INTERNATIONAL FOUNDATION FOR THERAPEUTIC & COUNSELLING CHOICE

Parliamentary Brief: THE CASS REVIEW AND PSYCHOTHERAPY BANS IN THE U.K.

Laura Haynes, Ph.D., Psychologist
[laura.haynesphd@iftcc.org]
Executive Board, Chair of the Science and Research Council,
International Foundation for Therapeutic and Counselling Choice (IFTCC.org)
25 May 2024

Summary:

(1) Findings of the Cass Review call for a fundamentally different treatment approach from the affirmative-only approach typical of therapy bans. Well-proven mental health therapies to help core gender dysphoria are promising, should be researched, and should be considered legitimate clinical work.
(2) Therapy bans in the form of the Memorandum of Understanding and proposed legislative bans have dangerously reduced access to care for the people they intend to help and have been unhelpful. Therapists avoid taking cases where they could be under threat.
(3) The same points apply to therapies for undesired same-sex attraction and behaviour, as evidenced by the best-available research though not covered in the remit of the Cass Review.

Supporting points with endnotes:

(1) Trans identity is not proven to be inborn. Dr. Cass reported there is no clear evidence that gender incongruence is simply biologically caused[i], but there is broad consensus that gender incongruence results from a complex interplay of biological, psychological and social factors[ii]**.** *Well-proven mental health therapies to help core gender dysphoria* are promising.[iii] They should be recommended and researched[iv] as legitimate clinical work, not criminalised.[v]
(2) The threats to professionals from the therapy bans of the Memorandum of Understanding and prospective legislation, the conflict between their required affirmative-only treatment approach versus the usual holistic and mental health approach to care and the weak research base for gender-related treatment have caused therapists to avoid the risks of treating gender diverse young people at all and have thereby reduced their access to care. To avoid the risks of treating gender distressed young people, mental health professionals were passing referrals for them to GIDS, contributing to overwhelming the Tavistock and ultimately its closure. The final Cass report said difficulty in recruiting and training professionals willing to treat gender dysphoric young people continues. The interference of therapy bans has not been helpful.[vi]
(3) Though not within the remit of the Cass Review, the same points hold for young people with same-sex sexuality, especially if they are distressed by it, as hold for gender distressed young people. (Access to care—testimonies[vii], not biologically determined and has psychological causes[viii], promising standard therapies to manage, reduce or change[ix])

Endnotes for more information and documentation:

[i] **There is no clear evidence that gender incongruence is simply biologically caused.**

> **"8.6 The search for a biological cause** for gender incongruence is important to some transgender people and for some clinicians it is seen to strengthen the justification that medical treatment is warranted." (Cass, April 2024, p. 114, bold added)
>
> "This goes to **the heart of some of the core controversies** in this area, specifically **the nature and causes** of gender incongruence and dysphoria, **which then has bearing on the appropriate clinical response."** (Cass, April 2024, p. 83, bold added)
>
> **"8.11 However, there is still no clear evidence that altered hormonal levels prenatally or during puberty are responsible for the development of gender incongruence**, apart from in [sic] those with DSD, and this is a difficult area in which to test hypotheses." (Cass, April 2024, bold added)
>
> "8.20 As imaging technology continues to advance, brain studies will remain a rich source of further information. However, to date, research in this area **has not reliably identified brain changes directly linked to gender incongruence.** Even if they could, **this might not provide information on [direction of] causality."** (Cass, April 2024, p. 116, bold added)
> Comment: Life experiences modify the brain. Gender incongruent or distressed thoughts, feelings, and behaviours after birth may be causes of changes in the brain.

[ii] **There is broad consensus that gender incongruence results from a complex interplay of biological, psychological and social factors.**

> **8.52** "**There is broad agreement that gender incongruence is a result of a complex interplay between biological, psychological and social factors.** This 'biopsychosocial' model for causation is thought to account for many aspects of human expression and experience including intelligence, athletic ability, life expectancy, depression and heart disease." (Cass, April 2024, p. 121, bold added)
>
> **8.54** "Although we do not have definitive evidence about biological causes of gender incongruence it may be that some people have a biological predisposition**. However, other psychological, personal and social factors will have a bearing on how gender identity evolves and is expressed**." (Cass, April 2024, p. 122, bold added)
>
> **"11.5** ….[The Review] "maintains the position that children and young people with gender dysphoria **may have a range of complex psychosocial challenges and/or mental health problems impacting on their gender-related distress. Exploration of these issues is essential** to provide diagnosis, clinical support **and appropriate intervention."** (Cass, April 2024, p. 150, bold added)

"8.40 Early audits and research suggest that **ACEs [adverse childhood experiences] are a predisposing factor.** This was demonstrated from the earliest audit of the GIDS service (Di Ceglie et al., 2002) and in the systematic review. (Taylor et al: Patient characteristics)" (Cass, April 2024, p. 119, bold added)

"5.50 A review of the first 124 cases seen by GIDS (Di Ceglie et al., 2002) found that **just over a quarter of all referrals had spent some time in care and nearly half of all referrals had experienced living with only one parent.** It showed that **42% of the children** covered by the audit experienced **the loss of one or both parents, mainly through separation**; 38% had family physical health problems; and **38% had family mental health problems**. Physical abuse was documented in 15% of cases." (Cass, April 2024, p. 94, bold added)

"4.10. Another significant issue raised with us is one of diagnostic overshadowing – **many of the children and young people presenting have complex needs**, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria. This issue is compounded by the waiting list, which means that there can be a significant period of time without appropriate assessment, treatment or care." (Cass, 2022, p. 46, bold added)

"8.41 Some people rebut the notion that **trans identity may be secondary to mental health problems,** and instead suggest that the mental health problems that are observed are a response to minority stress." (Cass, April 2024, p. 119, bold added)
"8.42 The association is likely to be complex and bidirectional - that is**, in some individuals, <u>preceding</u> mental ill health (such as anxiety, depression, OCD [obsessive compulsive disorder], eating disorders), <u>may result in</u> uncertainty around gender identity and therefore contribute to a presentation of gender-related distress**. In such circumstances, **treating the mental health disorder and strengthening an individual's sense of self may help to address some issues relating to gender identity.** For other individuals, gender-related distress may be the primary concern and living with this distress may be the cause of subsequent mental ill health. **Alternatively, both sets of conditions may be associated with and influenced by other factors, including experiences of neurodiversity and trauma."** (Cass, April 2024, pp. 119-120, bold added)

[iii] **Well-proven mental health therapies to help core gender dysphoria are promising.**

As previously quoted,
"11.5 ….[The Review] "maintains the position that **children and young people with gender dysphoria may have a range of complex psychosocial challenges and/or mental health problems impacting on their gender-related distress. Exploration of these issues is essential to provide diagnosis, clinical support and appropriate intervention."** (Cass, April 2024, p. 150, bold added)

"11.36 Some therapies, which are well proven for associated mental health problems, already have a strong evidence base. Where it is clear that children/young people have such problems, they should receive the appropriate therapies in the same way as any other young person seeking support from the NHS. **Outcome measures should include evaluating** the impact on the associated medical health condition, and **any additional impact on the gender-related concerns and distress."** (Cass, April 2024, p. 150)
"11.37 Beyond this first line approach, **it is important to understand how specific therapeutic modalities <u>may help the core gender dysphoria</u> and bodily distress."** (Cass, April 2024, p. 150, bold and underline added)

"10.74 The holistic needs assessment and subsequent formulation should lead to the development of **an individualised care plan** with input from the multidisciplinary team." (Cass, April 2024, p. 145, bold added)
"10.75 This should be a collaborative process that involves a young person and their healthcare professional working together to reach a joint decision about care. Shared decision making involves choosing treatments **based** both on evidence, and **on the person's individual preferences, beliefs and values [sic]** (NICE, 2021)"
(Cass, April 2024, p. 146, bold added)
Comment: The person's individual preferences, beliefs and values may be religious and aim to resolve the core gender dysphoria to become comfortable identifying with their sex. Politicians should not forbid them a treatment decision based on their preferences, beliefs and values.

[iv] **Well-proven mental health therapies to help core gender dysphoria should be researched.**
Comment: A therapy ban that prohibits therapies that may help resolve core gender dysphoria will preemptively prohibit research into these therapies that Dr. Cass recommends.

As previously quoted,
"11.36 Some therapies, which are well proven for associated mental health problems, already have a strong evidence base. Where it is clear that children/young people have such problems, they should receive the appropriate therapies in the same way as any other young person seeking support from the NHS. **Outcome measures should include evaluating** the impact on the associated medical health condition, and **any additional impact on the gender-related concerns and distress."** (Cass, April 2024, p. 150)
"11.37 Beyond this first line approach, **it is important to understand how specific therapeutic modalities <u>may help the core gender dysphoria</u> and bodily distress."** (Cass, April 2024, p. 150)

[v] **Well-proven mental health therapies should not be criminalized as "conversion therapy".**

> **"11.5** Whilst the Review's terms of reference do not include consideration of the proposed legislation to ban **conversion practices**, it believes that no LGBTQ+ group should be subjected to conversion practice. **It also maintains the position that children and young people with gender dysphoria may have a range of complex psychosocial challenges and/or mental health problems impacting on their gender-related distress. Exploration of these issues is essential to provide diagnosis, clinical support and appropriate intervention."** (Cass, April 2024, p. 150
>
> **"11.6** The **intent** of psychological intervention is **not to change the person's perception of who they are** but to work with them to explore their concerns and experiences and **help alleviate their distress**, regardless of whether they pursue a medical pathway or not. **It is harmful to equate this approach to conversion therapy as it may prevent young people from getting the emotional support they deserve."** (Cass, April 2024, p. 150)
> Comment: Psychological intervention may help to partially alleviate distress in a person who ultimately pursues a medical pathway.
>
> **"11.7** No formal science-based training in psychotherapy, psychology or psychiatry teaches or advocates **conversion therapy**. If an individual were to carry out such practices they would be acting outside of professional guidance, and this would be a matter for the relevant regulator." (Cass, April 2024, p. 151)
>
> **Comment: Whatever "conversion therapy" means here, *this statement is not true for treatment that has an intent to help reduce core gender dysphoria or incongruence by treating underlying mental health problems based on evidence and a patient's preferences, beliefs, and values. This should be recognized as legitimate clinical work.***
>
> **Support for this treatment intent** comes from Kenneth Zucker who headed the gender services in Toronto, Canada for many years. Dr. Zucker was on the overall Task Force of the American Psychiatric Association's official diagnostic manual in 2013, and he chaired the Sexual and Gender Identity Work Group that wrote the "Gender Dysphoria" diagnosis section for that manual. (American Psychiatric Association, *DSM-5*, pp. vii, x, 451-459) He continues to be the editor-in-chief of the eminent professional journal, *Archives of Sexual Behavior*. **Dr. Zucker is one of the world's leading authorities on gender dysphoria.**
>
> Zucker and his colleagues provided non-affirmative, developmentally focused psychotherapy in various forms—such as play therapy for the child, marital therapy for the parents, or family therapy—wherein, they said, "the goal is to help the child feel more comfortable in his or her own skin." (p. 388) Again, they said, "the goal is to help the child work through their gender dysphoric feelings." (p. 390) **That is, specifically and to be clear, the goal was *to help children resolve their gender dysphoria, become comfortable with their sex and identify with it.*** The therapists did so by exploring the

context in which the gender incongruence or dysphoria emerged and treating mental health challenges or problems that may have been leading to it. Zucker and his colleagues have published descriptive research and case studies on therapy they conducted for this intent. (Example: Zucker et al., 2012)

The largest and methodologically best study to date of gender dysphoria desistence was conducted on **boys who were treated in this clinic by Dr. Zucker and colleagues**. The vast majority of the boys in this study, **88%, became comfortable with their innate sex and came to identify with it.**

Zucker made the case for a gender dysphoric (GD) client's right to have a therapy goal to resolve gender discordance. He noted that the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) in version 6 (SOC-6, Meyer et al., 2001, VI, Options for Gender Adaption, Processes, 2, the organisation then called the Harry Benjamin International Gender Dysphoria Association) recognised this right, but version 7 (SOC-7) (Coleman et al., 2012) expunged it, wrongfully in Zucker's view (Zucker, Lawrence, & Kreukels, 2016, p. 237).

> If a client with GD decided that overt cross-gender expression carried too great a risk of unacceptable consequences and requested a psychotherapist's help in trying to make their gender identity and gender expression more congruent with their assigned sex, would the therapist's participation always be unethical, as the SOC-7 seems to assert? If so, the SOC's position would seem to conflict with the client's right to autonomy and self-determination. Perhaps the overarching treatment goal of psychotherapy for GD [gender dysphoria]—"long-term comfort in . . . gender identity expression, with realistic chances for success in . . . relationships, education, and work" (Coleman 2011, p. 184)—could sometimes best be achieved by supporting clients in a decision to forego gender transition or overt public cross-gender expression. This psychotherapeutic aim, which was explicitly set forth in version 6 of the SOC [i.e., "acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression" (Meyer et al. 2001, pp. 19–20 [if page numbers are different, go to VI, Options for Gender Adaption, Processes, 2], was expunged from the SOC-7. (Zucker, Lawrence, & Kreukels, 2016, p. 237)

Politicians should not forbid this treatment intent. It should be recognized as legitimate clinical work.

[vi] The therapy bans of the Memorandum of Understanding and prospective legislation have contributed to therapists avoiding the risks of treating gender (and sexuality diverse) people at all and have thereby reduced access to care for the people they meant to help. The interference of therapy bans has not been helpful.

"4.20. Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person **they should be taking a mental health approach** to formulating a differential diagnosis of the child or young person's problems. However, **they are afraid of the consequences of doing so in relation to gender distress** because of the pressure to take a purely affirmative approach. **Some clinicians feel that they are not supported by their professional body** on this matter. **Hence the practice of passing referrals straight through to GIDS is not just a reflection of local service capacity problems, but also of professionals' practical concerns about the appropriate clinical management of this group of children and young people."** (Cass, 2022, p. 48)
Comment: Some clinicians feel that they are not supported by their Memorandum of Understanding signatory professional body. The Memorandum of Understanding requires that interventions be based on an affirmation-only viewpoint approach.

"Recruitment and training" (Cass, April 2024, p. 202)
"17.20 The reluctance of clinicians to engage in the clinical care of gender-questioning children and young people was recognised earlier in this report. Clinicians cite this stems from the weak evidence base, lack of consistent professional guidance and support, and the long-term implications of making the wrong judgement about treatment options. In addition, **concerns were expressed about potential accusations of conversion practice when following an approach that would be considered normal clinical practice when working with other groups of children and young people."**
"17.21 Throughout the Review, clinicians working with this population have expressed concerns about the interpretation of potential legislation on conversion practices and its impact on the practical challenges in providing professional support to gender-questioning young people. **This has left some clinical staff fearful of accepting referrals of these children and young people."**
"17.22 Clinical staff must not feel that discharging their clinical and professional responsibility may expose them to the risk of legal challenge, and strong safeguards must be built into any potential legislation on conversion practices to guard against this eventuality. This will be of paramount importance in building (as opposed to diminishing) the confidence of clinicians working in this area. Any ambiguity could serve to further disadvantage these children and young people rather than support them."
"17.23 Clinicians are being asked to work within a **highly emotive and politicised** arena. This, coupled with concerns about the weakness of the evidence base and a lack of professional guidance, **has impacted on the ability of the new services to recruit the appropriate multi-disciplinary workforce."**

"Qualitative research summary":
"Responding to changing social and cultural expectations, **political interference and regulatory scrutiny [the Memorandum of Understanding]**, they [clinicians] said, **made for a difficult working environment."** (University of York, 2024, Appendix 3: Qualitative research summary: Narrative accounts of gender questioning, p. 9, in Cass, April 2024, p. 288)

TREATMENT FOR SEXUALITY DIVERSE PEOPLE WAS NOT WITHIN THE REMIT OF THE CASS REVIEW, BUT THE SAME POINTS AS FOR GENDER DISTRESS ALSO HOLD FOR SAME-SEX SEXUALITY.

[vii] **Access to care impaired--evidence from testimonies.** We may be certain that access to care for them has been likewise dangerously impaired, particularly for those who do not want an affirmative-only approach to treatment, as testimonies document. Political interference and regulatory scrutiny of the Memorandum of Understanding have also left some clinical staff fearful of accepting referrals for *sexuality* diverse young people, especially those who want a different approach to the affirmation-only approach based on their preferences, beliefs and values.

Testimonies. The following testimonies are important windows. The majority are from England, and they are from diverse Christian and Muslim backgrounds, both male and female. (IFTCC, 18 April 2024)

> "I sought numerous counselling with the **NHS** and a few churches, but **no one could really address it. Most were even scared to deal with it."** (Male, 35, England)
>
> **"I always had such a desire to one day see my wife walking down the aisle in a beautiful wedding dress, experience the joys of pregnancy with her, raise those same biological children together, and spend the rest of our lives together.** But one day, I realised that the services in my own country – the place which was meant to care for me until my dying breath – had begun their planning to ensure that my biggest dream was dead even before it had even had the chance to begin. This was the loneliest time of my life, and everywhere I turned I felt trapped.
> "Accept yourself, be true to who you are…" rang in my ears. I knew that if I was "just myself" I would be accused of having "internalized homophobia" and I would be called a "bigot". I feared that if I had been open about my feelings and wants, I may have risked penalties for upsetting people in the LGBTIQ+ community just because I did not want to accept that identity. No, it is not because my parents were 'bigoted' either because they always told me they would love me no matter what I would choose.
> **I would vomit from stress. I felt that if I wanted what I wanted, I would never be able to open my mouth to anyone else in a "free" country.**
> **Eventually, I opened my bedroom window, determined to jump.**
> **I eventually started counselling with a Christian counsellor who I met through the IFTCC from the United States because I did not feel safe doing counselling here in the UK.**
> **I noticed that when I would heal from one trauma, I would look back at a particular sexual fantasy/desire and realise that it was significantly weaker, or completely gone.**
> **I then started to become more curious about women.** I noticed myself admiring their beauty and experiencing those butterflies which I'd so wished to have.
> I look forward to experiencing my dream of marriage with a woman without an ounce of fear about the future. I am able to laugh heartily every day, I feel good

about and in myself, and **I would never take an opportunity to cut the life I now flourish in short. I despair, however, when I think how hard it is for people who are in the position I was in. Something needs to change** – they are people too and deserve to live fulfilled and happy lives just like mine. This was hard to find." (Male, 21, England, excerpts from longer testimony)

"I felt completely unable to approach the NHS for help with these issues, including depression which I knew to be related, because their answer would be that I should embrace my same sex attractions which is contrary to what I wanted to do. As a result, I felt trapped and said to myself that I would 'take this issue to the grave'. I no longer wanted to be alive." (Male, 31, England)

"After the break-up, **I knew immediately that the NHS would not help** with this specific issue due to the cultural norms around LGBT in the UK, which is why I sought help from [redacted] at Core Issues Trust and IFTCC. [redacted] was able to give me some wise counsel around how to deal with relational problems and he helped me to connect with other people on a similar journey." (Male, 33 England)

"How can the government not allow help for people like me?? Is it because they think we don't exist? I know our voices are being silenced and I don't feel heard, I feel attacked and singled out for my belief because it goes against LGBTQ community." (Female, 35, England)

"I am from an invisible minority of people who have been ignored, slandered, and hurt deeply by the NHS, the education system, **mental health bodies, the government**, and society itself. Until today, I still experience abuse online or mocking in person. If I identified as part of the LGBTIQ2+ community and my identity was attacked in this manner, all of these things would have been taken very seriously – and rightly." (Male 21, England)

Such individuals are not really even recognised to exist and are being systematically excluded from receiving care consistent with their own preferences, beliefs and values.

[ix] **Promising standard therapies to manage, reduce, or change.** Same sex attraction, behaviour and identity, like gender dysphoria, commonly become manageable, reduce or change through life experience, standard professional therapies or pastoral counselling.

There are more people in the United Kingdom of former same-sex sexuality than continuing same-sex sexuality. Researchers re-analysed UK population data and found,

> "The 2010 UK National Survey of Sexual Attitudes and Lifestyles (NATSAL-3) documented that the percent of ex-gays in the UK population—persons who formerly identified as LGB, described themselves as primarily attracted to

persons of the same sex, or engaged in same-sex relations, but now have partially or fully desisted from one or more of these things—was, **at 2.9% in that survey, slightly larger than that of persistently LGB-identified persons (2.8%).”** (Calatrava, Sullins, & James, 2023, p. 609, Table 2, males and females combined]

Men who have sex with men can decrease same-sex partners to reduce HIV risk, especially men who are fathers and men for whom same-sex behaviour is not consistent with their values (measured by researchers as “homonegativity”). (4 Randomized, controlled trials by LGB-affirming researchers and therapists: Shoptaw, et al., 2005; Shoptaw, et al., 2008; Repack & Shoptaw, 2014; especially fathers and values: Nyamathi et al., 2017)

People have reported same-sex attraction and behaviour change and improved psychological functioning through therapy. (Examples: 2 prospective, longitudinal, quasi-experimental, naturalistic, repeated measures studies: Pela & Sullins, 2021; Jones & Yarhouse, 2011. See also Sullins, Rosik, & Santero, 2022 for considerable detail on changes and mental health benefits.)

Even for LGB-identified people who do not change sexuality through professional or pastoral counselling, suicidality is less than it was before the counselling and less than for people who did not have the counselling. (This is the *only known study to date* of LGB-identified people who did and did not receive “SOCE”—"sexual orientation change efforts” *that is nationally representative, so generalisations can be made*. It analysed the Generations data set in the United States created by the author of the Minority Stress Theory (MST) and colleagues at the Williams Institute at the University of California (UCLA) School of Law. (Lifetime suicidality greater before versus after SOCE and responses to commentors on the study: 2022b; 2023a; 2023b; Suicidality during previous 12 months was less for those who had SOCE: Sullins 2022a; These studies reanalyse the same data set that Blosnich et al., 2020 used and constitute a significant rebuttal.)

Conclusion: Some people want to receive treatment, based on well-proven therapies and their preferences, beliefs and values, to explore the context in which their same-sex attraction or behaviour emerged and their potential to manage, reduce or change their same-sex attraction or behaviour. They deserve a registered, qualified counsellor skilled in helping them too. Politicians should not tell them who they are and what will make them happy. They should have the right to help to live the way that brings them health and happiness.

References

Blosnich, J.R., Henderson, E.R., Coulter, et al. (2020). Sexual orientation change efforts, adverse childhood experiences, and suicide ideation and attempt among sexual minority adults, United States, 2016-2018. *American Journal of Public Health Surveillance, 110(7)*, 1024-1030. https://doi.org/10.2105/ajph.2020.305637.

Calatrava, M.D., Sullins, P.D., & James, S. (2023). Sexual identity-behavior discordant heterosexuals in Britain: Findings from the National Survey of Sexual Attitudes and Lifestyle 2010-2012 (NATSAL-3), *Sexes, 4(4).* 609. https://doi.org/10.20944/preprints202310.1088.v1.

Coleman, E., Bockting, W., Botzer, M., et al. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. *International Journal of Transgenderism, 13*, 165-232. https://doi.org/10.1080/15532739.2011.700873

Coleman, E., Radix, A., Bouman, W., et al. (2022). Standards of care for the health of transgender and gender diverse people, Version 8. *International Journal of Transgender Health, 23(sup1),* S1-S259. https://doi.org/10.1080/26895269.2022.2100644.

Fergusson, D., Horwood, L., Beautrais, A. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 56,* 878. https://doi.org/10.1001/archpsyc.56.10.876.

Francis, A. M. (2008). Family and sexual orientation: The family-demographic correlates of homosexuality in men and women. *Journal of Sex Research, 45(4)*, 371-377. https://doi.org/10.1080/00224490802398357.

Frisch, M. & Hviid, A. (2006). Childhood family correlates of heterosexual and homosexual marriages: A national cohort study of two million Danes. *Archives of Sexual Behavior, 35,* 533-547. https://doi.org/10.1007/s10508-006-9062-2.

Ganna, A., Verweij, K.J.H., Nivard, et al. (2019a). Large-scale GWAS reveals insights into the genetic architecture of same-sex sexual behavior. *Science 365*, eaat7693. https://doi.org/10.1126/science.aat7693.

Ganna et al. (2019b). What we found and limitations. Genetics of Sexual Behavior: A website to communicate and share the results from the largest study on the genetics of sexual behavior. https://geneticsexbehaviour.info/what-we-found/

International Foundation for Therapeutic and Counselling Choice (IFTCC) (April 2024). My experience of accessing help for unwanted same-sex attractions. IFTCC Submission to PSA. Pre-online publication projected in due course to be open to the public at https://archive.iftcc.org .

Jones, S. & Yarhouse, M. (2011). A longitudinal study of attempted religiously mediated sexual orientation change. *Journal of Sex & Marital Therapy, 37*, 5, 404-427. https://doi.org/10.1080/0092623x.2011.607052.

Meyer, W., Bockting, W.O., Cohen-Kettenis, P., et al. (Feb. 2001). The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version. https://www.cpath.ca/wp-content/uploads/2009/12/WPATHsocv6.pdf

Nyamathi, A., Reback, D.J., Shoptaw, S., Salem, B.E., Zhang, S. & Yadav, K. (2017). Impact of tailored interventions to reduce drug use and sexual risk behaviors among homeless gay and bisexual men. *American Journal of Men's Health*, *11(2*), 208–220. https://doi.org/10.1177/1557988315590837.

Pela, C. & Sutton, P. (2021). Sexual attraction fluidity and well-being in men: A therapeutic outcome study. *Journal of Human Sexuality, 12*, 61-86. https://df6a7995-c8cd-4a49-bc0d-2ef92e2cf904.filesusr.com/ugd/ec16e9_08ac87b9a4a94711b6b72429723cda6a.pdf.

Reback, C. J., & Shoptaw, S. (2014). Development of an evidence-based, gay-specific cognitive behavioral therapy intervention for methamphetamine-abusing gay and bisexual men. *Addictive Behaviours, 39*, 1286-1291. https://doi.org/10.1016/j.addbeh.2011.11.029.

Shoptaw, S., Reback, C.J., Larkins, S., Wang, P., Rotheram-Fuller, E., Dang, J., & Yang, X. (2008). Outcomes using two tailored behavioral treatments for substance abuse in urban gay and bisexual men. *Journal of Substance Abuse Treatment, 35*, 285-293. https://doi.org/10.1016/j.jsat.2007.11.004.

Shoptaw, S., Reback, C.J., Peck, J.A., Yan, X., Rotheram-Fuller, E., Larkins, S., Veniegas, R.C., Freese, T.E., & Hucks-Ortiz, C. (2005). Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviours among urban gay and bisexual men. *Drug and Alcohol Dependence, 78(2)*, 125-134. https://doi.org/10.1016/j.drugalcdep.2004.10.004.

Singh D., Bradley S.J., and Zucker K.J. (2021) A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry, 12*, 632784. https://doi.org/10.3389/fpsyt.2021.632784.

Sullins, D. (2022a). Absence of behavioral harm following non-efficacious sexual orientation change efforts: A retrospective study of United States sexual minority adults, 2016-2018. *Frontiers in Psychology, 13*, article 823647. https://doi.org/10.3389%2Ffpsyg.2022.906401.

Sullins, D. (2022a). Corrigendum: Absence of behavioral harm following non-efficacious sexual orientation change efforts: A retrospective study of United States sexual minority adults, 2016-2018. *Frontiers in Psychology, 13*, article 823647. https://doi.org/10.3389%2Ffpsyg.2022.906401.

Sullins, D.P. (2023a). Critiques strengthen and improve the original findings: Rejoinder to commentaries on Sullins (2022b). *Archives of Sexual Behavior, 52(3),* 889-899. https://doi.org/10.1007/s10508-023-02566-x

Sullins, D.P. (2023b). Reply to Strizzi and Di Nucci (2023b) on ethical and human rights concerns of sexual orientation change efforts. *Archives of Sexual Behavior, 52(7),* 2727-2730. https://doi.org/10.1007/s10508-023-02684-6.

Sullins, D. P. (2022b). Sexual orientation change efforts do not increase suicide: Correcting a false research narrative. *Archives of Sexual Behavior, 51(7),* 3377-3393. https://doi.org/10.1007/s10508-022-02408-2.

Sullins, D.P., Rosik, C.H., & Santero, P. (2021). Efficacy and risk of sexual orientation change efforts: A retrospective analysis of 125 exposed men [version 2; peer review:2 approved]. *F1000Research, 10*:222. https://doi.org/10.12688%2Ff1000research.51209.2.

Tolman, D., & Diamond, L., Co-Editors-in-Chief (2014). *APA Handbook of Sexuality and Psychology*. 2 Volumes. Washington D.C.: American Psychological Association. https://www.apa.org/pubs/books/4311512.

Udry, J.R., & Chantala, K. (2005). Risk factors differ according to same-sex and opposite-sex interest. *Journal of Biosocial Science, 37,* 481–497. https://doi.org/10.1017/s0021932004006765.

Zucker, K.J., Lawrence, A., Kreukels, B. (2016). Gender dysphoria in adults. *Annual Review in Clinical Psychology, 12*, 217-247. https://doi.org/10.1146/annurev-clinpsy-021815-093034.

Zucker, K.J., Wood, H., Singh, D., & Bradley, S.J. (2012). A developmental, biopsychosocial model for the treatment of children with gender identity disorder, *Journal of Homosexuality, 59(3),* 369-397. https://doi.org/10.1080/00918369.2012.653309.