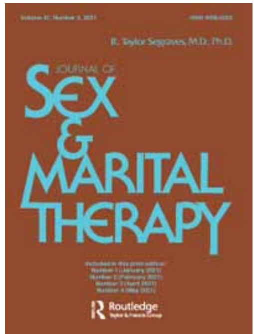

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A Typology of Gender Detransition and Its Implications for Healthcare Providers

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ABSTRACT
Gender detransition is an emerging yet poorly understood phenomenon in our society. In the absence of research, clinicians and researchers have applied the concept of detransition differently, leading to inconsistencies in its use. The article suggests a typology of gender detransition based on the cessation or the continuation of a transgender identity to address this issue. Implications of this typology for healthcare providers are discussed, emphasizing the increasing necessity of developing clinical guidelines for detransitioners. Finally, the article reflects on the possibilities of preventing detransition, which underlines the challenges that clinicians face when treating individuals with gender dysphoria.

Introduction

Gender detransition, i.e., the process of reidentifying with one's birth sex after having undergone a gender transition, has captured the attention of the scientific community, the media, and the public in the last few years. Despite not being a genuinely novel phenomenon from a historical perspective—psychiatrist Harry Benjamin described one such case in his 1966 book *The Transsexual Phenomenon*—, research on detransition has been absent from the academic literature until recently. As a consequence, our understanding of this issue is still limited and primarily based on anecdotal evidence, which comes from a variety of sources such as personal testimonies shared on the internet (e.g., González, 2019; Palmer, 2020), parent reports (e.g., Barnes, 2020), informal surveys carried out by detransitioners (Stella, 2016), media outlets (e.g., Dodsworth, 2020; Herzog, 2017), support groups (e.g., Post-Trans, n.d.; The Detransition Advocacy Network, n.d.), documentaries (e.g., BBC Newsnight, 2019), case studies (e.g., Cain & Velasco, 2020; Expósito-Campos, 2020; Levine, 2018b; Pazos-Guerra et al., 2020; Turban & Keuroghlian, 2018), and the experiences of clinicians who work with this cohort (e.g., Graham, 2017; Marchiano, 2020).

Gender detransition is as scientifically fascinating as socially controversial, for it poses significant professional and bioethical challenges for those clinicians working in the field of gender dysphoria (henceforth "GD"). However, the scarcity of information, along with the lack of formal recognition of detransitioners and their experiences—although this trend seems to be changing (e.g., Butler & Hutchinson, 2020; Entwistle, 2020)—, has contributed to a state of things in which we fall short of a shared and scientifically consolidated language to approach detransition. This gap has favored the proliferation of inconsistent usages of the concept, thus adding to the confusion and unclarity.

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The term "detransition" has been used to describe two types of situations. In the first, a person stops identifying as transgender[1] after having socially, legally, or medically transitioned. This decision usually involves halting and reversing the transition process, for instance, by stopping taking hormones and going back to the pre-transition name and pronouns. In the second, a person stops transitioning due to health concerns, lack of societal/familial support, or dissatisfaction with the results—among many other reasons—but does not cease to identify as transgender. That person would not have decided to stop transitioning had the circumstances been different.

There is a fundamental distinction to make between the two scenarios just delineated. In the first scenario, the person stops transitioning because he/she no longer identifies as transgender. He/she may still experience some symptoms of GD (Lev, 2019), but concludes that being transgender is not the reason underlying his/her distress and body discomfort. In this case, detransition is fundamentally driven by the cessation of a transgender identity, which renders the process of transitioning not desirable or necessary anymore. In the second scenario, the person stops transitioning for reasons beyond their control, but not because they do not identify as transgender. In this case, detransition is motivated by external forces that make transitioning difficult, risky, or a too-heavy load to bear. The critical factor that differentiates these two situations is the *cessation of a transgender identity through the reidentification with one's birth sex.*

If we abided by the definition of detransition given initially—i.e., reidentifying with one's birth sex after having transitioned—, the second scenario described above would not constitute a "genuine" instance of detransition. Nevertheless, many clinicians have used—and use—the concept as including examples of that sort. For instance, Turban and Keuroghlian (2018) describe the case of "Lupita," a transgender woman who stops and reverses her social and medical transition due to continuous harassment and institutional disregard but resumes the process after finding herself in a more favorable and accepting environment. Pazos-Guerra et al. (2020), on their part, report the case of a 16-year-old transgender man who stops his hormonal treatment with testosterone after considering that it brings no more benefit to his identity. He expresses feeling less gender dysphoric and comfortable with the experienced physical changes. At present, he keeps identifying, living, and presenting to others as a man. In these cases, the decision to stop medically transitioning is not driven by the cessation of a transgender identity, but by social discrimination and satisfaction with the already achieved physical changes, respectively.

If not by the term "detransition," how do we refer to these particular situations in which the reason to stop transitioning does not relate to a reidentification with one's birth sex? More importantly, is it feasible to maintain such a concrete definition when the term is already being used—and will most probably keep being used—with a different connotation? Instead of adopting a prescriptive stance, these difficulties could be resolved by (1) Accepting a rather general definition of detransition, e.g., as the *interruption or reversal of a gender transition process*; and (2) Delineating a typology of gender detransition based on the cessation or the continuation of a transgender identity, which is the *core or primary* reason behind people's desire to transition in the first place.

A typology of gender detransition

Typologies are useful because they allow clinicians to discriminate between situations that may appear to be similar but, in reality, have entirely distinct causes, trajectories and, more importantly, demand different therapeutic approaches. For example, in the past, researchers have widely used typologies of GD based on the age of onset or the individual's sexual orientation to describe, classify, and understand people who receive the diagnosis (see Lawrence, 2010). By having a typology of detransition, it would be possible to maintain a unified definition of detransition—thus overcoming the disparities in its use—while also signifying the primary rationale underlying each particular case. The typology proposed in this article distinguishes between two main types of detransitions: *core*—or primary—and *non-core*—or secondary—detransitions.

Core gender detransitions

In core or primary detransitions, the decision to detransition is primarily motivated by the cessation of a transgender identity. This category potentially includes anyone who identified as transgender, socially or medically transitioned, and later returned to identifying with his/her birth sex. The reasons behind core or primary detransitions are multifarious, and may comprise: realizing that transitioning does not alleviate GD (Dodsworth, 2020; Herzog, 2017; Lev, 2019; Marchiano, 2020), finding alternative ways to cope with GD (Herzog, 2017; Stella, 2016), mental health concerns (Post-Trans, n.d.; Stella, 2016), solving previous psychological/emotional problems that contributed to GD (Butler & Hutchinson, 2020; Stella, 2016), the remission of GD itself over time (Stella, 2016), understanding how past trauma, internalized sexism, and other psychological difficulties influenced the experience of GD (Dodsworth, 2020; González, 2019; Herzog, 2017; McFadden, 2017; Post-Trans, n.d.; Stella, 2016; Yoo, 2018); the reconciliation with one's sexuality (Marchiano, 2020; GNC Centric, 2019; Pazos-Guerra et al., 2020; Post-Trans, n.d.); and a change in individual, political, social, or religious views that leads the person to question his/her transgender status (Dodsworth, 2020; Expósito-Campos, 2020; Herzog, 2017; Kermode, 2019; Stella, 2016; Turban & Keuroghlian, 2018).

One particular subcase within core detransitions concerns people with autism spectrum disorders (ASD). Anecdotal reports (e.g., Barnes & Cohen, 2019; Post-Trans, n.d.; Prestidge, n.d.) indicate that the rate of detransitioned individuals who fall within the autistic spectrum is higher than one would expect in the general population. In this regard, emerging evidence suggests a co-occurrence of GD and ASD (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010; Glidden, Bouman, Jones, & Arcelus, 2016; van der Miesen, Hurley, & de Vries, 2016), which may be related to an elevation in intense/obsessional interests around gender-related themes (VanderLaan et al., 2014; Zucker et al., 2017). The high number of individuals with GD who appear to fall in the autistic spectrum may explain why a significant number of core detransitioners also present autistic traits.

One would expect the likelihood of future retransitioning—i.e., resuming or reinitiating one's gender transition—after a core detransition to be low. Nevertheless, given how fluid and changeable some individuals' identities are, this possibility should not be completely ruled out. In either case, any hypothesis relative to the developmental trajectories of core detransitioners would need to be verified by in-depth, preferably longitudinal research into their life experiences.

Non-core gender detransitions

In non-core or secondary detransitions, the decision to detransition is influenced by reasons other than the cessation of a transgender identity. This category potentially includes anyone who stops or reverses their gender transition but continues to identify as transgender. The reasons behind non-core or secondary detransitions are also diverse and extend to: health concerns, including medical complications and the appearance of undesired side-effects (Danker, Narayan, Bluebond-Langner, Schechter, & Berli, 2018); disappointment or dissatisfaction with the results of medical—hormonal or surgical—treatments (Cain & Velasco, 2020; Graham, 2017; Pinkston, 2017); lack of societal support and lack of financial resources (e.g., Rei, 2018); pressure from family members or spiritual counselors (James et al., 2016); social discrimination/harassment (e.g., Kanner, 2018; Rose, 2018; see James et al., 2016); having trouble getting a job (James et al., 2016); feeling already comfortable with the acquired physical changes and thus not wanting to go any further (Graham, 2017); and the desire to become a parent (e.g., Americo, 2018) or undertake fertility preservation procedures (e.g., White, 2018). Non-core or secondary detransitions also include those who stop medically transitioning due to a change in gender identity yet maintain a transgender identity. Cain and Velasco (2020), for instance, report the case of "Gray," a natal

female with ASD who initially identifies as a transgender man and begins hormone replacement therapy (HRT) with testosterone, but later decides to stop HRT and detransitions to a non-binary identity.

In many of the cases above, detransition has a temporary character (see, e.g., James et al., 2016), and the likelihood of future retransitioning may be higher, given that the underlying identitarian motivation to transition—be it socially or medically—remains.

Further clarifications

Some might have noticed that this typology does not include *desisters*, i.e., those who desist in their gender dysphoric feelings—and, in some cases, also from a transgender identity—*before undergoing any kind of gender transition*, be it social or medical. The reason behind this exclusion is purely conceptual: it is essential to separate between desistance and detransition, which are two closely related but qualitatively distinct phenomena. The difference between both concepts is twofold. First, desistance, as it has been described in the literature, involves the remission of GD (e.g., Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011), while detransition does not. Many detransitioners experience symptoms of GD long after having detransitioned (Lev, 2019). Second, desistance occurs without there being a gender transition process, while detransition occurs after having socially, legally, or medically transitioned.

It is also important to note that this typology does not suggest two clear-cut categories, for a secondary detransition can lead to a primary detransition—but not vice versa. In *r/detrans* (https://www.reddit.com/r/detrans/), a subreddit for detransitioners to share their experiences with more than 16.000 members, one can find several stories of people who call their transgender status into question after stopping transitioning due to medical complications or feeling dissatisfied with their treatment results. Furthermore, some individuals initially detransition to a non-binary identity to later end up reidentifying with their birth sex (e.g., tuffsofty, 2020). In some of these cases, a non-binary identity may be functioning as a "transitional period" before taking the definitive decision to stop identifying as transgender.

Admittedly, the relevance of the typology will depend on how well it encapsulates the experiences of all those who detransition, something that demands much more investigation—both quantitative and qualitative—into the phenomenon. However, based on our present knowledge, understanding the differences between core and non-core detransitions, as well as the reasons that might lead an individual to make such a decision, has particularly crucial implications for clinicians working in the field of GD.

Implications for healthcare providers

Core or primary detransitions underline Zucker's (2018) important—and often missed—remark that "a transgender identity is not isomorphic with a diagnosis of gender dysphoria" (p. 232). The former is the result of a subjective process of self-labeling and self-determination—that may be shared by others, including friends, family members, and clinicians—; the latter must be based on rigorous and comprehensive psychological assessments, which include attempts at differential diagnosis (Byne et al., 2018) and screening for any other potentially associated psychological issue (see Coleman et al., 2012, pp. 180–181).

On the one hand, this highlights the importance of not drawing *solely* on people's identities as the basis for decision making in clinical settings. Identities can be fluid and variable over time and thus do not constitute a reliable ground for clinicians to judge the best therapeutic approach for each patient. In this regard, some of the detransitioners interviewed by Yoo (2018) regret not having received a sufficient exploration of their previous psychological and emotional problems before transitioning, which may have played a significant role in their experience of GD. Others

express having been too enthusiastically "affirmed" in their identities by their clinicians, which led to a poor understanding of the medical procedures and the consequences of those changes. Clinicians have the "epistemological responsibility" (Van Baalen & Boon, 2015) of constructing a comprehensive and coherent picture of their patients by gathering all sorts of information to ensure that their treatment decision is indeed the best possible.

On the other hand, Zucker's (2018) observation evinces the importance of offering individuals various alternatives to address their concerns instead of promoting a one-and-only therapeutic approach. Some patients might prefer to deal with their GD in a non-affirmative manner but might be unaware of how or where to get that kind of help. They deserve to be supported in that decision and have their needs served to the best of the clinicians' abilities. For instance, many detransitioners in Yoo's (2018) study "wished their providers […] had initiated a discussion about other ways to address, treat, or live with gender dysphoria" (p. 184). Thus, developmentally informed, ethical, exploratory psychotherapy should be equally available for individuals—along with biomedical interventions—as a first-line treatment to ameliorate their feelings of GD (D'Angelo et al., 2020). This is especially significant insofar as considerable gaps in knowledge still exist regarding the impact and safety of gender-affirmative medical interventions for youth with GD (Olson-Kennedy et al., 2016), a circumstance that requires clinicians to be open about different therapeutic approaches instead of fostering a single view, for doing so "is worse than admitting uncertainty" (Lenzer, Hoffman, Furberg, & Ioannidis, 2013, p. 2).

Non-core or secondary detransitions emphasize the importance of communication between healthcare providers and their gender dysphoric patients. Clinicians should avoid creating unrealistic or unattainable expectations around the impacts and benefits of gender-affirmative treatments (GAT). Several studies have found GAT to improve gender dysphoric individuals' mental health and psychosocial functioning (e.g., Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; Costa & Colizzi, 2016; de Vries et al., 2014), but others have reported no significant differences (see Costa & Colizzi, 2016). In this regard, it is crucial to bear in mind that one size does not fit all (D'Angelo et al., 2020), meaning that GAT may not be a panacea for every individual with GD. Moreover, GAT do not necessarily bring benefits to other domains of the individual's life, so clinicians must address any potential issue in these areas in addition to GD. Finally, the physical results of biomedical GAT are not equal for everyone and, in some cases, they may involve side effects and medical complications (Chew, Anderson, Williams, May, & Pang, 2018; Scahrdein, Zhao, & Nikolavsky, 2019).

However, the insistence and pressure to initiate GAT that some adolescents with GD put upon clinicians can hinder the conducting of adequate psychological assessments (Becerra Fernández, 2020) and the fluid communication during the whole process. Therefore, it is more important than ever that clinicians be honest and transparent with their patients about the *known* benefits, risks—biological, social, and psychological—, and long-term consequences associated with each treatment option, which is the only way to ensure the obtention of meaningful informed consent (Levine, 2018a).

Additionally, non-core detransitions highlight the crucial role of clinicians in providing comprehensive psychosocial support through the process of gender transition, which may function as a protective factor for those individuals facing societal, institutional, or workplace discrimination, as well as pressure to detransition from their families or spiritual advisors. Regular and frequent follow-ups ensure transgender individuals' adjustment and well-being and, as such, they should always be an essential feature of a high-quality service for patients with GD.

The increasing necessity of developing clinical guidelines for detransitioners

The rising numbers of detransitioners (Lane, 2019; Marchiano, 2020) who are publicly sharing their experiences speaks to the necessity of developing and implementing new clinical guidelines for clinicians working in the field of GD (Butler & Hutchinson, 2020). These would preferably

need to address the differential—though sometimes overlapping—necessities of both core and non-core detransitioners.

For core detransitioners, these may include (1) Obtaining information on how to safely stop HRT; (2) Finding alternative, non-medical ways to cope with GD; (3) Securing ongoing psychological support to deal with the possible distress, anxiety, shame or regret associated with the experience of detransition; (4) Securing ongoing psychological support to address any other existing mental health issue; (5) Understanding the origins of GD and the role that identifying as transgender and transitioning played in that person's life; (6) Receiving counseling on how to announce detransition to family and friends; (7) Obtaining information about the possibilities of reversing some the physical changes derived from HRT and/or sex reassignment surgeries (SRS); (8) Obtaining information on the possibility to change back one's legal name and sex on the civil registry; and (9) Accessing legal support in cases of possible medical malpractice—organizations such as the Gender Care Consumer Advocacy Network (GCCAN; https://www.gccan.org/) have been created with this purpose.

For non-core detransitioners, these may include (1) Obtaining information on how to safely stop—and resume, in case of retransitioning—HRT; (2) In case of side effects or medical complications, receiving counseling on how to cope with these fallouts, as well as obtaining information on the possibilities of undergoing a less invasive GAT; (3) Securing ongoing psychological support to deal with discrimination, anxiety, uncertainty, or any other negative experience associated with being transgender; (4) In case of dissatisfaction with the results of the GAT, obtaining information about the possibilities of reversal; (5) Receiving counseling on how to announce detransition—and retransition, given the case—to family and friends; (6) Exploring how detransitioning might affect their experienced gender identity; and (7) Accessing social and legal support in cases of possible medical malpractice.

When facing a person who decides to detransition, clinicians must always adopt a non-judgmental, compassionate stance. Detransitioning can be as difficult as transitioning due to societal lack of understanding, social isolation, fear, shame, trauma, and the paucity of answers and resources for those who take that path. Even when the person has only undergone a social transition, going back to living according to one's birth sex can be troublesome (Steensma et al., 2011). Many core detransitioners lose the social support they had during their transition process (Kermode, 2019; Marchiano, 2020), leading to feelings of loneliness and helplessness. For some of them, their clinicians could be one of the primary sources of support in their lives. For this reason, guidelines should stress the importance of regular and long-term follow-ups to ensure that every detransitioner gets adequate care through the process of detransitioning. This point acquires critical relevance as many anecdotal accounts online point to detransitioners not going back to their gender therapists to inform them of their decision to detransition (see, e.g., GCCAN, 2020), be it out of resentment, mistrust, or the conviction that it will not make things better.

Furthermore, clinicians should not approach detransition exclusively through the monolithic lens of regret since regret and detransition are not always synonymous. For example, some core detransitioners express that transitioning was part of their own gender exploration process and that they could not know whether it was the right decision until they did it (Graham, 2017; Kermode, 2019; Turban & Keuroghlian, 2018). Detransition processes are as multiple and diverse as transition processes, so clinicians must avoid applying a homogeneous prism of interpretation.

Is it possible to prevent detransition?

One of the most crucial questions that the study of detransition poses to healthcare providers is whether detransition can be prevented and, if so, how this could be achieved. There is no easy answer to this inquiry. However, some would argue that a focus on *preventing* detransition is laden with negative values judgments about detransition and that researchers and clinicians

should instead concentrate on *supporting* detransitioners by looking at their unique life experiences (Hildebrand-Chupp, 2020). This distinction between preventing and supporting detransition might be useful from a theoretical point of view, but it does not fit so well in a real-life clinical context, where healthcare providers have the responsibility to ensure that their patients' decisions are thoughtful, well-informed, and beneficial in the long term. Imagine that a clinician identifies other issues, concerns, or factors that could be influencing one person's GD and that may jeopardize the benefits of transitioning, ultimately leading to a detransition. In such a case, it would seem highly unethical to leave those matters unaddressed and not to be cautious before making a decision.

This is not an argument for restricting access to gender-related healthcare. Instead, it intends to highlight how important it is for healthcare providers to develop an integrated view of each patient by carrying out comprehensive exploratory assessments. There is a variety of reasons to support this point. First, because there are different pathways to GD (see Zucker, 2019), which demands from clinicians an individualized approach that allows discerning its possible causes, developmental trajectories, and potential outcomes. Second, because individuals with GD may present with a range of additional concerns relating to sexuality, gender, family, and friendships (Bewley, Clifford, McCartney, & Byng, 2019) that may play an important role in the experience of GD and during the whole gender transition process. Third, because GD may come in associated with other complex psychological issues, such as mood, anxiety, and eating disorders, ASD, substance abuse, deliberate self-harm, suicidal ideation, and suicide attempts (e.g., Bechard, VanderLaan, Wood, Wasserman, & Zucker, 2017; de Graaf et al., 2020; de Vries, Doreleijers, Steensma, & Cohen- Kettenis, 2011; Donaldson et al., 2018; Holt, Skagerberg, & Dunsford, 2016; Kaltiala-Heino, Sumia, Työläjärvi, & Lindberg, 2015; Khatchadourian, Amed, & Metzger, 2014; Olson, Schrager, Belzer, Simons, & Clark, 2015; Peterson, Matthews, Copps-Smith, & Conard, 2017; Reisner et al., 2015; Sevlever & Meyer-Bahlburg, 2019; Spack et al., 2012). It is vital to explore whether these problems precede or follow the onset of GD and, more importantly, their possible relationship with GD. Finally, because other cultural, societal, and psychological factors may be influencing young people's identities and decisions to seek gender-related healthcare (see, e.g., Pang et al., 2020). In this regard, clinicians must be aware of how their young patients navigate a world of continuous changes and challenges and how these affect and shape their gender-related experiences.

Nevertheless, even when comprehensive exploratory assessments have been carried out, some individuals might decide to detransition in the future (see, e.g., Pazos-Guerra et al., 2020). *Prevention does not equate to prescience*: it is very complicated—if not impossible—to know what will happen in each particular case. Some people may detransition after a few months on their gender transition; for others, it may take several years (e.g., Dhejne, Öberg, Arver, & Landén, 2014). All of them need to be listened to and fully supported in their processes by all means, since *prevention and support are not exclusionary terms*. The logic of prevention primarily responds to an attempt to avoid any potential harm that detransition may come with, such as the irreversibility of some physical changes—derived from HRT and SRS—, trauma, shame, or social isolation, for this is inherent to the task of ensuring individuals' well-being in the long term. However, this does not mean that detransition is a clinical "failure" or that clinicians should stop their patients from detransitioning. *Life after detransition can be livable, meaningful, and fulfilling*. The role of healthcare providers is, precisely, to work toward that end.

Conclusion

Gender detransition is an emerging yet poorly understood phenomenon in our society, which poses significant professional and bioethical challenges for clinicians working in the field of GD. The absence of systematic research around detransition has given rise to inconsistencies in its

conceptual use and application, adding to the unclarity and confusion. A typology of gender detransition based on the cessation or the continuation of a transgender identity could address these issues, while offering clinicians a framework to reflect on their therapeutic endeavor when treating patients with GD. Furthermore, recognizing the disparities between core and non-core detransitioners could also help develop clinical guidelines, thus assisting healthcare providers to accommodate their different needs and demands. The conducting of comprehensive exploratory assessments can prove to be a useful tool to ensure thoughtful decision-making and prevent any potential harm associated with the experience of detransition. In conclusion, detransitioners are an underserved population whose experiences we need to listen to and understand if we truly aim to improve healthcare for people with GD. This will require extensive research to learn more about their unique experiences, motivations, needs, and demands.

Note

1. In this article, "transgender" is used as an umbrella term to include a wide range of gender identities that depart from the sociocultural expectations associated with one's birth sex (e.g., man, woman, transgender man, transgender woman, transsexual, non-binary, genderqueer, agender, etcetera) (see, e.g., Davidson, 2007).

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References

Americo, L. (2018, May 13). *I'm a trans woman who detransitioned to become a mom*. Them. https://www.them.us/story/im-a-trans-woman-who-detransitioned-to-become-a-mom

Barnes, R. [RivalMaverick]. (2020, August 13). *DETRANSITION: A parents perspective* [Video]. YouTube. https://www.youtube.com/watch?v=pIRK0at261s&ab_channel=RivalMaverick

Barnes, H., & Cohen, D. (2019, November 26). *How do I go back to the Debbie I was?* BBC Newsnight. https://www.bbc.com/news/health-50548473

BBC Newsnight. (2019, November 26). *Detransitioning: Reversing a gender transition – BBC Newsnight* [Video]. YouTube. https://www.youtube.com/watch?v=fDi-jFVBLA8&ab_channel=BBCNewsnight

Becerra Fernández, A. (2020). Disforia de género/incongruencia de género: Transición y detransición, persistencia y desistencia [Gender dysphoria/gender incongruence: Transition and detransition, persistence and desistence]. *Endocrinología, Diabetes y Nutrición*, *67*(9), 559−561. doi:10.1016/j.endinu.2020.03.011

Bechard, M., VanderLaan, D. P., Wood, H., Wasserman, L., & Zucker, K. J. (2017). Psychosocial and psychological vulnerability in adolescents with gender dysphoria: A "Proof of Principle" study. *Journal of Sex & Marital Therapy*, *43*(7), 678−688. doi:10.1080/0092623X.2016.1232325

Benjamin, H. (1966). *The transsexual phenomenon*. New York, NY: Julian Press.

Bewley, S., Clifford, D., McCartney, M., & Byng, R. (2019). Gender incongruence in children, adolescents, and adults. *British Journal of General Practice*, *69*(681), 170−171. doi:10.3399/bjgp19X701909

Butler, C., & Hutchinson, A. (2020). Debate: The pressing need for research and services for gender desisters/detransitioners. *Child and Adolescent Mental Health*, *25*(1), 45−47. doi:10.1111/camh.12361

Byne, W., Karasic, D. H., Coleman, E., Eyler, A. E., Kidd, J. D., Meyer-Bahlburg, H. F. L., Pleak, R. R., & Pula, J. (2018). Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health*, *3*(1), 57. doi:10.1089/trgh.2017.0053

Cain, L. K., & Velasco, J. C. (2020). Stranded at the intersection of gender, sexuality, and autism: Gray's story. *Disability & Society*. Advance online publication. doi:10.1080/09687599.2020.1755233.

Chew, D., Anderson, J., Williams, K., May, T., & Pang, K. (2018). Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*, *141*(1), e20173742. doi:10.1542/peds.2017-3742

Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior*, *40*(4), 843−847. doi:10.1007/s10508-011-9758-9

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P. T., DeCuypere, G., Feldman, J., … Zucker, K. J. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. *International Journal of Transgenderism*, *13*(4), 165−232. doi:10.1080/15532739.2011.700873

Costa, R., & Colizzi, M. (2016). The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: A systematic review. *Neuropsychiatric Disease and Treatment*, *12*, 1953−1966. doi:10.2147/NDT.S95310

D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2020). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*. Advance online publication. doi:10.1007/s10508-020-01844-2.

Danker, S., Narayan, S. K., Bluebond-Langner, R., Schechter, L. S., & Berli, J. U. (2018). Abstract: A survey study of surgeons' experience with regret and/or reversal of gender-confirmation surgeries [Abstract]. *Plastic and Reconstructive Surgery - Global Open*, *6*(9), 189. doi:10.1097/01.GOX.0000547077.23299.00

Davidson, M. (2007). Seeking refuge under the umbrella: Inclusion, exclusion, and organizing within the category transgender. *Sexuality Research & Social Policy*, *4*(4), 60−80. doi:10.1525/srsp.2007.4.4.60

de Graaf, N. M., Steensma, T. D., Carmichael, P., Vanderlaan, D. P., Aitken, M., Cohen-Kettenis, P. T., … Zucker, K. J. (2020). Suicidality in clinic-referred transgender adolescents. *European Child & Adolescent Psychiatry*. Advance online publication. 10.1007/s00787-020-01663-9.

de Vries, A. L. C., Doreleijers, T. A., Steensma, T. D., & Cohen- Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*, *52*(11), 1195−1202. doi:10.1111/j.1469-7610.2011.02426.x

de Vries, A. L. C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, *134*(4), 696−704. doi:10.1542/peds.2013-2958

de Vries, A. L. C., Noens, I. L. J., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. H. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, *40*(8), 930−936. doi:10.1007/s10803-010-0935-9.

Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, *43*(8), 1535−1545. doi:10.1007/s10508-014-0300-8

Dodsworth, L. (2020, August 18). *The Detransitioners*. Medium. https://medium.com/@barereality/the-detransitioners-72a4e01a10f9

Donaldson, A. A., Hall, A., Neukirch, J., Kasper, V., Simones, S., Gagnon, S., Reich, S., & Forcier, M. (2018). Multidisciplinary care considerations for gender nonconforming adolescents with eating disorders: A case series. *International Journal of Eating Disorders*, *51*(5), 475−479. doi:10.1002/eat.22868

Entwistle, K. (2020). Debate: Reality check – Detransitioner's testimonies require us to rethink gender dysphoria. *Child and Adolescent Mental Health*. Advance online publication. 10.1111/camh.12380

Expósito-Campos, P. (2020). *Destransición de género: Una historia de vida* [Gender detransition: A life-story] [Unpublished master thesis]. University of Granada.

Gender Care Consumer Advocacy Network (GCCAN). (2020, February 10). Interview with A: On detransition, obsessive thoughts, and "really trans." https://www.gccan.org/blog/interview-with-a-detransition-obsessive-thoughts-and-the-concept-of-really-trans

Glidden, D., Bouman, W. P., Jones, B. A., & Arcelus, J. (2016). Gender dysphoria and autism spectrum disorder: A systematic review of the literature. *Sexual Medicine Reviews*, *4*(1), 3−14. doi:10.1016/j.sxmr.2015.10.003

GNC Centric. (2019, July 19). *Internalized homophobia is more powerful than you know* [Video]. YouTube. https://youtu.be/k6Xe2P9c5x0

González, S. (2019, June 24). *DETRANSITION: A short documentary by Silas González*. [Video]. YouTube. https://youtu.be/j7rtj6xtThU

Graham, J. (2017, October 13 – 15). *Detransition, retransition: What providers need to know* [Conference session]. Advancing Excellence for Transgender Health, Boston, MA.

Herzog, K. (2017, June 28). *The detransitioners: They were transgender, until they weren't*. The Stranger. https://www.thestranger.com/features/2017/06/28/25252342/the-detransitioners-they-were-transgender-until-they-werent

Hildebrand-Chupp, R. (2020). More than "canaries in the gender coal mine": A transfeminist approach to research on detransition. *The Sociological Review*, *68*(4), 800–816. doi:10.1177/0038026120934694

Holt, V., Skagerberg, E., & Dunsford, M. (2016). Young people with features of gender dysphoria: Demographics and associated difficulties. *Clinical Child Psychology and Psychiatry*, *21*(1), 108–118. doi:10.1177/1359104514558431

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 US transgender survey*. National Center for Transgender Equality.

Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: Overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, *9*(1), 1−9. doi:10.1186/s13034-015-0042-y

Kanner, R. (2018, June 22). *I detransitioned. But not because i wasn't trans*. The Atlantic. https://www.theatlantic.com/family/archive/2018/06/i-detransitioned-but-not-because-i-wasnt-trans/563396/

Kermode, J. (2019). *Supporting transgender and non-binary people with disabilities or illnesses*. London, UK: Jessica Kingsley Publishers.

Khatchadourian, K., Amed, S., & Metzger, D. L. (2014). Clinical management of youth with gender dysphoria in Vancouver. *The Journal of Pediatrics*, *164*(4), 906−911. doi:10.1016/j.jpeds.2013.10.068

Lane, B. (2019, October 14). *Regretful 'detransitioners' on rise*. The Australian. https://www.theaustralian.com.au/nation/regretful-detransitioners-on-rise/news-story/627a9cc0f42d700be7dfab435c0522a9

Lawrence, A. A. (2010). Sexual orientation versus age of onset as bases for typologies (subtypes) for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior*, *39*(2), 514−545. doi:10.1007/s10508-009-9594-3

Lenzer, J., Hoffman, J. R., Furberg, C. D. & Ioannidis, J. P. A. (2013). Ensuring the integrity of clinical practice guidelines: A tool for protecting patients. *The BMJ*, *347*, f5535. 10.1136/bmj.f5535

Lev, A. I. (2019). Introduction. In A. I. Lev & A. R. Gottlieb (Eds.), *Families in transition: Parenting gender diverse children, adolescents, and young adults* (pp. 11−36). New York, NY: Harrington Park Press.

Levine, S. B. (2018a). Informed consent for transgendered patients. *Journal of Sex and Marital Therapy*, *45*(3), 218–229. doi:10.1080/0092623X.2018.1518885

Levine, S. B. (2018b). Transitioning back to maleness. *Archives of Sexual Behavior*, *47*(4), 1295−1300. doi:10.1007/s10508-017-1136-9

Marchiano, L. (2020, January 2). *The ranks of gender detransitioners are growing: We need to understand why*. Quillette. https://quillette.com/2020/01/02/the-ranks-of-gender-detransitioners-are-growing-we-need-to-understand-why/

McFadden, J. (2017, September 16). *Transition caused more problems than it solved*. The Guardian. https://www.theguardian.com/lifeandstyle/2017/sep/16/transition-caused-more-problems-than-it-solved

Olson, J., Schrager, S. M., Belzer, M., Simons, L. K., & Clark, L. F. (2015). Baseline physiologic and psychosocial characteristics of transgender youth seeking care for gender dysphoria. *Journal of Adolescent Health*, *57*(4), 374−380. doi:10.1016/j.jadohealth.2015.04.027

Olson-Kennedy, J., Cohen-Kettenis, P. T., Kreukels, B. P. C., Meyer-Bahlburg, H. F. L., Garofalo, R., Meyer, W., & Rosenthal, S. M. (2016). Research priorities for gender nonconforming/transgender youth: Gender identity development and biopsychosocial outcomes. *Current Opinion in Endocrinology, Diabetes & Obesity*, *23*(2), 172–179. doi:10.1097/MED.0000000000000236

Palmer, E. (2020, January 9). *Why I transitioned and detransitioned* [Video]. YouTube. https://youtu.be/n0pVuZ0CT7Q

Pang, K. C., de Graaf, N. M., Chew, D., Hoq, M., Keith, D. R., Carmichael, P., & Steensma, T. D. (2020). Association of media coverage of transgender and gender diverse issues with rates of referral of transgender children and adolescents to specialist gender clinics in the UK and Australia. *JAMA Network Open*, *3*(7), e2011161. doi:10.1001/jamanetworkopen.2020.11161

Pazos-Guerra, M., Gómez Balaguer, M., Gomes Porras, M., Hurtado Murillo, F., Solá Izquierdo, E., & Morillas Ariño, C. (2020). Transexualidad: Transiciones, detransiciones y arrepentimientos en España [Transsexuality: Transitions, detransitions and regrets in Spain]. *Endocrinología, Diabetes y Nutrición*, *67*(9), 562−567. doi:10.1016/j.endinu.2020.03.008

Peterson, C. M., Matthews, A., Copps-Smith, E., & Conard, L. A. (2017). Suicidality, self-harm, and body dissatisfaction in transgender adolescents and emerging adults with gender dysphoria. *Suicide and Life-Threatening Behavior*, *47*(4), 475−482. doi:10.1111/sltb.12289

Pinkston, D. (2017, December 5). *Why do people consider de-transitioning? 3 Reasons Why* [Video]. YouTube. https://www.youtube.com/watch?v=SZ0-6TC05NE&feature=youtu.be

Post-Trans. (n.d). *Detransition stories*. https://post-trans.com/Detransition-Stories-English

Prestidge, G. (n.d.). *Gender issues for Autistic girls*. Bayswater Support Group. https://www.bayswatersupport.org.uk/gender-issues-for-autistic-girls#

Rei, M. (2018, February 7). *My detransition: How it happened* [Video]. YouTube. https://youtu.be/JUoY15ceUp4

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health*, *56*(3), 274−279. doi:10.1016/j.jadohealth.2014.10.264

Rose, I. (2018, February 27). *Why I detransitioned (Not Clickbait)* [Video]. YouTube. https://youtu.be/lLVUdGpWQ0w

Scahrdein, J. N., Zhao, L. C., & Nikolavsky, D. (2019). Management of vaginoplasty and phalloplasty complications. *Urologic Clinics of North America*, *46*, 605−618. doi:10.1016/j.ucl.2019.07.012

Sevlever, M., & Meyer-Bahlburg, H. F. L. (2019). Late-onset transgender identity development of adolescents in psychotherapy for mood and anxiety problems: Approach to assessment and treatment. *Archives of Sexual Behavior*, *48*(7), 1993–2001. doi:10.1007/s10508-018-1362-9

Spack, N. P., Edwards-Leeper, M., Feldman, H. A., Leibowitz, S., Mandel, F., Diamond, D. A., & Vance, S. R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics*, *129*(3), 418–425. doi:10.1542/peds.2011-0907

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, *16*(4), 499–516. doi:10.1177/1359104510378303

Stella, C. (2016, September 3). *Female detransition and reidentification: Survey results and interpretation* [Post]. Tumblr. https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey

The Detransition Advocacy Network. (n.d.). *About us*. https://www.detransadv.com/about

tuffsofty. (2020, October 10). *i'm going back on Testosterone! MTFTM Detransition* [Video]. YouTube. https://youtu.be/-9EtxIjhbR4

Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: Understanding transition and "de-transition" among transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(7), 451–453. doi:10.1016/j.jaac.2018.03.016

Van Baalen, S., & Boon, M. (2015). An epistemological shift: From evidence-based medicine to epistemological responsibility. *Journal of Evaluation in Clinical Practice*, *21*(3), 433–439. doi:10.1111/jep.12282

van der Miesen, A. I., Hurley, H., & de Vries, A. L. C. (2016). Gender dysphoria and autism spectrum disorder: A narrative review. Int Rev Psychiatry, *28*(1), 70–80. doi:10.3109/09540261.2015.1111199

VanderLaan, D. P., Postema, L., Wood, H., Singh, D., Fantus, S., Hyun, J., … & Zucker, K. J. (2014). Do children with gender dysphoria have intense/obsessional interests? *The Journal of Sex Research*, *52*(2), 213–219. doi:10.1080/00224499.2013.860073

White, B. (2018, November 21). *I'm detransitioning* [Video]. YouTube. https://youtu.be/FZnAsk5vWzE

Yoo, A. (2018). Transition regret and detransition. In C. Stewart (Ed.), *Lesbian, gay, bisexual, and transgender Americans at risk: Problems and solutions. Volume 2: Adults, Generation X, and Generation Y* (pp. 181–192). Santa Barbara, CA: Praeger.

Zucker, K. J. (2018). The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018). *International Journal of Transgenderism*, *19*(2), 231–245. doi:10.1080/15532739.2018.1468293

Zucker, K. J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*, 48(7), 1983–1992. doi:10.1007/s10508-019-01518-8

Zucker, K. J., Nabbijohn, A. N., Santarossa, A., Wood, H., Bradley, S. J., Matthews, J., & VanderLaan, D. P. (2017). Intense/obsessional interests in children with gender dysphoria: A cross-validation study using the Teacher's Report Form. *Child and Adolescent Psychiatry and Mental Health*, *11*, 51. 10.1186/s13034-017-0189-9