is weak. The law would not seek to protect against 'sexual orientation and goth conversion therapy'. It's not that a protected attribute has to be endogenous rather than exogenous; we protect disability whether had since birth or incurred in the course of life. But an attribute has to rise to a certain level of permanence and seriousness. If atypical gender identity is neither (or more moderately, for many of those who claim to have it, is neither) then it is as though the law is protecting against sexual orientation and goth conversion therapy, and responding obtusely, when challenged, that it doesn't matter what causes a person to be a goth.

Their second response is simply false. There is a wealth of scientific literature on the possible cause(s) of each of sexual orientation and gender identity, and these are in almost all cases approached separately. We still don't have a definitive answer to what causes either, and there is substantially more scientific literature on sexual orientation (see discussion in Bailey et al. 2016). But the TLRI's response misleadingly suggests it to be settled that sexual orientation and gender identity have the same cause, bolstering the idea that because sexual orientation is generally considered to be innate, gender identity must be innate too. But again, 'there is no... evidence' is not equivalent to 'there is evidence that it is not the case that...'. They have not satisfactorily explained why sexual orientation and gender identity are being so insistently paired.

4. Conclusions

This paper had a narrow focus: to take advantage of the fact that the Tasmanian Law Reform Institute conducted an inquiry and made a partly evidence-based case for conversion therapy legislation, rather than the Tasmanian state government simply pushing such legislation through (as has happened elsewhere). The TLRI claimed conclusions for 'SOGI' that were only established for 'SO' (TLRI 2020, p. 15). Yet they have recommended going ahead with legislation for both (TLRI 2022, pp. *vi-ix*). Law, of course, does not have to be evidence-based. But if it isn't, it shouldn't present itself as such. If the pairing of sexual orientation and gender identity is political, those politics should be made transparent, so that citizens with very different conceptions of the good can decide whether to accept or reject them.

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