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Debate: The pressing need for research and services for gender desisters/detransitioners

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The number of people presenting at gender clinics is increasing worldwide. Many people undergo a gender transition with subsequent improved psychological well-being (*Paediatrics*, 2014, *134*, 696). However, some people choose to stop this journey, 'desisters', or to reverse their transition, 'detransitioners'. It has been suggested that some professionals and activists are reluctant to acknowledge the existence of desisters and detransitioners, possibly fearing that they may delegitimize persisters' experiences (*International Journal of Transgenderism*, 2018, *19*, 231). Certainly, despite their presence in all follow-up studies of young people who have experienced gender dysphoria (GD), little thought has been given to how we might support this cohort. Levine (*Archives of Sexual Behaviour*, 2017, *47*, 1295) reports that the 8th edition of the WPATH Standards of Care will include a section on detransitioning – confirming that this is an increasingly witnessed phenomenon worldwide. It also highlights that compared to the extensive protocols for working with children, adolescents and adults who wish to transition, nothing exists for those working with desisters or detransitioners. With very little research and no clear guidance on how to work with this population, and with numbers of referrals to gender services increasing, this is a timely juncture to consider factors that should be taken into account within clinical settings and areas for future research.

Keywords: gender dysphoria; gender identity; therapy

Prevalence of desisters/detransitioners

The actual numbers of those who desist or detransition are currently unknown and difficult to assess. For children who present to gender clinics, estimates vary from 98% to 73% (Ristori & Steensma, 2016). Steensma and Cohen-Kettenis (2015) found some children who desisted returned to gender clinics in adolescence or adulthood, although these authors still estimate the desistence rate to be 85%. Adolescents may have lower rates of desisting, and once started on hormones, clinicians in the Netherlands found that no one desisted at 1-year follow-up (de Vries et al., 2014).

Theories of desistence/detransitioning

For some people, a period of gender transitioning that ends with desisting/detransitioning is an important part of a developmental trajectory. For others, confounding factors that contributed to a decision to transition may later reverse when these issues are resolved. Churcher Clarke and Spiliadis (2019) suggest factors such as homophobic bullying, isolation, exclusion, difficulties with peer relations, distress over ones developing sexed body and separation difficulties with parents. Similarly, Steensma et al. (2011) found desisters had greater body acceptance and pleasure with emerging sexuality. Ristori and Steensma (2016) found desisters have lower intensity GD, less cross-gendered behaviour, lower age at assessment and higher social class.

Family and friends are critical in supporting those who transition, with a lack of support for those who regret transition (Dhejne et al., 2014). Steensma et al. (2011) found that transitioning twice (i.e. returning to the gender one was assigned at birth) can bring feelings of shame at being seen to have 'got it wrong' and fear of being teased.

Problems with the existing research

There are higher levels of desistance reported prior to the year 2000. Ristori and Steensma (2016) highlight that prior to 1980 (DSM-III) there were no diagnostic criteria for childhood GD and so children with gender nonconfirming behaviour but who did not have GD might have been included in studies. Similarly, studies post-2000 tend to be with clinical samples where GD is clearly established.

The adult literature is likely to have a sampling bias: those who are unhappy about their transition may be less likely to take part, and some of those who persist may relocate and so be lost to follow-up. With high rates of dropout, follow-up studies often have low numbers making conclusions difficult (Dhejne et al, 2014). In addition, most follow-up studies are conducted within a year, whereas Dhejne et al. (2014) found an average of 8 years before regret operationalized. If changes to the patient cohort over the past decade impact on regret rates, we may not have seen this yet.

There have been five notable changes to the recent patient cohort:

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1 An exponential increase in the numbers of children and adolescents seeking help for gender-related distress.

2 A significant increase in patients assigned female at birth.

3 More young people reject gender binaries altogether and present in 'fluid' or 'nonbinary' ways (Zucker, 2018).

4 More young people are attending gender services having already 'socially transitioned', that is already living, at least in part, in their preferred gender role (Zucker, 2018).

5 More adolescents are presenting to clinics with GD that developed in puberty and not before (Kaltiala-Heino et al., 2015).

Additionally, many of the current young cohort present with coexisting complexities, including psychiatric problems and autistic spectrum disorders (Ristori & Steensma, 2016). Sexual identity also intersects with gender identity: most children who desist go on to identify as cisgendered and lesbian or gay in adolescence or adulthood (Ristori & Steensma, 2016). Interestingly, Steensma et al. (2011) reported that 100% of persisters were same-sex attracted but rather than consider themselves homosexual, this confirmed to them that they must be the opposite sex than that assigned at birth and therefore heterosexual; 100% of the desisting females became attracted to boys and identified as heterosexal, whereas there was a more mixed picture for the desisting boys - however for both groups of desisters, this caused them to question their transition. It is noteworthy that for both persisters and most desisters, they were more comfortable identifying as heterosexual than homosexual.

The lack of research into how the complexities described above intersect with persistence and desistence, and the lack of follow-up research with the current cohort, makes it difficult to draw conclusions on best practice in working with desisters and detransitioners, highlighting the need for more research.

Clinical implications

Not all of those who desist or detransition need help or support. Some may experience their changing identifications as part of a healthy developmental process of exploration and creativity. Nonetheless, some will also feel distress either in relation to their gendered identity (Steensma et al., 2011) or specifically in response to the interventions they received when transitioning (Levine, 2017).

As with all work in GD, the primary aim should be to reduce distress. Clinicians need experience in working with complex presentations and political and social awareness of the psychosocial issues connected to gender diversity. It is useful to view gender identity and expression as fluid to maintain a nonpathologizing, nonjudgement stance towards a wide range of gender expression, and to accept that some people may change their gender expression and/or identity multiple times. Similarly, an open and accepting position on sexual identity that may also be fluid is crucial. Finally, attention to clients' contexts is essential in terms of family, friends, communities and institutions and whether these have accepted the person's gender presentation.

Linking clients to relevant supportive peer groups may be useful, to reduce feelings of isolation and encourage a sense of belonging; ideally groups with mixed presentations of gender expression and sexual identity, and that all manifestations of this are accepted. In addition, online resources can help support exploration about different ways to understand sex, gender and sexuality and reduce isolation. Finally, some who detransition may need access to the professionals who helped them transition, that is psychiatry, endocrinology and surgery, amongst others.

Conclusion

Research with populations who desist and detransition is in its infancy, and little is known about how best to work with this growing population. While there is increasing recognition of the need for support for those who require it, there are still no clear guidelines on how to do this work. We are at an important juncture where our evidence base is based on previous cohorts that may not be applicable to the current population of desisters and detransitioners; it is prudent to consider their needs alongside those who go on to identify as trans for life.

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Ethical information

No ethical approval was required for this article.

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