GENSPECT REVIEW OF THE TRINITY COLLEGE DUBLIN RESEARCH ON "GENDER IDENTITY CONVERSION THERAPY"

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Executive Summary

This paper reviews evidence presented in the February 2023 Trinity College Dublin, School of Nursing and Midwifery (TCD) research report An Exploration of Conversion Practices in Ireland[1] commissioned by the Department for Children, Equality, Disability, Integration and Youth (DCEDIY).

A Request for Tender for Conversion Therapy Research was issued by DCEDIY in November 2021 and said the research was intended to "*help to inform the policy rationale for and development of a cross-Government approach to dealing with conversion practices in Ireland, including the development of legislation if required*" (p.4).[2]

The TCD research report stated that "*interactions with therapists who created barriers to gender affirming care or closed down discussions about gender identity*" should be considered within conversion practices, and concludes "*legislation to ban conversion therapy is likely to focus on professional contexts with licenced practitioners*" (p.5 & p.69).[2]

This Genspect Review highlights issues with the case presented in the TCD report for banning gender identity and expression change efforts in professional contexts with licenced practitioners.[1] In the context of so-called "gender identity conversion therapy", the TCD research[1] does not provide robust evidence to demonstrate that legislation is required. Furthermore, it does not clearly define the scope of what conversion therapy legislation including gender identity would or would not cover, and risks negatively impacting clinically necessary ethical professional assessment and treatment of individuals with gender dysphoria.

Key areas of concern with the TCD research report[1] are as follows:

- The report does not provide a clear definition of what should be considered a conversion practice in the context of gender identity and expression. Critically, the report does not provide clear delineation between clinically necessary ethical professional assessment and treatment of individuals with gender dysphoria, and unethical coercive practices with a pre-defined aim of changing a person's gender identity.
- The quality of evidence presented in the report is low:
    - The quantitative research data in the report relating to gender identity came from 23 responses to an anonymous online survey recruited via advocacy groups, which may have influenced survey responses, making the data susceptible to selection bias, recall bias and demand bias. Survey responses were self-reported and unverified.
    - The qualitative research evidence presented in the report relating to gender identity is based upon interviews with just two individuals, one of whom "*was not sure if what he experienced could be described as conversion therapy*" (p.64).[1] The other interviewee who identified as intersex and transgender "*argued that surgery she had to assign gender when she was born was a form of conversion therapy*" (p.66).[1] No details are provided on how long ago this interviewee had this surgery, whether the surgery was performed in Ireland or any other clinical details.

- The report conflates gender identity, gender expression and sexual orientation and thereby repeatedly creates confusion and ambiguity within the report.
- The report does not directly address clinical concerns that conversion therapy legislation that includes gender identity could restrict the efficacy of therapy for individuals experiencing gender identity issues. These concerns have been published in the UK[3] and Ireland[4] and have been the subject of public debate and government policy changes[5] in the UK. The TCD research, which was publicly funded, was a missed opportunity to address these clinical concerns.
- The report does not acknowledge the heated disagreement within the international medical community regarding the safety and efficacy of medical treatment of young people with gender dysphoria. Within the Health Service Executive (HSE) in Ireland there are currently two conflicting sets of guidelines (or "Models of Care"),[6] with the children's service aligning with the gender affirmative approach and the adult service offering a more cautious, least-invasive-first approach. The TCD report ignores this lack of consensus and blandly states that "*guidelines are available to support practitioners to work therapeutically with LGBTI+ individuals*" (p.69).[1] Within the international medical community there is significant divergence between gender affirming guidelines from the USA[7] versus the latest guidelines from Sweden, Finland, France, New Zealand, the U.K. and Norway that favour psychological support as first-line treatment.[8,9]

- The report provides no corroborating evidence of gender identity conversion therapy in the form of complaints, investigations and/or professional sanctions from any professional clinical bodies in Ireland.
- The report repeatedly infers that harm is caused by efforts to change gender identity and expression, but none of the studies relating to gender identity provide evidence to demonstrate causation. Misrepresentation of evidence of causality has been spread to the public via media reports quoting Minister O'Gorman saying "*This practice is abusive and causes significant harms to people already in distress*".[10]
- The TCD research was not independent. The government department that commissioned the research appointed a Research Advisory Group with representatives from advocacy groups (LGBT Ireland, TENI and Gay Project [Cork]) who co-signed a public letter[11] before the research had begun, stating their "*firm commitment*" to a "*fully LGBT+ inclusive ban*" on conversion therapy. The Research Advisory Group did not include any individuals or groups representing other viewpoints.

Conclusion

If legislation to ban conversion therapy is based upon the TCD research report, the legislation will put clinicians working with patients with gender identity issues in an impossible situation: if they follow a gender affirmative approach they will be at risk of carrying out inappropriate therapy and subsequent legal action from patients who regret their medical transition, however if they do not follow a

gender affirmative approach they will be at risk of accusations of conversion therapy.

A result of this legal minefield will be that many clinicians will choose not to work with anyone with gender identity issues. This will leave the growing community of people with gender dysphoria (who already face unconscionably long waiting lists) even worse off than they are currently.

While the TCD research report does not provide evidence that gender identity conversion therapy legislation is required, it does, however, highlight deficiencies in health services. Genspect recommends that policy makers wishing to improve the lives of people with gender dysphoria focus their attention not on conversion therapy legislation, but instead on the following areas:

- Substantial investment in mental health services
- Statutory regulation of counsellors, psychologists and psychotherapists
- Specific improvements to gender identity services

Contents

1 Introduction

1.1 Background

1.1.1 Expanded re-definition of conversion therapy to include gender identity

When most people hear the words “conversion therapy” they think of gay conversion therapy: of barbaric, coercive practices including electro-convulsive therapy and corrective rape which seek to change a person’s sexual orientation from homosexual to heterosexual.

In 2021, the Department for Children, Equality, Disability, Integration and Youth (DCEDIY) led by Minister Roderic O’Gorman issued a comprehensive academic research review on LGBTI+ youth in Ireland and across Europe that defined conversion therapy as

> "*a psychotherapeutic intervention that attempts reverting someone’s lesbian, gay or bisexual orientation to heterosexual* “(p.175).[12.]

There is an extensive body of peer-reviewed evidence showing that not only are practices that seek to change an individual’s sexual orientation morally wrong, they do not change sexual orientation and they cause harm.[13,14]

The issues being addressed in this document relate to the recent expanded re-definition of “conversion therapy” to include not only practices that seek to change a person’s sexual orientation, but to also include changing a person’s gender identity and/or expression.

This redefinition comes in part from a political organising tactic to combine sexual orientation and gender identity into "the LGBT[QI+] community".[15] The characterisation of people as "LGBT" and talk of "LGBT conversion therapy" reflects this political coalition. Solidarity between groups is legitimate as a political axis for organising, however the shift to combine "gay conversion therapy" with "gender identity conversion therapy" under the heading Sexual Orientation Gender Identity Change Efforts (SOGICE)[1] gives the misleading impression that there is a solid evidence base for policy making and legislation with regard to both types of so-called conversion therapy, when in fact there is not. There are decades of research on "gay conversion therapy" [13], in contrast the research on "gender identity conversion therapy" is just emerging within the last 5 years and is empirically weak[15].

A key issue with the TCD research report is that it sets out findings relating to sexual orientation conversion practices separately from those relating to gender identity, but often recombines the two into generalised conclusions. This approach, which combines two different datasets, implies that the evidence relating to coercive attempts to alter an individual's sexual orientation (on which there is significant research)[13] can be applied to attempts to explore the reasons why an individual feels distress about his or her body and the gender stereotypes associated with their sex (where there is a paucity of research).[15] There is no empirical justification for this combined approach.

1.1.2 Why is the inclusion of gender identity under conversion therapy problematic?

Sexual orientation refers to a person's romantic and/or sexual attraction to other people, whereas gender identity refers to how a person feels about themselves. Sexual orientation and gender identity are very different things. The following differences are critically important in the context of the expanded redefinition of conversion therapy to include gender identity:

1.1.2.1 No medication or surgery is needed for sexual orientation

People who are homosexual or bisexual do not seek medication or surgeries relating to their sexual orientation, whereas many people with gender identity issues (including severe distress defined diagnostically as "gender dysphoria"[16] or "gender incongruence"[17]) often seek clinical support for cross-sex medication and/or surgeries. There is no equivalent condition to gender dysphoria in relation to sexual orientation.

1.1.2.2 Lack of evidence on medical gender transition for young people

Independent evidence reviews in Sweden, Finland, France, New Zealand, the U.K. and Norway have all found evidence lacking regarding the safety and efficacy of medically treating gender dysphoria in young people, and consequently these countries are now all moving towards psychological support as first-line treatment.[8,9]

NHS England recently said that there was "*scarce and inconclusive evidence to support clinical decision making*" for minors with gender dysphoria and that for most who present before puberty it will be a "*transient phase*" requiring clinicians

to focus on psychological support and '*to be "mindful" even of the risks of social transition*'.[8]

Research from the Health Promotion Research Centre, National University of Ireland Galway, commissioned and published by Minister Roderic O'Gorman's Department for Children, Equality, Disability, Integration and Youth (DCEDIY) in 2021 reported that:

> "*Evidence on medical interventions to assist gender transitioning of trans young people, especially that on pubertal blocking and administration of cross-sex hormones, is very scarce, and the long-term impact on cognitive and physical development, fertility or on other outcomes remains largely unknown*" (p.14).[12]

1.1.2.3 Gender dysphoria often co-occurs with psychiatric conditions

Individuals with gender dysphoria have very complex clinical needs: many have complex family histories or been exposed to major trauma[18] and many have co-occurring psychiatric conditions.[19,20,21,22] Researchers have reported rates of autism among children and young people referred to gender clinics as high as 48%.[23] This compares to rates of autism in the general population are 1-2%.[66] As a consequence of these complexities, individuals with gender dysphoria often need professional clinical support including psychotherapy for issues not specifically relating to their gender identity. Individuals who are not heterosexual do not have similar levels of clinical complexities that require professional clinical support.

1.1.2.4 Association between childhood gender dysphoria and homosexuality in adulthood

To further complicate matters, many young people who seek therapy for gender related distress resolve that distress through coming to terms with a lesbian, gay or bisexual orientation.

Dr Erica Anderson, a transgender Clinical Psychologist and a former board member of the World Professional Association of Transgender Healthcare (WPATH) recently said:

> "*Some critics who decry conversion therapy may inadvertently be practicing a version of it by directing gender questioning proto gay young people into transgender identities*".[24]

Due to intolerance of homosexuality, the Islamic Republic of Iran is a hub for sex-reassignment surgery.[25] In Iran opposite-sex hormones and sex-reassignment surgery are used as extreme forms of conversion therapy on gay men.[26]

1.1.2.5 Medical transition regret

Although historic research suggests regret among the tiny number of adults who had undergone cross-sex surgery was low,[27]evidence has started to emerge of much higher rates of both transition regret and "detransition" in recent years among the much larger population of younger people now seeking cross-sex hormones and surgery.[28] Detransition broadly describes people returning to live in their original gender role following a process of gender transition.[28] Many of the physical effects of cross-sex hormones and surgeries are irreversible.

Dr Laura Edwards-Leeper, Chair of the Child/Adolescent Committee on the World Professional Association for transgender Health (WPATH) has noted:

> *"we do not currently have medical or psychological means to predict an individual child's future course. Thus, there will undoubtedly be "false positives" who transition early and later are faced with the challenge of transitioning back to their assigned gender*" (p.167).[29]

Media stories are emerging of young people affected by gender dysphoria who felt that medical transition was not appropriate for them, and who have detransitioned and are taking legal action against clinicians who affirmed their gender identity and were part of the clinical team that provided them with so-called "gender affirming care" (e.g. Richie Herron, [30] Sinead Watson,[31] and Keira Bell[18]).

1.1.3 Clinical concerns regarding the inclusion of gender identity

Irish clinicians voiced many of the concerns listed here regarding the inclusion of gender identity in proposed conversion therapy legislation in an article published in the Irish Times in August 2021.[4]

The key issues highlighted by the clinicians were:

- The very sharp increase in adolescents presenting with gender dysphoria or gender questioning or identifying as transgender, particularly in recent years.
- The association between childhood gender dysphoria and homosexuality and bisexuality in adulthood.

- Gender dysphoria may have many underlying causes not necessarily related to being transgender.
- Affirming a 13 year old with recent gender dysphoria as "trans" when they are in fact gay could leave therapists open to accusations of conversion therapy after the client has completed adolescence.
- If therapists are fearful of accusations of "conversion" therapy, many will avoid working with anyone with gender identity issues.

1.1.4 Unintended consequences on ethical clinical practice

The TCD research report not only fails to adequately address well-publicised concerns[3,4,5] regarding the inclusion of gender identity within conversion therapy legislation, it goes a step further by suggesting that legislation will specifically focus on clinicians working with individuals with gender identity issues. The TCD report says that "*legislation to ban conversion therapy is likely to focus on professional contexts with licenced practitioners*" (p.69)[1] and states that "*interactions with therapists who created barriers to gender affirming care or closed down discussions about gender identity were interpreted as a form of conversion therapy*" (p.66).[1]

If the Irish government implements conversion therapy legislation based upon the TCD report conclusions, it will have the unintended consequence of negatively impacting people with gender dysphoria seeking clinical support by putting clinicians working with patients who have gender identity issues in a legal "Catch 22" situation. Clinicians who follow their training and professional standards to complete clinically appropriate assessments,[37] and who explore factors which may be contributing to a patient's gender dysphoria and who

proceed with caution before advocating for gender affirming medication or surgery, will be at risk of accusations of conversion therapy. At the same time, clinicians taking a purely affirmative approach, who accept and affirm a patient with gender dysphoria's declared gender identity who do not explore any contra-indications for gender affirming medicine or surgery, will be at risk of legal action from patients who subsequently regret medical gender transition.[18,30,31]

Clinical professional judgement can be negatively impacted with devastating consequences when clinicians are trying interpret the law at the same time as making clinical decisions.[32]

The 2020 Judgement in the Judicial Review of the case of Keira Bell and Mrs. A versus the Tavistock and Portman NHS Foundation Trust regarding prescribing puberty-suppressing drugs to persons under the age of 18 who experience gender dysphoria, found that it is not for the courts "*to determine clinical disagreements between experts about the efficacy of a treatment*".[33]

A result of this legal minefield, will be that many ethical clinicians will not work with anyone with gender identity issues, leaving the growing community of people with gender dysphoria who already face years long waiting lists, even worse off than they are currently.[a]

[a] At time of writing in early 2023, waiting lists in the Irish National Gender Service (NGS) for adults with gender identity issues currently stand at 3 to 3.5 years.[38]

1.1.4.1 Other countries conversion therapy laws pose risk to clinical practice - and parents

The TCD research cites an international study on recently enacted Australian conversion therapy laws which contends "*that laws which prohibit conversion practices pose no risk to evidence based and clinically appropriate practice*".[34] The TCD research does not mention another international study which reached the opposite conclusion regarding the very same Australian conversion therapy laws that "*The laws in Victoria and the ACT provide inadequate protection for clinically appropriate psychiatric practice and may deprive patients of mental health care.*" [35]

One of the Australian laws researched in these international studies is the Victoria, Australia "Change or Suppression (Conversion) Practices Prohibition Act 2021." This act extends the threat of legal action for conversion therapy beyond clinicians to family members. An example of an illegal practice under the Victoria, Australia conversion therapy law is

> "*a parent refusing to support their child's request for medical treatment that will enable them to prevent physical changes from puberty that do not align with the child's gender identity and denying their child access to any health care services that would affirm their child's gender identity*".[36.]

This is an example of an unintended consequence of the widening of the parameters of "conversion therapy" legislation far beyond what most people understand to be the scope of a "conversion therapy bans".

2 Assessing the evidence

The objectives of the TCD study, according to the Request for Tender[2] commissioning the research were to:

- Establish a definition of conversion therapy and conversion practices as they operate in Ireland (including what conversion practises are used, what signifiers are used and how people consent or assent).
- Establish who is subjected to conversion practices (minority sexual orientation/minority gender orientation).
- Establish if there are longer term consequence of such practices for the individual.
- Establish if there are any support needs for people who have been subjected to conversion therapy.

The TCD research[1] followed a multi-phase mixed methods design with three phases:

1. Literature review
2. Cross-sectional survey of the LGBT+ community
3. Individual interviews with some survey participants who said they experienced conversion therapy.

The Request for Tender was issued in November 2021 and stated that the research was intended to "*help to inform the policy rationale for and development of a cross-Government approach to dealing with conversion practices in Ireland, including the development of legislation if required* "(p.4).[2.]

In September 2021, Minister Roderic O'Gorman, who commissioned the TCD research, said this research will guide the Government "*to design effective and carefully considered legislation*", that it will be "*based upon evidence*" and will "*rightly be subject to rigorous analysis.*"[39]

In May 2022, Minister O'Gorman said the Irish ban on conversion therapy practices *will be aimed at transgender people, as well as gay, lesbian and bisexual people*" and that "*the findings of this research [referring to the TCD research] will be really important in assisting the Government in developing legislation*". [40] The Minister also said "*I am very conscious that this legislation is not a given . . . That's why it's so important that when we bring forward this proposal it's clear, it's watertight and we have the research to back it up.*" [40.]

This Genspect Review demonstrates that, in the context of gender identity conversion therapy, the evidence presented in the TCD report to define conversion therapy/practices and longer-term consequences of perceived conversion practices is not sufficiently robust to inform legislation, and does not demonstrate that such legislation is required.

3 Literature Review

3.1 UK Government Coventry University Review

The TCD research report relies upon research commissioned by the UK Government Equalities Office (GEO) completed by researchers in Coventry University to support its case for legislation to ban conversion therapy that would include gender identity. The team from Coventry University completed a rapid evidence assessment (REA) of the evidence on conversion therapy and this was published online in October 2021.[41]

The TCD research cites the Coventry research verbatim many times in the report and reviews only new academic research published (between 2020 and 2022) since the Coventry review. The TCD report states:

> "*Given that a rapid evidence assessment (REA) had been recently conducted by Jowett and colleagues and published online in October 2021 (Jowett et al., 2021) it was not the intention of this review to repeat work that had already been completed*" (p.16).[1.]

Dr Adam Jowett, the lead researcher on the Coventry study, was provided with an honorary position in TCD to consult and advise on the TCD research.

3.1.1 Issues with the Coventry University Review methodology, findings and conclusions

Significant issues have been documented regarding the methodology, findings and conclusions of the Coventry research in relation to gender identity conversion therapy.[15]

A summary of these issues is provided here:

The Coventry study based their findings relating to gender identity upon four published studies relating to gender identity conversion therapy, and interviews with six people.[15]

Two[42,43] of the four studies cited by the Coventry team were from research led by Dr Jack Turban. Dr Turban's findings for both studies were based upon a single question in an anonymous online survey carried out in the U.S.A. In 2015 from which the authors claimed to have found that exposure to gender identity conversion efforts are associated with adverse mental health outcomes.[42,43]

This conclusion has been challenged by other researchers[44] who contend that Turban *et al's*. analysis is compromised by serious methodological flaws, including the use of a biased data sample reliance on survey questions with poor validity, and the omission of a key control variable, namely subjects' baseline mental health status.[44]

The third study[45] in the Coventry review, collected transgender participant's perceptions on the therapeutic relationship via an online survey based upon six-minute videos of fictitious short videos of therapists being very affirming, moderately affirming and not affirming of transition to transgender patients. The study found that there were less positive perceptions of the scene involving actors playing the non-affirming therapist. The researchers in this study attached a "Public Significance Statement" to their study claiming that:

> "*Transgender and gender nonbinary people perceive a therapist and mock therapy session more negatively when the therapist is not affirming of a client's possible transgender identity. The study provides empirical evidence for the negative effects that conversion therapy efforts (with transgender and gender nonbinary people) can have on the therapeutic relationship*" (p.423).[45.]

This study does not provide empirical evidence to support this claim.

The fourth study[46] in the Coventry review is a systematic review of academic articles on conversion therapy since 1990. The review found just four studies relating to "gender identity conversion therapy" involving a total of ten individuals[46]. Three of the studies in the review were case studies of specific individuals (a six year old, a seven year old and a 42 year old respectively). The

fourth study[47] was led by one of the leading psychologists specialising in gender dysphoria, Professor Ken Zucker. Zucker *et al*. provided a summary of the therapeutic model and approach used in the Gender Identity Service at the Centre for Addiction and Mental Health in Toronto since the clinic was established in the mid-1970s for the treatment of children aged 2-12 years old referred with gender identity issues[47]. The goal of the Toronto approach is to help the child "*feel more comfortable in his or her own skin*" within a holistic context of positive psychosocial adjustment and adaptation. It includes a strong emphasis on developmental factors. This approach is commonly referred to as "watchful waiting".

Because the gender dysphoria of most of the seven children studied by Zucker resolved, this study was characterised in the review as "gender identity conversion therapy". We strongly refute this characterisation. Prior to the recent emergence of medical gender transition for children and young people, existing research consistently found that with a "watchful waiting" approach, the majority of childhood gender dysphoria (61%-98%) resolved before adulthood, with the majority growing up to be homosexual adults.[48]

Following publication of the Coventry study and a public consultation, the UK Government announced in April 2022 that it would exclude gender identity from the UK conversion therapy bill.[49] On 17th January 2023 the UK government modified their stance, saying the UK draft bill would include conversion practices targeted on the basis of being transgender but specifically acknowledged clinical concerns noting:

> "*The legislation must not, through a lack of clarity, harm the growing number of children and young adults experiencing gender related distress, through inadvertently criminalising or chilling legitimate conversations parents or clinicians may have with their children.*" [50]

None of the methodological issues identified with the Coventry research are acknowledged or addressed in the TCD research report.

3.2 Literature Review Research Papers 2020 – 2022

The TCD report includes a literature review of 12 peer-reviewed academic articles published between 2020 and 2022 investigating conversion therapy including gender identity:

Authors	Location	Type (GICE = gender Identity Conversion Effort)	Anonymous online survey	Interviews	Convenience sampling	Cross-Sectional Design	No baseline mental health	Poor validity survey questions
Heiden-Rootes *et al.* (2022)	USA	GICE	X		X	X	X	X
Lee *et al.* (2022)	South Korea	GICE	X		X	X	X	X
Veale *et al.* (2021)	New Zealand	GICE	X		X	X	X	X
Blais *et al.* (2022)	Canada	SOCE* & GICE	X		X	X	X	X
del Río-González *et al.* (2021)	Columbia	SOCE & GICE	X		X	X	X	X
Goodyear *et al.* (2021)	Canada	SOCE & GICE		X	X	X	X	

Green *et al.* (2020)	USA	SOCE & GICE	X		X	X	X	X
Jones *et al.* (2021)	Australia	SOCE & GICE	X		X	X	X	X
Jones *et al.*(2022a)	Australia	SOCE & GICE		X	X	X	X	
Jones *et al.*(2022b)	Australia	SOCE & GICE		X	X	X	X	
Kinitz *et al.* (2021)	Canada	SOCE & GICE		X	X	X	X	
Salway *et al.* (2021)	Canada	SOCE & GICE	X		X	X	X	X

Table 1: Summary of gender identity conversion research studies included in TCD literature review.

*SOCE = Sexual Orientation Change Efforts

3.2.1 Issues with the evidence presented in the 12 Studies

All 12 studies[51-62] used a cross-sectional design (meaning the participants were studied at a single point in time). Cross-sectional studies are a valid research method, however, they have key limitations:

- Cross-sectional studies deliver low-quality evidence.[63.]
- It is not possible to infer causation from a cross-sectional design.[64.]

Other key limitations which all 12 studies[51-62] were subject to were:

- Varying and vague definitions of "conversion therapy."
- High levels of bias.

- Lack of objective base-line measures of mental health to validate whether an individual's mental health deteriorated following an interaction perceived by the individual as conversion therapy.

3.2.2 Low quality evidence

Cross-sectional studies are a valid research design for testing an initial hypothesis. However, the quality and reliability of the evidence from these types of research are low.[63] Cross-sectional studies are generally followed up with studies using research methods that can deliver higher quality evidence to eliminate erroneous alternative explanations for the study findings.[63]

3.2.3 Inference of causation

All of the studies reviewed relating to gender identity conversion practices use cross-sectional surveys or interviews. It is not possible to determine causation from this type of research[64] and hence results are open to interpretation depending upon researcher perspectives.

Some of the studies acknowledged that causation could not be inferred:

> "*Our cross- sectional study design does not allow conclusions about causal relationships between GICE experiences and mental health indicators"* [52]
>
> "*cross-sectional, retrospective design is subject to recall bias and prevents any causal inferences*", [54.]
>
> "*Alternative possible explanation (*for the results of their research*) is that people with mental health problems are more likely to interpret their interaction with a professional as the professional trying to make them identify only with their sex assigned at birth*".[53]

Yet there are numerous instances in the TCD report[1] where causation is very strongly implied (see

Appendix 1).

The misrepresentation of causation in the TCD report[1] has spread to the public via media reports. Announcing the publication of the report, Minister O'Gorman said "*This practice is abusive and causes significant harms to people already in distress*".[10]

The difference between causation and correlation is extremely important in scientific research. It is also critically important in how that research is interpreted and communicated to the public.[b]

3.2.4 Bias

3.2.4.1 Sampling/Selection bias

Recruitment for participants in at least two[52,57] of the 12 international studies was promoted via LGBT+ advocacy organisations who are publicly

[b] A real-life example of the widespread negative impact which can happen as a result of the misrepresentation of correlation as causation is the MMR vaccine and autism. There is a **correlation** (an association) between the age at which the measles, mumps and rubella (MMR) vaccine is administered and the age at which parents often start to notice autistic traits in their children, but there is no evidence that the MMR vaccine **causes** autism. In 1998, Dr Andrew Wakefield and others published a study in The Lancet medical journal which suggested that the MMR vaccine could predispose children to a regressive form of autism. The study received widespread coverage in the media. The Wakefield paper was eventually retracted by the Lancet in 2010, and Dr Wakefield was found guilty of ethical, medical and scientific misconduct, but not before vaccination rates dropped due to parents' fears that vaccination caused autism and as a consequence there has been a resurgence of measles, mumps and rubella. [68]

campaigning[65] about the harms of conversion therapy and lobbying for policy changes to ban conversion therapy. Recruitment by these groups risks skewing the responses towards respondents who support these advocacy organisations, are aware of their policy aims and are politically active, which means the results may not be representative of the wider affected population.

Sampling via LGBT+ advocacy organisations would likely not include detransitioners who are individuals with gender dysphoria who later regret medical transition. Detransitioners who move beyond a transgender identity are rarely, if ever, included within LGBT+ advocacy. Failure to include detransitioners in research regarding interventions for gender identity issues is a significant oversight.[44] These individuals, whose transgender identification was transient, may have reported differing viewpoints, for example they may have felt that therapies that affirmed their gender identity were harmful.[44]

Research by Dr Lisa Littman on detransitioners[67] found that their decision to detransition was most often tied to the realisation that their gender dysphoria was related to other issues (70%), and the fact that transition did not alleviate their gender dysphoria (50%). 43% of the participants studied by Littman said that a change in political views was one of the reasons for their detransition.[67]

When patients are seeking approval for medical treatment for gender dysphoria, therapists are often required to assess the individual's mental health to ensure that gender dysphoria is not secondary to another condition[44] to try to minimise the likelihood of regret.[67] Hence, the viewpoints of detransitioners are particularly important to consider in clinical contexts relating to gender identity.

The lack of recognition given to the experiences of detransitioners is a massive gap in the TCD research particularly since it concluded that conversion therapy legislation is "*likely to focus on professional contexts with licenced practitioners*".[1.]

3.2.4.2 Demand Bias

Demand bias is also known as the "good subject effect". This form of bias occurs when the researchers reveal their hypothesis and aims which encourages participants to support the researcher's aims with their answers.[69] One of the studies included in the TCD literature review based their research upon the US Transgender Survey 2015 (USTS 2015).[51] The USTS 2015 anonymous online survey recruited participants through transgender advocacy organisations who campaign about the harms of so-called conversion therapy and call to ban it, hence participants would likely know in advance what the researchers were hoping to find. The same risk of bias applies to another study[57] included in the TCD literature review which was run by researchers from the Trevor Project whose "Ending Conversion Therapy" campaign claims:

> "*We are the largest campaign in the world endeavouring to protect LGBTQ young people from conversion therapy" … "Every day we engage in legislation, litigation and public education to end these dangerous and discredited practices*".[65.]

3.2.4.3 Recall Bias

Recall bias is when study participants can erroneously provide responses that depend on his/her ability to recall past events and, if not given proper consideration, it can either underestimate or overestimate the true effect or association.[70] All of the results in the 12 studies[51-62] included in the literature

review were at risk of recall bias as no base-line measures of mental health were taken to independently validate whether an individual's mental health deteriorated following an interaction perceived by the individual as conversion therapy.

3.2.5 Limitations

It is standard practice in academic research for researchers to openly acknowledge the limitations of their research and only draw conclusions that are supported by their findings.

Many of the 12 papers in the TCD review acknowledged some limitations and biases:

> *"The variable used for identifying exposure to GICE did not give details about the nature of the change efforts enacted by the professional(s)." …" we do not know for certain the exact types of interventions the participants experienced*" (p.940)[51]
>
> "*Our cross-sectional study design does not allow conclusions about causal relationships between GICE experiences and mental health indicators. Second, it is difficult to generalize our findings to the total population of trans-gender individuals due to the nonprobability sampling method*" (p.7)[52.]

A study which concluded that participants exposed to gender identity change efforts were at great risk of severe psychological distress admitted that:

> an "*alternative possible explanation (*for the results of their research*) is that people with mental health problems are more likely to interpret their*

interaction with a professional as the professional trying to make them identify only with their sex assigned at birth" [53].

Another study noted "*cross-sectional, retrospective design is subject to recall bias and prevents any causal inferences*".[54].

Despite these limitations, most of the studies concluded - without sufficient supporting empirical evidence - that their findings show that gender identity conversion efforts contribute to mental distress and go on to recommend policy changes to criminalise "gender identity conversion practices". [51-58] Legislators are likely unaware of the lack of evidence underpinning these recommendations.

3.2.6 More research needed

The TCD literature review shows that more research using different research methods is needed. Due to obvious ethical concerns, it would not be possible to design a high-quality evidence study that measured participants wellbeing at a point in time, then subjected participants to potentially harmful practices and then measured participants wellbeing after. However, there are other research designs which could be used ethically, for example, a cohort study that measured the mental health of a group of participants at risk of being subjected to so-called gender identity conversion practices over a period of time could independently record mental health before and after any interventions perceived by the individual as a form of "conversion therapy." This method would reduce the likelihood of recall bias and demand bias.

In addition, the quality of evidence could be strengthened by independently validating participant reports via independent investigation of specific cases of

complaints of conversion therapy relating to gender identity to professional bodies.

3.3 Systematic Review

The TCD research also chose to focus on two systematic reviews:

1. Forsythe, A., Pick, C., Tremblay, G., Malaviya, S., Green, A., & Sandman, K. (2022). Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States. *JAMA Pediatrics*, 176(5), 493–501. https://doi.org/10.1001/jamapediatrics.2022.0042[71]
2. Przeworski, A., Peterson, E., & Piedra, A. (2020). A systematic review of the efficacy, harmful effects, and ethical issues related to sexual orientation change efforts. *Clinical Psychology: Science and Practice*, 28(1), 81–100. https://doi.org/10.1111/cpsp.12377[72]

The systematic review by Przeworski[72] is solely regarding Sexual Orientation Change Efforts (SOCE) so does not provide any further evidence relating to gender identity.

The Forsythe review[71] includes 28 academic studies. Just five of the 28 articles cited in the review relate to gender identity change efforts, the other 25 relate to sexual orientation change efforts.

Three of the five gender identity studies are references to studies led by Dr Jack Turban, but there are in fact just two underlying studies as there is some duplication - Forsythe *et al.* (2022) Reference 72 is a research poster for the same study referenced in Forsythe *et al.* (2022) Reference 12.

The two unique studies led by Dr Jack Turban[42,43] and another study led by Wright[46] were all included in the UK Government Coventry University Review. Significant issues have been documented regarding the methodology, findings and conclusions of these studies in relation to gender identity conversion therapy.[15,44.]

The fourth study by Green *et al*.[57] was included in the TCD Literature Review Research Papers 2020 – 2022 already discussed here.

Since all of the studies relating to gender identity were already included within either the Coventry or TCD literature reviews, the Forsythe systematic review[71] does not provide any additional evidence relating to gender identity conversion efforts.

The claims made by Forsythe *et al.* [71] and repeated in the TCD report[1] regarding gender identity conversion therapy extrapolates "*associated harms totalling over nine billion dollars.*" However, these claims are based upon low-quality evidence, subject to bias on a number of fronts and do not support an inference of causality.

The TCD report[1] notes that the Forsythe review[71] included papers with over 190,000 participants. However, if a research method delivers low quality data and is subject to bias, replication of the same study will not improve the quality of the data or reduce the risk of bias no matter how many participants are studied.

The Forsythe review[71] was funded by the Trevor Project which claims to run the largest campaign in the world to end conversion practices.[65] The Forsythe review acknowledges that the Trevor project was

"*Involved in the design and conduct of the study; collection, management, analysis, and interpretation of the data; review and approval of the manuscript; and decision to submit the manuscript for publication*" (p.500).[71]

3.4 Grey Literature

The TCD review[1] of grey literature only found articles regarding sexual orientation change efforts so does not provide any further evidence relating to gender identity change efforts.

4 Cross-sectional survey and individual interviews

In addition to the literature review of international research the TCD research report included new research in the form of an anonymous online survey and interviews.

4.1 Issues identified with the survey

4.1.1 Anonymous unvalidated responses

The survey was an anonymous online survey. However, there was no validation in place to verify that respondents fit the inclusion criteria[74] that the survey was intended only for participants who are:

- Lesbian, gay, bisexual, transgender or intersex, or have a minority sexual orientation or gender identity.
- Heterosexual (straight) or cisgender (personal identity and gender corresponds with birth sex) and have experienced a therapy, intervention or treatment that aimed to change their sexual orientation or gender identity.
- 18 years old or over.

- Living in the Republic of Ireland.

Respondents were anonymous, could have been any age, and/or living outside Ireland or living in Ireland and recounting experiences that took place in another country. There was no external validation of survey responses or measures in place to ensure respondents only submitted responses to the survey once.

Research has found that complete anonymity decreases motivation to answer thoughtfully and precisely, and that complete anonymity may compromise accuracy of answers.[73]

Due to the nature of the survey design, no base-line measures of mental health were taken to objectively validate whether an individual's mental health deteriorated following an interaction perceived by the individual as conversion therapy[44] therefore any reports of harms were based upon unvalidated self-reports and subject to recall bias and demand bias.[69]

4.1.2 Bias

Organisations with active, public campaigns to ban conversion therapy (LGBT Ireland; Gay Project [Cork] and Transgender Equality Network Ireland (TENI)) provided guidance on the survey design, the interview guide, dissemination of the survey and participant recruitment for the interviews. Recruitment for the survey was by these groups who have publicly declared a "*firm commitment to a ban on so-called "conversion therapy."* These groups have also publicly rejected "*any assertion that the kind of legislation proposed would in any way hinder ethically responsible professionals from providing care, counselling and support to clients*".[11]

Involvement of these groups in the research design and recruitment increases the likelihood of selection bias and demand bias.[69] Selection bias is when the sample recruited for a study does not represent the target population to be studied.[75] In this case the target population was anyone over 18 living in Ireland who had experienced conversion therapy. However, detransitioners or members of the LGB or T communities who are not supporters of these organisations may not have been aware of the survey and not volunteered to participate skewing the results to only include those who share the political views of these groups. Demand bias (also known as good participant bias) occurs when researchers reveal their hypothesis and aims which encourages participants to support the researcher's aims with their answers.[69] Campaigns to ban conversion therapy by organisations who helped with recruitment for the survey may have skewed the sample towards participants who support those organisation's campaigns and hence the results may not be representative.

4.1.3 Validity of conversion therapy question

The survey question about whether participants ever experienced "conversion therapy" was phrased as follows:

> "*Have you ever had any practice, therapy, intervention, or treatment that aimed to change your sexual orientation or gender identity expression to heterosexual/cisgender? These are sometimes referred to as conversion therapies or conversion practices.*"

The survey question does not differentiate between diagnostic evaluations or a specific therapeutic intervention. There is also no information about whether the focus of the encounter was gender dysphoria or another condition. And finally, it

does not determine whether shaming, threats, or other unethical tactics were utilised during the encounter. This lack of context and detail renders the question incapable of differentiating between ethical non-affirmative (neutral) clinical encounters and unethical conversion therapy.[44] Researchers D'Angelo *et al.* (2020) have reported how

> "*Patients with psychiatric diagnoses, highly prevalent in transgender populations, can potentially experience or misinterpret neutral interpersonal interactions as invalidating or rejecting*".[44]

There is further evidence that this survey question may have been misinterpreted by some respondents as the TCD report said, "*interactions with therapists who … closed down discussions about gender identity were interpreted as a form of conversion therapy*" (p.66).[1.]

4.1.4 Survey limitations

The TCD research report acknowledged some limitations to the research noting that due to the sample size and non-probability sampling used, the findings are not representative or generalisable.

Among the other limitations of their research were:

- A cross-sectional survey study design does not allow conclusions to be drawn about causal relationships between perceived gender identity conversion experiences and harm.[64.]
- Survey and interview responses relied upon unvalidated participant self-reports of recalled harms which may have been subject to recall bias.[70.]

- Groups that are actively campaigning to ban conversion therapy formed part of the Research Advisory Group advising the researchers. These groups have published pre-determined viewpoints about the harms of so-called gender identity conversion therapy and the need for legislation to ban it.
    - Recruitment of participants via groups campaigning to ban "harmful conversion therapy" may have made the research vulnerable to overreporting of adverse experiences due to "demand bias.[69]
    - The involvement of individuals from these groups may have introduced confirmation bias to the research. Confirmation bias is a type of psychological bias in which decisions are made according to the subject's pre-conceptions, beliefs, or preferences.[70]
- Other possible explanations [for the TCD research report finding of harm as a result of so-called gender identity conversion therapy] could be that that people with gender dysphoria with underlying mental health problems are more likely to interpret neutral interactions with a professional as invalidating or rejecting.[44,53.]

4.2 Survey Results Analysis

23 of the 38 anonymous online survey respondents said they had some experience of gender identity conversion therapy.

Survey participants reported very different perceptions of what they considered conversion therapy for gender identity:

TCD report findings	Genspect Commentary
Survey participants recounted experiences with mental health professionals "*anxiety provoking, and that they felt that they had to prove themselves in order to access the health care that they required*".	The UK NHS Independent Review into Gender Identity Services for Children and Young People Cass Review interim report notes "*Clinical staff are governed by professional, legal and ethical guidance which demands that certain standards are met before a treatment can be provided. Clinicians carry responsibility for their assessment and recommendations, and any harm that might be caused to a patient under their care*."(p.19)[37] What some participants perceived to be having to "*prove themselves*" may have been clinicians adhering to necessary professional, legal and ethical standards of assessment prior to provision of treatment. The psychotherapeutic process in many cases involves exploring distressing feelings, which can provoke anxiety, this is not necessarily

	evidence of coercive or unethical practices.
One survey respondent described how: *"When I expressed that I didn't feel like the gender other people identified me as and expressed feelings of (what I now recognise as) dysphoria, they told me that what I described made no sense and wasn't possible, and that I must just be afraid of 'becoming an adult'. I felt so belittled I never mentioned it again to anyone for more than a decade. [Extract from survey comments]".* (p.43)[1]	The TCD report said *"For this participant, the therapist's lack of knowledge and expertise in LGBTI+ issues were seen as the root cause for the approach taken. It was also noted that the therapist was not consciously trying to change the persons gender identity. However, this was not everyone's perception, and some participants ceased their interactions and sought out a more affirming therapist* "(p.44)[1] The TCD report exposes contradictions between different participant perceptions of what conversion therapy is: in one instance a therapist not affirming was *not* interpreted as the therapist trying to change the person's gender identity whereas in other instances it was.
"In the context of therapy or professional support, other	

participants also wrote about how they had attended therapy for a specific reason unrelated to their gender identity and believed that the therapist focused too much on this aspect of their lives, rather than their presenting issue." (p.44)[1]	Interactions when therapists focussed too much on gender identity and when therapists did not focus enough on gender identity and closed down discussions about gender identity were both perceived as conversion therapy by different survey participants
"*Interactions with therapists who … closed down discussions about gender identity were interpreted as a form of conversion therapy*" (p.66)[1]	

Table 2: TCD Report findings on what participants perceived to be conversion practices.

4.2.1 Inconsistencies and contradictions

An aim of the research was to:

> "*Establish a definition of conversion therapy and conversion practices as they operate in Ireland (including what conversion practises are used, what signifiers are used and how people consent or assent).* "(p.66)[1]

Table 2 shows inconsistent survey responses that contradict each other regarding the conversion practices participants perceive to be in use or operating in Ireland.

The participant survey responses not only conflict, they do not provide a clear delineation between clinically necessary, ethical professional assessment and treatment of individuals with gender dysphoria and unethical coercive conversion practices.

The 23 anonymous, online survey responses do not provide sufficiently robust evidence to inform a legal definition of gender identity conversion practices as they operate in Ireland.

4.2.2 Key issues highlighted by the survey

The anonymous online survey responses included some negative interactions with mental health professionals for individuals with gender dysphoria or others with gender identity issues who are attending mental health professionals for other reasons. These reports included the following: "*they told me that what I described made no sense*", "*the first thing that came out of the [mental health professional's] mouth was like you know are you sure this isn't just a fashion phase, and you will just grow out of this you know*" and "*The therapist said that all trans people should get therapy and that their gender identity might change after therapy*".[1]

While the TCD research report does not provide evidence that gender identity conversion therapy legislation is required, it does highlight deficiencies in mental health services. Policy makers wishing to improve the lives of people with gender dysphoria should focus their attention not on conversion therapy legislation, but instead on the following areas:

- Substantial investment in mental health services.
- Statutory regulation of counsellors, psychologists and psychotherapists.

- Specific improvements to gender identity services

4.2.2.1 Substantial investment in mental health services

Over the past few decades, successive Irish governments have acknowledged the need to drastically improve mental health services[77], but have consistently failed to follow through and implement recommendations.[78,79,80] Healthcare expenditure in Ireland is comparable with other European countries; Ireland ranks first in health care expenditure as a percentage of GDP and ninth in health care expenditure per capita compared with 14 other European Union member states and the U.K.[81] yet Irish public investment in mental health services for the past decade has been approximately 6% of the total national health budget compared to 10-15% of similar countries including the U.K., France, and the Netherlands.[79,80]

Investment is particularly critical in Child and Adolescent Mental Health Services (CAMHS), particularly the already over-stretched nature of the CAMHS,[38] evidenced both in the recent review report into the care received by children and young people at South Kerry Child and Adolescent Mental Health services between July 2016 and April 2021[82] and in the January 2023 Interim Report of the Independent Review of the provision of Child and Adolescent Mental Health Services in the State by the Inspector of Mental Health Services.[83]

4.2.2.2 Statutory Regulation of Counsellors, Psychologists and Psychotherapists

Professional regulation of counsellors, psychologists and psychotherapists via CORU Ireland's multi-profession health regulator under the Health and Social Care Professionals Act 2005 (amended) is long overdue. The Counsellors and Psychotherapists Registration Board was established in February 2019, as of March 2023 there are outstanding tasks to be completed (including setting pre-

registration education and training standards) prior to the opening of registers for Counsellors and Psychotherapists. Statutory regulation can provide a consistent, transparent process to investigate and adjudicate negative clinical experiences equivalent to the UK Health and Care Professions Tribunal Service (HCPTS). In the UK members of the public can submit official complaints to the HCPTS against professionals. HCPTS panels hear evidence from both complainant and professionals, hearings can be attended by members of the public and journalists and panel decisions are publicly available online.

4.2.2.3 Specific improvements to gender identity services

Specific improvements are needed to gender identity healthcare services including:

- Gender identity services should be governed by clinical need and outcome rather than activist pressure or undue influence.
- Independent review of gender identity services in Ireland is needed similar to the Cass Review in the UK
- Gender identity services should be embedded in the HSE annual service reviews, with adequate and systematic data collection, allowing follow up of outcomes, clear clinical and administrative governance, and excellent standards of quality care.[38]
- Experience from the UK Tavistock GIDS clinic highlights the risks associated with confining care to isolated, singular specialist services and highlights the need to involve local CAMHS and other support services. Specialist services should function as a resource for local services, providing consultation and training, and have structured engagement with

patients, families, educators, and other clinicians and HSE providers and innovate changes based on updated research.[38]

- The importance of evidence-based education about this sensitive topic cannot be underestimated.[38]

4.2.3 Survey claim that 12 years old was forcibly given ECT

Following publication of the TCD report it was widely reported in the media,[10] that a participant was "*forcibly given electro-convulsive therapy (ECT) when he was 12 years old to change his sexual orientation and gender identity*"(p.49).[1] What was not mentioned in media reports was that this claim came from the anonymous online survey, the claim was not independently verified and no details were provided when or where this incident happened. No information has been provided whether this alleged incident of retrospective abuse has been reported by either TCD or the Minister for Children, Equality, Disability, Integration and Youth to TUSLA (the Child and Family Agency) or been followed up or investigated further in any way. If the researchers believe this is a credible allegation then it should be followed up and reported to TUSLA, if the researchers believe it is not credible then it should be noted as such within the TCD research report.

4.3 Interviews

Just two of the seven interviewees in the TCD research report[1] (identified as P4 and P6 in the report) said they had experienced conversion therapy relating to gender identity.

4.3.1 Interviewee P4

4.3.1.1 Intersex Surgery

The first interviewee P4 identified as intersex and transgender: "*P4 talked about their experiences of being intersex and trans. When they were born, the medical staff assigned their gender and performed a surgical operation to align physical appearance with the assigned gender. However, this assigned gender, did not correspond with their gender identity and P4 believed that this is a type of conversion therapy and one that continues to be practiced in Ireland and elsewhere. For P4, this has led to significant health problems.*" (p.42)[1]

Further research is needed to investigate and determine if any unnecessary intersex surgeries have happened and continue to happen in Ireland. A complaints process exists via the Irish Medical Council to investigate complaints against medical doctors including surgeons. The Irish Medical Council can impose restrictions on a doctor's registration and restrict or remove their right to practice medicine in Ireland and this can involve The Courts Service if necessary.

The determination of the appropriateness of complex and rare medical or surgical treatments for intersex conditions (also known as Differences of Sex Development) should not come under the scope of conversion therapy legislation.

Clinical professional judgement can be negatively impacted with devastating consequences when clinicians are trying to interpret the law at the same time as making clinical decisions.[32] The 2020 Judgement in the Judicial Review of the case of Keira Bell and Mrs. A versus the Tavistock and Portman NHS Foundation Trust regarding prescribing puberty-suppressing drugs to persons under the age

of 18 who experience gender dysphoria said it is not for the courts "*to determine clinical disagreements between experts about the efficacy of a treatment*".[33]

4.3.1.2 Gender expression

The TCD report says:

> "*Despite knowing from an early age that their gender identity did not align with the one that was assigned at birth, P4 was not permitted to live in an authentic way and was severely punished by their parents when they expressed anything other than the gender that was assigned to them…These experiences were described as traumatic and had lasting impact on their mental health, resulting in suicidal thoughts and behaviour*." (p.42).[1]

Punishment for gender non-confirming behaviour is wrong. However, criminalisation of anything other than absolute gender identity affirmation within conversion therapy legislation is not an appropriate way to address this issue. Challenging sexist stereotypes via education that there is no right or wrong way to be a boy or a girl is far more appropriate.

4.3.2 Interviewee P6

4.3.2.1 Negative experiences with mental health professionals & views on legislation

The second interviewee P6 began to experience gender dysphoria around 13 years old and attended a mental health service for reasons "*that were intertwined with his gender identity*".[1] P6 described how "the *first thing that came out of the (mental health professional's) mouth was like you know are you sure this isn't just*

a fashion phase, and you will just grow out of this you know. And I kind of, that really put me into a sense of shock" (p.43).[1.]

P6 described how this experience,

> "*Left him feeling alone, isolated and a feeling of being dismissed. This was experienced as a setback, delaying his access to appropriate care and making him feel hopeless for the future. These feelings were worsened by the fact that it was a person with authority who had suggested that it was a phase he was going through*".

P6 "*was not sure if what he experienced could be described as conversion therapy but generally supports the ban on SOGICE*" (p.64).[1.]

P4 shared their views on conversion therapy legislation:

> "*One it needs to be banned, it just needs to be banned in all its forms outright as long as it isn't it sends a message that conversion therapy lite can exist everywhere else... good parents are bringing their kids to see a therapist. And then when they do, they are meeting this [] person who's like look they've got the authority of a therapist and they are like look I teach [name of course] I know for a fact that your child is just [] confused. That's conversion therapy.* (p.63).[1]

The widely differing experiences viewpoints of P4 and P6 do not provide robust evidence from which to derive a definition of conversion therapy to inform legislation.

While the interviews from the TCD research report do not provide evidence that gender identity conversion therapy legislation is required, they do highlight

deficiencies in mental health services. Policy makers wishing to improve the lives of people with gender dysphoria should focus their attention not on conversion therapy legislation, but instead on the following areas detailed earlier in this document:

- Substantial investment in mental health services.
- Statutory regulation of counsellors, psychologists and psychotherapists.
- Specific improvements to gender identity services.

4.3.3 No evidence provided of complaints to Professional Bodies

Further research is needed to verify the reports of the 23 anonymous survey participants and the two interviewees. Evidence of complaints of conversion therapy relating to gender identity should be requested from professional bodies representing clinicians involved in the care of people with gender dysphoria, including the details of any investigations into complaints and professional sanctions resulting from complaints.

Although statutory regulation of psychotherapy and counselling professions in Ireland is not complete, there is a process of self-regulation by existing professional bodies representing psychotherapy and counselling professionals. The largest of these bodies are the Irish Council for Psychotherapy and the Irish Association of Counsellors and Psychotherapists. The Psychological Society of Ireland is the professional body representing psychologists in Ireland and The College of Psychiatrists of Ireland represents psychiatrists.

The fact that that no evidence of “gender identity conversion therapy” has been sought from any professional bodies to corroborate the evidence provided by 23 anonymous survey participants and two interviewees highlights a significant gap

in the TCD research, particularly when this research is intended to inform legislation.

5 Research Independence

5.1 Research Advisory Group Bias

The TCD report says that:

> *"A research advisory group was formed which had representatives from the Department of Children, Equality, Disability, Integration and Youth [DCEDIY]; LGBT Ireland; Gay Project [Cork]; Transgender Equality Network Ireland (TENI) and the psychotherapy services. They provided guidance on the survey design, the interview guide, dissemination of the survey and participant recruitment for the interviews"* (p.16)[1.]

In response to an article detailing clinical concerns about the inclusion of gender identity in proposed conversion therapy legislation published in The Irish Times,[4] the three advocacy groups appointed to the Research Advisory Group co-signed a letter to the Irish Times publicly expressing their *"firm commitment to a ban on so-called "conversion therapy"* stating that they *"reject any assertion that the kind of legislation proposed would in any way hinder ethically responsible professionals from providing care, counselling and support to clients"*.[11]

These groups did not provide any reasoning or evidence to support their rejection of clinical concerns. This letter was published in advance of the commencement of this research and at that time these groups all said in the letter *"we now need to get on with enacting a comprehensive, fully LGBT+ inclusive ban."*[11]

Alan Edge of LGBT Ireland was singled out for specific thanks in the TCD report. Alan Edge is campaign officer of the Ban Conversion Therapy campaign in LGBT Ireland.[40] In response to the 1st April 2022 UK government decision to exclude gender identity from the UK conversion therapy legislation,[49] LGBT Ireland organised a protest outside the British Embassy in Dublin and said "To abandon transgender people in this way exposes them to the real risk of significant and long-lasting psychological harm because of these out-dated and unscientific practices and flies in the face of empirical evidence which demonstrates the harm such practices cause".[84]

In June 2021, Minister Roderic O'Gorman met with Senator Fintan Warfield and lobby group the Anti-Conversion Therapy Coalition, and it was reported that reported Minister O'Gorman "*intends to move forward with further detailed research which will provide the necessary evidence base for legislative proposals to ban conversion therapy*".[85]

In August 2021 before completion of the research he commissioned to "*help to inform the policy rationale for and development of a cross-Government approach to dealing with conversion practices in Ireland, including the development of legislation if required*", Minister O'Gorman announced publicly that "*legislation banning conversion therapy is coming*".[39]

These statements show that the Minister who sponsored the research and a key member of the Research Advisory group believed before the research had begun, that the research would find evidence of harms caused by gender identity conversion therapy.

The individuals appointed to the Research Advisory Group by the Minister all share the Minister's predetermined viewpoints on the need for the inclusion of gender identity within conversion therapy legislation and dismissal of clinical concerns. The Research Advisory Group did not include any members with differing viewpoints.

The TCD research report conclusions align very closely with the Minister's *a priori* expectations of what the research would find, despite - as detailed in this document - the lack of strong supporting empirical evidence. Public statements from the Minister sponsoring the research and the individuals involved within the Research Advisory Group indicate confirmation bias. Confirmation bias is a type of psychological bias in which decisions are made according to the subject's pre-conceptions, beliefs, or preferences.[70] The shared pre-conceptions and beliefs of individuals closely involved with the research and the lack of involvement of any individuals with differing viewpoints, may have influenced the research and suggest that the research was not independent.

5.2 Clinical concerns not addressed

Clinicians working with people with gender dysphoria both in the UK[3] and Ireland[4] have been voicing concerns about the expanded definition of conversion therapy in proposed legislation to include gender identity and expression. The TCD research report made very minor oblique references to these very public concerns: noting "*In the United Kingdom, a partial bill that only bans sexual orientation change efforts for minors and non-consenting adults is being proposed.*" (p. 14)[1]

The UK government decision on 1st April 2022 to exclude gender identity from the UK conversion therapy bill, followed submissions to the UK public consultation on conversion therapy to safeguard[86] evidence-based therapy for people particularly children and young people struggling with gender dysphoria. On 17th January 2023 the UK government modified their stance on this issue again, saying the UK draft bill would include conversion practices targeted on the basis of being transgender but specifically acknowledged clinical concerns noting

> "*The legislation must not, through a lack of clarity, harm the growing number of children and young adults experiencing gender related distress, through inadvertently criminalising or chilling legitimate conversations parents or clinicians may have with their children.*"[50].

The UK government changes in direction are evidence of the ongoing debate and lack of consensus on this complex issue.

It could perhaps be argued by the research team that it was not in the scope of their research brief to directly address clinical concerns, but the Minister who commissioned the research has publicly referenced these concerns[39] so was not unaware. This publicly funded research was a missed opportunity to address these concerns.

6 Conclusion

Based on this review of the evidence presented in the TCD report[1] we conclude that:

- The research does not clearly define the scope of what conversion therapy legislation including gender identity would or would not cover.

- The research does not provide robust evidence to show that legislation to ban "gender identity conversion therapy" in professional contexts with licenced practitioners is required.

If this research is used to inform legislation to ban "gender identity conversion therapy", it risks of negatively impacting ethical professional assessment and treatment of individuals with gender dysphoria. This will leave the growing community of people with gender dysphoria even worse off than they are currently.

Genspect recommends that policy makers wishing to improve the lives of people with gender dysphoria focus their attention not on conversion therapy legislation, but instead on the following areas:

- Substantial investment in mental health services
- Statutory regulation of counsellors, psychologists and psychotherapists
- Specific improvements to gender identity services

Appendix 1

Examples of inference of causality in TCD Report: [1]

"Legislation to ban conversion therapy will also support safety and health by ensuring that those who experience distress about their sexual orientation or gender identity because of homophobia or transphobia are unable to access

formal conversion practices which *have the potential to cause further harm*." (p. 7)

"Prayer and pastoral care can provide support to LGBTI+ people of faith however, efforts to change or suppress sexual orientation or gender identity that are rooted in worship or spirituality *can cause significant harm*." (p. 70)

"Legislation to ban conversion therapy will also support safety and health by ensuring that those who experience distress about their sexual orientation or gender identity because of homophobia or transphobia are unable to access formal conversion practices which *have the potential to cause further harm*" (p. 69)

"One paper specifically focuses on the spiritual *harm that was caused by exposure to SOGICE*"(p. 36)

"Those working with LGBTI+ individuals need to be aware that SOCE and GICE are ineffective and *harmful* and that people who seek out these practices need to be given clear and accurate information about their ineffectiveness and their potential for harm." (p. 7)

"For both the survey and interview participants there were *both short and long term harmful consequences for those exposed*." (p. 6)

"The research studies that were reviewed primarily examined the negative impact of SOGICE on people who were exposed to it. The literature adds to the *growing body of evidence that finds SOGICE harmful and provides evidence of long-term harms*. In the qualitative studies some of the participants were able to

draw a line between their experiences of SOGICE and current mental health difficulties." (p. 36)

"While the focus here is still on changing individuals' sexual orientation or gender identity, there is some emphasis in the literature reviewed on practices that modify, suppress or deter adoption of lesbian, gay, bisexual or transgender identities. Similarly these terms, while less familiar, provide a more accurate description as efforts to change sexual orientation or gender identity are not therapy, are not evidence based and *are often harmful to those exposed*" (p. 68)

"For both the survey and interview participants *there were both short and long term harmful consequences* for those exposed. ... *The combined evidence from the literature and the study is clear that conversion practices pose a significant risk to mental health*." (p. 67)

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