Rethinking Transition:
On the History, Experience and Current Research Regarding Gender Transition, Transition Regret and Detransition

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Contents

Introduction

It appears that within our current cultural climate, virtually every aspect of transgender experience is charged with controversy and susceptible to political cooptation and polarization. This is certainly the case with the topic of *detransition*. Broadly speaking, detransition refers to halting or, in some sense, reversing a prior gender transition and/or transgender identification. Yet, as we will see, even the very definition of detransition is embroiled in controversy.[2] It is the purpose of this study to explore this contested issue of detransition. It will begin by surveying the history and current state of gender transition. Second, it will outline some of the ways in which the topic of detransition has become highly politicized fodder in the contemporary culture war. Next, some reflections on the history and contemporary landscape of detransition will be offered. Following this, six-plus decades of research findings on transition outcomes – including both transition regret and detransition – will be considered. Finally, a concluding section will draw this study to a close.

I. Detransition in Context: On Gender Transition

As noted above, at its most fundamental level, detransition involves the experience of reversing one's prior decision to undergo a gender transition. Thus, in order to understand detransition, we must first have a basic sense of *gender transition*. In broad terms, gender transition involves the choice to make a transition from one sex/gender to another.

A. Clarifying Gender Transition

Beyond this broad concept, the possibilities related to transition quickly diversify. For example, in light of the contemporary distinction between *gender identity* (i.e., one's own internal sense of being a man/male, a woman/female, or some alternative gender identity, such as agender, nonbinary, genderfluid, etc.) versus *gender expression* (i.e., the ways in which someone presents or signals gender to those around them, typically by affirming or transgressing a culture's *gender*

[2] See Pablo Expósito-Campos, "A Typology of Gender Detransition and Its Implications for Healthcare Providers," *Journal of Sex & Marital Therapy* 47/3 (2021), 270-80.

roles, as defined by expected norms, social scripts, and behaviors associated with men/masculinity and women/femininity), it is possible to undergo a gender transition in terms of one's gender identity without transitioning in terms of one's gender expression – and vice versa.[3]

It is also possible to index transition to at least three different forms of public expression: social transition, medical transition, and legal transition. *Social transition* typically involves making gender appropriate adjustments to things like clothing, hairstyle, personal name, pronoun preference, etc.

Medical transition typically involves a number of possible medical procedures that transform the body in ways that align with one's gender identity. Currently, the World Professional Association for Transgender Health's (WPATH) *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, now in its 7th version (SOC-7), serves as a standard guide for medical transition protocols, along with a set of clinical guidelines produced by the Endocrine Society.[4] Traditionally, the medical establishment has insisted that people seeking medical transition services meet certain eligibility requirements. In the U.S., for example, this would include receiving a diagnosis of *gender dysphoria* as presented in the current (5th) edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).[5] However, many trans activists and gender affirming medical practitioners are increasingly pressing instead for an Informed Consent model, "which allows for clients who are transgender

[3] The importance of distinguishing between gender identity and gender expression is being emphasized today by leading gender affirmative researchers who work with young gender-variant children. See e.g., M. A. Hidalgo, D. Ehrensaft, A. C. Tishelman, L. F. Clark, R. Garofalo, S. M. Rosenthal, N. P. Spack, and J. Olson, "The Gender Affirmative Model: What We Know and What We Aim to Learn," *Human Development* 56 (2013), 285–90 (here pp. 285-86).

[4] World Professional Association for Transgender Health's (WPATH) *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (WPATH, 2012). Available at https://www.wpath.org/publications/soc. The Endocrine Society's guidelines were first published in 2009; see W. C. Hembree, P. T. Cohen-Kettenis, H. A. Delemarre-van de Waal, L. J. Gooren, W. J. Meyer III, N. P. Spack, et al., "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," *Journal of Clinical Endocrinology & Metabolism* 94/9 (2009), 3132–54. These guidelines were then adopted by the WPATH's SOC-7. The Endocrine Society's guidelines were subsequently updated in 2017; see W. C. Hembree, P. T. Cohen-Kettenis, L. Gooren, et al., "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline," *Journal of Clinical Endocrinology and Metabolism* 102/11 (2017), 3869-3903. For a helpful summary of these current guidelines, see M. Hadj-Moussa, D. A. Ohl, and W. M. Kuzon Jr., "Evaluation and Treatment of Gender Dysphoria to Prepare for Gender Confirmation Surgery," *Sexual Medicine Reviews* 6/4 (2018), 607-17.

[5] American Psychiatric Association, "Gender Dysphoria," in *The Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. DSM-5 (Washington, DC: American Psychiatric Association, 2013), 451-59.

to access hormone treatments and surgical interventions without undergoing mental health evaluation or referral from a mental health specialist."[6]

Common aspects of medical transition involve hormone replacement therapy (HRT) – "the backbone of medical interventions for patients undergoing gender transition"[7] – and various surgical procedures commonly referred to as sex reassignment surgery (SRS), gender confirmation surgery (GCS) or gender-affirming surgery (GAS), e.g., top surgeries, bottom surgeries, facial surgeries.[8] For those transitioning from male to female, protocols can include HRT to induce feminization (i.e., antiandrogen and oestrogen), facial hair removal, facial and/or voice femininzation procedures, Adam's apple reduction, breast augmentation, and various forms of genital/bottom surgery procedures such as orchidectomy, penectomy, labiaplasty, clitoroplasty, and vaginoplasty. For those transitioning from female to male, common protocols include HRT to induce masculinization (i.e., testosterone), and surgical procedures such as mastectomy, hysterectomy, vaginectomy and Adam's apple augmentation. Generally less common are surgical procedures to create male genitalia, such as scrotoplasty, urethroplasty,

[6] Sarah L. Schulz, "The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria," *Journal of Humanistic Psychology* 58/1 (2018), 72–92 (here p. 72). Others question the wisdom of moving to an Informed Consent model. See e.g., Alessandra Lemma and Julian Savulescu, "To Be, or Not To Be? The Role of the Unconscious in Transgender Transitioning: Identity, Autonomy and Well-Being," *Journal of Medical Ethics* (2021), 1–8; doi:10.1136/medethics-2021-107397; Stephen B. Levine, "Informed Consent for Transgendered Patients," *Journal of Sex and Marital Therapy* 45/3 (2019), 218-29.

[7] J. J. Shatzel, K. J. Connelly, and T. G. deLoughery, "Thrombotic Issues in Transgender Medicine: A Review," *American Journal of Hematology* 92 (2017), 204-08 (here p. 204).

[8] For helpful discussions of HRT and/or SRS, see W. C. Hembree, P. T. Cohen-Kettenis, L. Gooren, et al., "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline," *Journal of Clinical Endocrinology and Metabolism* 102/11 (2017), 3869-3903; Loren S. Schechter, *Surgical Management of the Transgender Patient* (Philadelphia: Elsevier, 2016); Randi Ettner, Stan Monstrey, and Eli Coleman, eds., *Principles of Transgender Medicine and Surgery* (2nd ed.; New York: Routledge, 2016 [2007]); Trystan T. Cotten, ed., *Hung Jury: Testimonies of Genital Surgery by Transsexual Men* (Oakland, CA: Transgress, 2012); Miroslav L. Djordjevic and Marta R. Bizic, "Sexual Reassignment Surgery: Male to Female," in *Aesthetic and Functional Surgery of the Genitalia*, eds. C. J. Salgado and R. Redett (New York: Nova, 2014), 109-26; Stan J. Monstrey, Philippe Houtmeyers and Piet Hoebeke, "Sexual Reassignment Surgery: Female to Male," in Salgado and R. Redett, *Aesthetic and Functional Surgery of the Genitalia*, 283-304; G. Selvaggi and J. Beliringer, "Gender Reassignment Surgery: An Overview," *Nature Revies Urology* 8/5 (2011), 274-82; Jason M. Weissler, Brian L. Chang, Martin J. Carney, David Rengifo, et al., "Gender-Affirming Surgery in Persons with Gender Dysphoria," *Plastic and Reconstructive Surgery* 141/3 (2018), 388e-396e; doi: 10.1097/PRS.0000000000004123; Shelagh Davies, Viktória Papp, and Christella Antoni, **"**Voice and Communication Change for Gender Nonconforming Individuals: Giving Voice to the Person Inside," *International Journal of Transgenderism* 16/3 (2015), 117-59; Sydney R. Horen and Alireza Hamidian Jahromi, "Chondrolaryngoplasty in Transgender Women: Prospective Analysis of Voice and Aesthetic Satisfaction," *International Journal of Transgender Health* 23/3 (2022), 375-76.

phalloplasty, testicular prostheses, etc.[9] More recently, facial masculinization procedures are being explored.[10] It is common for trans people to pursue HRT apart from any surgical transition whatsoever.[11] For many children and adolescents who experience gender dysphoria, accessing puberty suppression drugs is seen as the "first step" in medical transition.[12]

Finally, *legal transition* typically involves changes in legal name and sex status on official governmental documents, etc. Certain European countries led the way in terms of legal recognition of trans persons. As early as the 1930s, Switzerland granted individuals the ability to change their legal sex status following surgical treatment.[13] In 1972, Sweden was the first country to pass specific legislation for recognizing transsexual people's preferred legal sex. It was followed by other European nations, including Germany (1980), Italy (1982), Austria (1983), the Netherlands (1985), Finland (2002), the UK (2004), Belgium (2007) and Spain (2007).[14]

While it is common for someone to pursue all three forms of transition, it is not unusual for someone to adopt only one or two forms. For example, a recent survey of detransitioners found that while "[c]lose to two thirds (65%) [had] transitioned both socially and medically; 31% [had

[9] Katherine Rachlin, "Factors which Influence Individual's Decisions when Considering Female-to-Male Genital Reconstructive Surgery," *International Journal of Transgenderism* 3/3 (1999), 12 pp; Yiu Tung Suen, Randolph C. H. Chan and Eliz Miu Yin Wong, "Heterogeneity in the Desire to Undergo Various Gender-Affirming Medical Interventions Among Transgender People in Hong Kong: Findings from a Community-Driven Survey and Implications for the Legal Gender Recognition Debate," *Archives of Sexual Behavior* (September 19, 2022), https://doi.org/10.1007/s10508-022-02352-1 [online ahead of print].

[10] Jordan C. Deschamps-Braly, Caitlin L. Sacher, Jennifer Fick, and Douglas Ousterhout, "First Female-to-Male Facial Confirmation Surgery with Description of a New Procedure for Masculinization of the Thyroid Cartilage (Adam's Apple)," *Plastic and Reconstructive Surgery* 139/4 (2017), 883e-87e; doi: 10.1097/PRS.0000000000003185.

[11] Griet De Cuypere and Luk Gijs, "Care for Adults with Gender Dysphoria," in *Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge*, eds. B. P. C. Kreukels, T. D. Steensma, and A. L. C. de Vries (New York: Springer, 2014), 231-54 (here p. 239).

[12] Thomas D. Steensma, S. Annelijn Wensing-Kruger, and Daniel T. Klink, "How Should Physicians Help Gender-Transitioning Adolescents Consider Potential Iatrogenic Harms of Hormone Therapy?," *AMA Journal of Ethics* 19/8 (2017), 762-70.

[13] Friedemann Pfäfflin, "Transgenderism and Transsexuality: Medical and Psychological Viewpoints," in *The Legal Status of Transsexual and Transgender Persons*, ed. J. M. Scherpe (Portland, OR: Intersentia, 2015), 17.

[14] Ibid; Jens M. Scherpe, "The Legal Status of Transsexual and Transgender Persons – An Introduction," in Scherpe, ed., *Legal Status of Transsexual and Transgender Persons*, 3-4; Jens M. Scherpe and Peter Dunne, "The Legal Status of Transsexual and Transgender Persons – Comparative Analysis and Recommendations," in Scherpe, ed., *Legal Status of Transsexual and Transgender Persons*, 619-20.

transitioned] only socially."[15] Much less common is the decision to pursue medical transition apart from social transition.[16] Much of the cultural controversy surrounding both gender transition and detransition is related to medical transition per se. To set the stage for the following study of detransition, then, it will be helpful briefly to consider something of the history and current status of medical transition.

B. On the History of Medical Gender Transition

Research has shown that, across time and cultures, human beings have frequently recognized – and, in a variety of ways, enacted – various forms of sex/gender variance and transition.[17] For example, it appears there were at least four different gender change rituals available in the ancient Near East.[18] The ancient world even offers examples of those who desired surgical transition of their bodies to reflect the opposite sex – e.g., the Roman emperor Elagabalus' request that his physicians create for him a vagina by means of a surgical incision.[19] However, in order for what we know today as *medical* gender transition to become viable, certain medical

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[15] Elie Vandenbussche, "Detransition-Related Needs and Support: A Cross-Sectional Online Survey," *Journal of Homosexuality* 69/9 (2022), 1602-20.

[16] Katherine Rachlin, "Medical Transition without Social Transition: Expanding Options for Privately Gendered Bodies," *Transgender Studies Quarterly* 5/2 (2018), 228-44.

[17] Vern L. Bullough, "Transsexualism in History," *Archives of Sexual Behavior* 4 (1975), 561-71; Richard Green, "Mythological, Historical, and Cross Cultural Aspects of Transsexualism," in *Transsexualism and Sex Reassignment*, eds. R. Green and J. Money (Baltimore: Johns Hopkins University Press, 1969), 13-22; Gilbert Herdt, ed., *Third Sex, Third Gender: Beyond Sexual Dimorphism in Culture and History* (New York: Zone Books, 1994); Dallas Denny, "Transgender: Some Historical, Cross-cultural, and Contemporary Models and Methods of Coping and Treatment," in *Gender Blending*, eds. B. Bullough, V. L. Bullough, and J. Elias (Amherst, NY: Prometheus, 1997), 33-47; J. Cromwell, "Making the Visible Invisible: Female Gender Diversity Cross-Culturally," *Journal of Gender Studies* 17 (1994-1995), 21-26; Matthew Stief, "The Sexual Orientation and Gender Presentation of *Hijra*, *Kothi*, and *Panthi* in Mumbai, India," *Archives of Sexual Behavior* 46/1 (2017), 73-85.

While cross-cultural comparisons between various gender-variant experiences and identities can be instructive, scholars have warned against the tendency to impose contemporary Western concepts such as "transgender" or "third gender" upon other times and places. See Evan B. Towle and Lynn M. Morgan, "Romancing the Transgender Native: Rethinking the Use of the 'Third Gender' Concept," in *Transgender Studies Reader*, eds. S. Stryker and S. Wittle (New York: Routledge, 2006), 666-84; Carolyn Epple, "Coming to Terms with Navajo 'Nádleehí': A Critique of 'Berdache,' 'Gay,' 'Alternate Gender,' and Two-Spirit,'" *American Ethnologist* 25/2 (1998), 267-90; Enrique Moral, "Qu(e)erying Sex and Gender in Archaeology: A Critique of the 'Third' and Other Sexual Categories," *Journal of Archaeological Method and Theory* 23/3 (2016), 788-809; Bernice L. Hausman, *Changing Sex: Transsexualism, Technology, and the Idea of Gender* (Durham: Duke University Press, 1995), 2-19.

[18] Kathleen McCaffrey, "Gendering for Fortune and Misfortune: Ritual Gender Assignment in the Ancient Near East," in *Fortune and Misfortune in the Ancient Near East: Proceedings of the 60th Rencontre Assyriologique Internationale, Warsa, 21-25 July, 2014*, eds. Olga Drewnowska and Malgorzata Sandowicz (Winona Lake, IN: Eisenbrauns, 2017), 75-96.

[19] Eric R. Varner, "Transcending Gender: Assimilation, Identity, and Roman Imperial Portraits," *Memoirs of the American Academy in Rome*, supp vol. 7 (2008), 185-205 (here p. 201).

advances were necessary, including anesthesia, hormone therapy, and plastic surgery.[20] Genital reconstruction surgery initially developed in response to children with intersex conditions (i.e., differences/disorders of sexual development) and victims of war injuries and accidents.[21]

But medical advances were not the only necessary condition for medical gender transition to arise. Technological capabilities had to be paired with a hospitable theory of sexuality. And just such a theory was in the air in the late nineteenth and early twentieth centuries, namely the *universal constitutional bisexuality* of humanity. Here, *bisexuality* refers to the non-binary nature of human sexual differentiation. The germ of this idea can be traced back to Charles Darwin who set the stage for a "new genderless human nature."[22] This idea can be found in the thought of many of the early leading sexologists (e.g., Magnus Hirschfield, Havelock Ellis, Sigmund Freud, James Kiernan). Evidence for this theory was drawn from evolutionary theory (i.e., lower life forms are asexual, etc.), comparative anatomy, embryology, endocrinology, and the phenomenon of intersexuality. This idea leads to the conclusion that the male and female sexes do not form a strict binary but, rather, reflect something of a continuum. Within this intellectual atmosphere, the idea that a man could become a woman, and vice versa, seemed increasingly plausible.

Many of the early explorations of medical transition were carried out in Germany in the early 20th century.[23] At the center of this exploration was leading German sexologist, Magnus Hirschfield, and his Berlin-based Institut für Sexualwissenschaft (Institute for Sexual Science),

[20] It is important to keep in mind that *medical* transition is not the only dimension of gender transition (more on this below), and that some within the trans community reject the medical pathway as a necessary component of transition. See J. R. Latham, "Axiomatic: Constituting 'Transexuality' and Trans Sexualities in Medicine," *Sexualities* 22/1-2 (2019), 13-30.

[21] Alice D. Dreger, *Hermaphrodites and the Medical Intervention of Sex* (Cambridge, MA: Harvard University Press, 1998); Geertje A. Mak, "Conflicting Heterosexualities: Hermaphroditism and the Emergence of Surgery around 1900," *Journal of the History of Sexuality* 24/3 (2015), 402-27.

[22] Lawrence Birken, *Consuming Desire: Sexual Science and the Emergence of a Culture of Abundance 1871-1914* (Ithaca, NY: Cornell University Press, 1989), 74. See also Joanne Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Cambridge, MA: Harvard University Press, 2002), 22-29.

[23] Helpful resources on the history of modern medical transition include: Meyerowitz, *How Sex Changed*; Jasmine Bhinder and Prashant Upadhyaya, "Brief History of Gender Affirmation Medicine and Surgery," in *Urological Care for the Transgender Patient: A Comprehensive Guide*, eds. D. Nikolavsky and S. A. Blakely (New York: Springer, 2021), 249-54; Jordan D. Frey, Grace Poudrier, Jennifer E. Thomson, and Alexes Hazen, "A Historical Review of Gender-Affirming Medicine: Focus on Genital Reconstruction Surgery," *Journal of Sexual Medicine* 14 (2017), 991-1002; Friedemann Pfäfflin and Astrid Junge, "Sex Reassignment: Thirty years of International Follow-up Studies After Sex Reassignment Surgery: A Comprehensive Review, 1961–1991," *International Journal of Transgenderism* – Book Section, trans. R. B. Jacobson and A. B. Meier (Dusseldorf, Germany: Symposion, 1998 [1992]).

which he founded in 1919. In May 1933, the Institute was raided by Nazi storm troopers, destroying much of its contents in a public book-burning. But in the fourteen years of its existence, Hirschfeld's Institute was a leading force in the development of medical transition procedures. Early on, Hirschfeld began working with the Austrian endocrinologist, Eugen Steinach, to develop transition techniques. Steinback was a pioneer in the use of sex hormones (testosterone, estrogen) for various purposes. For much of his career, Hirschfeld was involved with assessing and referring people for SRS, popularly referred to in the 20th century simply as a "sex change." As early as 1912, Hirschfeld was involved with incomplete SRS, i.e., the removal of sexual organs without creating new genitalia.[24]

Ludwig Levy-Lenz, Felix Abraham and Erwin Gohrbandt eventually joined Hirschfeld's Institute and oversaw transition-related surgeries. 1931 was a significant year, in which three people underwent landmark medical transition procedures. That year, Dora Richter, an assigned/natal male, who had already undergone an orchiectomy (i.e., surgical removal of the testicles) in 1922, underwent a penectomy (removal of the penis) and vaginoplasty (creation of a neovagina). Also in 1931, Toni Ebel, an assigned/natal male, completed genital surgery and eventually made a formal application for a legal name change. Felix Abraham reported on the cases of Richter and Ebel in an early article on medical transition.[25]

Finally, 1931 was also year that Lili Ilse Elvenes, an assigned/natal male – better known as Lili Elbe – completed a series of four transition-related surgeries. Elbe had come from Denmark to Hirschfeld's Institute in 1930, and underwent her first surgery, an orchiectomy. The remaining surgeries – conducted by Kurt Warnekros of the Dresden Municipal Women's Clinic – involved the implantation of an ovary onto her abdominal musculature; a penectomy; and, finally, the transplantation of a uterus and vaginoplasty (for the purpose of bearing a child). Elbe died later in 1931 of an infection associated with her final surgery. She became international known and is

[24] Hirschfeld reports on these early incomplete SRS procedures in his *Sexuelle Zwischenstufen* (Sexualpathologie 2, Teil; Bonn: Marcus & Webers, 1918).
[25] Felix Abraham, "Genitalumwandlung an zwei maenlichen Transvestiten," *Zeitschrift für Sexualwissenschaft* 18 (1931), 223–26. Translated and published as: Felix Abraham, "Genital Reassignment on Two Male Transvestites," *International Journal of Transgenderism* 2/1 (1997). These early incomplete procedures were also reported on in Richard Mühsam, "Der Einfluss der Kastration auf Sexualneurotiker," *Deutsche Medizinische Wochenschrift* 47/6 (1921), 155-56; idem, "Chirurgische Eingriffe bei Anomalien des Sexuallebens," *Therapie der Gegenwart* 67 (1926), 451-55.

considered the most famous pre-WWII male-to-female (MtF) trans person. A book, titled *Man into Woman: An Authentic Record of a Change of Sex*, chronicling her experiences was published posthumously in 1931.[26]

Another significant moment in medical transition history involved Alan Hart, an assigned/natal female in the U.S. Apparently inspired by the earlier case of Karl Baer in Germany, Hart contacted Joshua Allen Gilbert at the University of Oregon in 1917 to request a hysterectomy in order to eliminate menstruation and the possibility of pregnancy.[27] Hart underwent the surgery in the winter of 1917-18, and later began hormone therapy when synthetic hormones became available in the 1920s. Gilbert reported on Hart's procedure in a 1920 article.[28]

A landmark moment in medical transition came in the late 1940s when Michael Dillon, an assigned/natal female and British citizen, became the first person to undergo female-to-male (FtM) phalloplasty. Dillon, who had begun taking testosterone in 1939, underwent 13 surgeries from 1946 to 1949 at the hand of Harold Gilles, who had pioneered plastic surgery while operating on soldiers injured in war.[29] In May 1951, Gilles performed the first vaginoplasty for a trans woman in Britain, Roberta Cowell.[30]

Gilles was not the only physician to begin exploring medical transition procedures with the help of medical-surgical innovations developed during the war. In the 1950s, various transition-

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[26] Lili Elbe, *Man into Woman: An Authentic Record of a Change of Sex* (London: Blue Boat, 1933 [Danish original - 1931]).

[27] Karl Baer had an intersex condition called hypospadias, which involves the displacement of the urethra on the penis. Although Baer was both genetically and hormonally male, because of his unusually shaped genitals he was raised as a girl (Martha). However, in 1906-1907, Baer underwent both medical and legal transition with the help of Hirschfeld. For Baer's own reflections on his experience, see Karl M. Baer [published under the pseudonym N. O. Body], *Aus eines Mannes Mädchenjahren* (Berlin: Riecke, 1907). Translated into English as: Karl M. Baer [N. O. Body], *Memoirs of a Man's Maiden Years*, trans. Deborah Simon (Philadelphia: University of Pennsylvania Press, 2006 [1907]). On Baer's case, see Jana Funke, "The Case of Karl M.[artha] Baer: Narrating 'Uncertain' Sex," in *Sex, Gender and Time in Fiction and Culture*, ed. B. Davies and J. Funke (New York: Palgrave Macmillan, 2011), 132-53.

[28] J. Allen Gilbert, "Homo-sexuality and Its Treatment," *Journal of Nervous and Mental Disease* 52/4 (1920), 297-322.On Hart, see also Colin P. Close, "Manifesting Manhood: Dr. Alan Hart's Transformation and the Embodiment of Sex in Early Twentieth-Century Sexology" (M.A. thesis; Sonoma State University, 2014).

[29] On Dillon's experiecne, see: Michael Dillon, *Self: A Study in Ethics and Endocrinology* (London: Heinemann, 1946); Pagan Kennedy, *The First Man-Made Man: The Story of Two Sex Changes, One Love Affair, and a Twentieth-Century Medical Revolution* (New York: Bloomsbury, 2007).

[30] Roberta Cowell, *Roberta Cowell's Story* (New York: British Book Centre, 1954).

related hormonal and surgical procedures began to be performed in Europe (i.e., Sweden, Denmark, The Netherlands, Italy), in Mexico, and in Casablanca, Morocco.[31] In Casablanca, the French gynecologist, Georges Burou, developed an innovative surgical technique at his Clinique du Parc, one that would become "the gold standard of skin-lined vaginoplasty in transsexuals."[32] He would go on to perform over 800 vaginoplasties for trans people from around the world.

In December of 1952, people in the U.S. were introduced to the idea of medical transition in a new way when the *New York Daily News* ran a front-page story with the headline: "Ex-GI Becomes Blonde Beauty." The headline, of course, referred to Christine Jorgensen. Jorgensen's original transition procedures – including HRT under the care of the Danish endocrinologist Christian Hamburger, and two surgical procedures (orchiectomy and penectomy) – were conducted in Copenhagen in 1951-1952. She later pursued vaginoplasty in the U.S. Upon returning to America, she became an instant celebrity. Jorgensen went on to work as an actress and entertainer and became an early transgender advocate.[33] Due to his connection with Jorgensen's transition, Hamburger's fame exploded internationally. Within one year, he published an article discussing 465 letters he had received requesting his assistance with medical transition.[34]

Upon Christine Jorgensen's post-surgical return to the U.S., a physician named Harry Benjamin served as her endocrinologist. Benjamin went on to become the most influential advocate for medical transition in America. Although born and medically trained in Germany, Benjamin spent most of his life in the U.S. Both his friendship with Hirschfeld – and his skepticism toward

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[31] Harry Benjamin, "Transvestism and Transsexualism in the Male and Female," *Journal of Sex Research* 3/2 (1967), 107-27 (p. 122). E.g., see Paul Fogh-Andersen, "Transvestism and Trans-sexualism: Surgical Treatment in a Case of Auto-Castration," *Acta Medicinae Legalis et Socialis* 9 (1956), 33-40; B. Haeseker and J. P. Nicolai, "De eerste geslachtsveranderende operatie van vrouw naar man in Nederland, 1959/'60 [The first gender-changing operation from female to male in The Netherlands, 1959/'60]," *Nederlands Tijdschrift voor Geneeskunde* 151/9 (2007), 548-52.

[32] J. J. Hage, R. B. Karim, and D. R. Laub, "On the Origin of Pedicled Skin Inversion Vaginoplasty: Life and Work of Dr. Georges Burou of Casablanca," *Annals of Plastic Surgery* 59/6 (2007), 723-29 (p. 723). See Georges Burou, "Male to Female Transformation," in *Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome*, eds .D. R. Laub and P. Gandy (Palo Alto, CA: Stanford University Press, 1973), 188-94.

[33] See Christine Jorgensen, *Christine Jorgensen: A Personal Autobiography* (New York: Bantam, 1967); Meyerowitz, *How Sex Changed*, ch. 2; Deborah Rudacille, *The Riddle of Gender: Science, Activism, and Transgender Rights* (New York: Anchor, 2006), ch. 3.

[34] Christian Hamburger, "Desire for Change of Sex as Shown by Personal Letters From 465 Men and Women," *Acta Endocrinologica* 14 (1953), 361-75.

Freudian psychoanalytic theory – inclined him to be open to the path of medical transition for people suffering from gender dysphoria.[35] Benjamin's serious engagement with supporting medical transition began in 1948 when the famous sexologist, Alfred Kinsey, introduced him to a transsexual person in San Francisco for a consultation. Christine Jorgensen would eventually become his seventh trans patient.[36] By the early-to-mid-1950s, Benjamin was having articles on transsexualism published in academic journals.[37] In 1966, Benjamin published *The Transsexual Phenomenon*, one of the early – and now classic – books on the subject.[38] As the trans historian, Susan Stryker, notes: "By 1966, when he published *The Transsexual Phenomenon*, Benjamin was justly regarded at the world's most prominent expert on the subject."[39]

Much of Benjamin's work focused on exploring the dynamics of GD, including the question of what characteristics separate those who report post-transition satisfaction as opposed to post-transition dissatisfaction and/or regret. Inspired by Alfred Kinsey's sexual orientation scale, Benjamin devised a six-point "Sex Orientation Scale" that categorized people according to the intensity of their desire to identify with the opposite biological sex. The scale ran from "pseudo-transvestites" (i.e., those who have an intermittent desire to cross-dress) to the "true transsexual" who expresses the highest level of desire to become the opposite sex.[40] Motivated both by concern for patient outcomes and fear of malpractice lawsuits, Benjamin spent significant time and energy engaging the question of which people seeking medical transition would be good candidates for a successful outcome.[41]

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[35] On Benjamin and his pioneering role in supporting medical transition, see Pfäfflin, "Sex Reassignment, Harry Benjamin, and Some European Roots"; Charles Ihlenfeld, "Harry Benjamin and Psychiatrists," *Journal of Gay & Lesbian Psychotherapy* 8/1-2 (2004), 147–52; Richard Green, "The Three Kings: Harry Benjamin, John Money, Robert Stoller," *Archives of Sexual Behavior* 38 (2009), 610–13; Beans Velocci, "Standards of Care: Uncertainty and Risk in Harry Benjamin's Transsexual Classifications," *TSQ* 8/4 2021, 462-80; Betty Luther, "The Medical Invention of Gender: Harry Benjamin and Transsexual Surgery, 1949-1966" (B.A. Honors Thesis; Harvard University, 2003).

[36] Leah Cahan Schaefer and Connie Christine Wheeler, "Harry Benjamin's First Ten Cases (1938-1953): A Clinical Historical Note," *Archives of Sexual Behavior* 24/1 (1995), 73-93.

[37] E.g., Harry Benjamin, "Transvestism and Transsexualism," *International Journal of Sexology* 7 (1953), 12–14; idem, "Transsexualism and Transvestism as Psychosomatic and Somato-Psychic Syndromes," *American Journal of Psychotherapy* 8 (1954), 219–30.

[38] Harry Benjamin, *The Transsexual Phenomenon* (New York: Julian, 1966).

[39] Susan Stryker, "Benjamin, Dr. Harry (1885-1986)," *GLBTQ Archive*, www.glbtqarchive.com/ssh/benjamin_h_S.pdf.

[40] Benjamin, *Transsexual Phenomenon*, 21-24.

[41] Velocci, "Standards of Care."

Benjamin's work led to the publication of the first Standards of Care (SOC) treatment protocols for transsexual persons in 1979. Known as the Harry Benjamin Standards of Care, this document was produced by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) – which, in 2007, changed its name to the World Professional Association for Transgender Health (WPATH). This SOC – eventually re-titled *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* – was designed for several purposes, including advising the health care world on appropriate treatment protocols, protecting transgender patients from less-than-appropriate treatment methods, and safe-guarding medical professionals from accusations of malpractice.[42] Just one year later, in 1980, a diagnosis of *transsexualism* – along with *gender identity disorder of childhood* – appeared for the very first time in the DSM-III.[43] With regard to Benjamin's influence in the field of medical gender transition, Richard Ekins goes so far as to say that "contemporary western transsexuals are as much the product of Harry Benjamin as contemporary psychoanalysts are the product of Sigmund Freud."[44]

In 1966, the same year that Benjamin's *The Transsexual Phenomenon* was published, the first university-based gender clinic to perform SRS opened in the U.S. – the Johns Hopkins Gender Identity Clinic.[45] Within the next few years, the launching of other U.S. university-based gender clinics quickly followed, including clinics at the University of Minnesota, the University of Washington, Northwestern University, and Stanford University. By 1975, over twenty major medical centers were offering transition-related treatments.[46] In a review of the field of transition-related medicine published in the mid-1980s, Ira Pauly and Milton Edgerton summarize what they refer to as the "gender identity movement," which has

[42] Available at https://www.wpath.org/publications/soc
[43] Titia F. Beek, Peggy T. Cohen-Kettenis and Baudewijntje P.C. Kreukels, "Gender Incongruence/Gender Dysphoria and Its Classification History," *International Review of Psychiatry* 28/1 (2016), 5-12.
[44] Richard Ekins, "Responses to Colette Chiland's 'The Psychoanalyst and the Transsexual Patient,'" *International Journal of Psychoanalysis* 82/2 (2001), 389.
[45] On the history of the Johns Hopkins clinic, see Charalampos Siotos, Paula M. Neira, Brandyn D. Lau, Jill P. Stone, James Page, Gedge D. Rosson, and Devin Coon, "Origins of Gender Affirmation Surgery: The History of the First Gender Identity Clinic in the United States at Johns Hopkins," *Annals of Plastic Surgery* 83/2 (2019), 132-36.
[46] Meyerowitz, *How Sex Changed*, 217-22. Among the new centers were those associated with Vanderbilt University, the University of Virginia at Charlottesville, Duke University, and the Georgia Mental Health Institute in Atlanta. For a critique of the general approach of these early university-affiliated gender clinics – including first-person accounts from transsexual people who underwent procedures at these clinics – see Dallas Denny, "The Politics of Diagnosis and the Diagnosis of Politics: The University-Affiliated Gender Clinics, and How They Failed to Meet the Needs of Transsexual People," *Chrysalis Quarterly* 1/3 (1992), 9-20.

> brought together such unlikely collaborators as surgeons, endocrinologists, psychologists, psychiatrists, gynecologists, and research specialists into a mutually rewarding arena . . . . This interdisciplinary collaboration has resulted in the birth of a new medical subspecialty, which deals with the study of gender identification and its disorders.[47]

Despite the growing availability of medical centers providing medical transition, most trans people were unable to afford such an expensive procedure. In the mid-1960s, the Erickson Educational Foundation (EEF) – founded and run by Reed Erickson, a trans man – stepped in to aid in the funding of transsexual research. The EEF was instrumental in helping to launch both the Johns Hopkins Gender Identity Clinic and the Harry Benjamin Foundation.[48]

Throughout the 1960s and 1970s, public awareness and even (to some degree) acceptance of transgender experience – particularly in the form of transsexualism – grew noticeably.[49] During these decades, transition-related gender medicine also grew, both in terms of the number of people accessing medical transition procedures and the sophistication of the procedures themselves. Throughout these years, a steady number of publications reported on advances in transition-related surgical methods.[50] In 1969, Stanely Biber – a physician based in Trinidad, Colorado – was asked to perform a SRS for a trans friend whose hormone treatment was being supervised by Harry Benjamin. Guided by diagrams and notes from the Johns Hopkins clinic, Biber carried out the procedure. Biber's center became the first private-practice surgical gender clinic in the U.S., where he performed well over 3,000 transition-related surgeries. In 2003, Biber retired, handing the practice over to Dr. Marci Bowers, herself a trans woman.[51]

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[47] Ira B. Pauly and Milton T. Edgerton, "The Gender Identity Movement: A Growing Surgical-Psychiatric Liaison," *Archives of Sexual Behavior* 15/4 (1986), 315-29 (here p. 315).
[48] On Reed Erickson and the EEF, see Aaron H. Devor and Nicholas Matte, "ONE Inc. and Reed Erickson: The Uneasy Alliance of Gay and Trans Activism, 1964-2003," *GLQ* 10/2 (2004), 179-209.
[49] Meyerowitz, *How Sex Changed*, 188-254; Rudacille, *Riddle of Gender*, chs. 4-6; Susan Stryker, *Transgender History* (Berkeley, CA: Seal, 2008), chs. 3-4; Barry Reay, "The Transsexual Phenomenon: A Counter-History," *Journal of Social History* 47/4 (2014), 1042-70.
[50] E.g., H. W. Jones, Jr., H. K. Schirmer, and J. E. Hoopes, "A Sex Conversion Operation for Males with Transsexualism," *American Journal of Obstetrics and Gynecology* 100 (1968), 101-09; Richard Green and John Money, eds., *Transsexualism and Sex Reassignment* (Baltimore: Johns Hopkins University Press, 1969); D. R. Laub and N. Fisk, "A Rehabilitation Program for Gender Dysphoria Syndrome by Surgical Sex Change," *Plastic and Reconstructive Surgery* 53 (1974), 388-403.
[51] On Biber, Bowers and the Trinidad clinic, see Martin J. Smith, *Going to Trinidad: A Doctor, a Colorado Town, and Stories from an Unlikely Gender Crossroads* (Denver: Bower, 2021).

1979 brought the unexpected closing of the Johns Hopkins gender clinic. Inspired by a study published the same year concluding that sex reassignment "confers no objective advantage in terms of social rehabilitation,"[52] the new director of the department of psychiatry at John Hopkins, Paul McHugh, put an end to the practice of surgical transition at the very clinic where it had all begun in the U.S. McHugh has gone on to become a leading voice among those argue that medical transition is not the best response to gender dysphoria.[53] Throughout the 1980s, a number of coalescing factors – social, financial, and otherwise – led to the closing of virtually all the university-affiliated gender clinics that had arisen in the 1960s and 1970.[54]

C. Gender Transition Today

1. The Remarkable Growth of Gender Transition

With the expansion of the internet in the 1990s came a new ability for the trans community to easily connect. This led to a revitalization of trans activism, the birth of the interdisciplinary academic field of *transgender studies*, and a new level of political alliance such that the "T" was increasingly included in the now-standard "LGBT" acronym.[55] Since that time, several factors – including growing social acceptance, gender-related surgical advancements, and increasing insurance coverage for transition-related medical procedures – have led to a stunning increase in the number of trans identified people choosing to transition in one form or another.[56] Once again, the primary focus of this section will be upon medical transition, since this dimension of the

[52] Jon K. Meyer and Donna J. Reter, "Sex Reassignment. Follow-up," *Archives of General Psychiatry* 36/9 (1979), 1010-15 (p. 1010). This study, which eventually drew serious criticism, will be discussed further below.
[53] Paul R. McHugh, "Surgical Sex: Why We Stopped Doing Sex Change Operations," *First Things* (November 2004), at http://www.firstthings.com/article/2004/11/surgical-sex. See also McHugh, "Transgender Surgery Isn't the Solution," *Wall Street Journal* (June 12, 2014), at http://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120; idem, "Transgenderism: A Pathogenic Meme," *Public Discourse* (June 10, 2015), at http://www.thepublicdiscourse.com/2015/06/15145/.
[54] Denny, "Politics of Diagnosis"; Siotos, et al., "Origins of Gender Affirmation Surgery," 133-34; William Byne, Dan H. Karasic, Eli Coleman, A. Evan Eyler, Jeremy D. Kidd, Heino F. L. Meyer-Bahlburg, et al., "Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists," *Transgender Health* 3/1 (2018), 57-70 (esp. 57-58, 66-68).
[55] Riki Wilchins, *TRANS/gressive: How Transgender Activists Took on Gay Rights, Feminism, the Media & Congress… and Won!* (Riverdale, NY: Riverdale Avenue, 2017); Kristen Schilt and Danya Lagos, "The Development of Transgender Studies in Sociology," *Annual Review of Sociology* 43 (2017), 425-43; Amy L. Stone, "More Than Adding a T: American Lesbian and Gay Activists' Attitudes Towards Transgender Inclusion," *Sexualities* 12 (2009), 334-54.
[56] Siotos, et al., "Origins of Gender Affirmation Surgery," 135.

transition experience is commonly cited by detransitioners as the most difficult aspect to deal with and recover from.

The growth in gender transition is an international phenomenon. For example, a Swedish study investigating the rates of applications for legal and medical-surgical transition over a 50-year period (1960-2010) found that rates "increased significantly from 0.16 to 0.42/100,000/year (FM) and from 0.23 to 0.73/100,000/year (MF). The most pronounced increase occurred after 2000."[57] Regarding genital surgery rates in the U.S., a 2018 study found that among people seeking some form of medical transition

> [t]he incidence of genital surgery increased over time: in 2000-2005, 72.0% of patients who underwent gender-affirming procedures had genital surgery; in 2006-2011, 83.9% of patients who underwent gender-affirming procedures had genital surgery.[58]

In 2017, the American Society of Plastic Surgeons (ASPS) – in their first-ever report on surgical transition rates – announced that more than 3,250 gender-related surgeries were performed in 2016 – representing a 19% increase compared to U.S. gender surgeries done just one year prior in 2015.[59] Of these surgeries, 1,759 represented transfeminine (e.g., MtF) procedures, while 1,497 represented transmasculine (e.g., FtM) procedures. Just one year later, when the ASPS posted its 2017 statistics, it reported 8, 304 gender-related procedures – a 155% increase over the 2016 rate.[60] Most noticeably, this remarkable increase was largely driven by an exponential increase in transmasculine surgical procedures: of the 8,304 surgeries, 2,483 involved transfeminine procedures, while 5, 821 involved transmasculine procedures.[61] For 2018, the

[57] Cecelia Dhejne, Katarina Öberg, Stefan Arver, and Mikael Landén, "An Analysis of all Applications for Sex Reassignment Surgery in Sweden, 1960–2010: Prevalence, Incidence, and Regrets," *Archives of Sexual Behavior* 43 (2014), 1535–45 (p. 1535).
[58] Joseph K. Canner, Omar Harfouch, Lisa M. Kodadek, Danielle Pelaez, Devin Coon, Anaeze C. Offodile, et al., "Temporal Trends in Gender-Affirming Surgery Among Transgender Patients in the United States," *Journal of the American Medical Association* 153/7 (2018), 609-16 (p. 609).
[59] American Society of Plastic Surgeons, "Gender Confirmation Surgeries Rise 20% in First Ever Report" (May 22, 2017), https://www.plasticsurgery.org/news/press-releases/gender-confirmation-surgeries-rise-20-percent-in-first-ever-report.
[60] American Society of Plastic Surgeons, *2017 Plastic Surgery Statistics Report* (ASPS National Clearinghouse of Plastic Surgery Procedural Statistics, 2018), 23; https://www.plasticsurgery.org/documents/News/Statistics/2017/plastic-surgery-statistics-full-report-2017.pdf.
[61] Ibid.

ASPS reported 9,576 gender-related surgeries.[62] For 2019, the number of annual procedures had climbed to 14,602.[63] And for 2020 (the last available year's data at the time of writing), the ASPS reported 16,353 gender-related surgeries.[64]

In 2020-2021, studies were published on U.S. gender-related surgery in terms of its market trends, market size/share, and future market forecasts.[65] Among the more notable findings:
(1) The "Sex Reassignment Surgery Market size was more than USD 316 million in 2019 and will witness 25.1% CAGR during 2020 to 2026" which means a "2026 value projection" of "1.5 billion (USD)."[66]
(2) The transmasculine/FtM segment has dominated the market in recent years, and in 2019 "accounted for 55.2% share of the overall revenue." It is anticipated that this population will "maintain the lead of the segment over the forecast period" (i.e., 2020 – 2027).[67]
(3) The International Society of Aesthetic Plastic Surgery reported that, worldwide, 9.2% of Plastic Surgeons performed sex reassignment surgery in 2020.[68]
(4) The COVID-19 pandemic has impacted the (anticipated) pace of market growth. Because transition-related surgeries are considered "elective" in nature, they were delayed during the medical crisis associated with the pandemic, which directly impacted market growth forecasts.[69]
(5) Among the most prominent U.S. medical institutions providing medical transition services are Mount Sinai (New York), Transgender Surgery Institute of Southern California (Santa Monica, CA), Cedars Sinai (Los Angeles), Moein Surgical Arts (Los Angeles), Boston Medical

[62]American Society of Plastic Surgeons, *2018 Plastic Surgery Statistics Report* (ASPS National Clearinghouse of Plastic Surgery Procedural Statistics, 2019), 25; https://www.plasticsurgery.org/documents/News/Statistics/2018/plastic-surgery-statistics-full-report-2018.pdf
[63] American Society of Plastic Surgeons. *2020 Plastic Surgery Statistics Report* (ASPS National Clearinghouse of Plastic Surgery Procedural Statistics, 2021), 26; https://www.plasticsurgery.org/documents/News/Statistics/2020/plastic-surgery-statistics-full-report-2020.pdf.
[64] Ibid.
[65] Sumant Ugalmugle and Rupali Swain, "Sex Reassignment Surgery Market Size By Gender Transition (Male to Female {Facial, Breast, Genitals}, Female to Male {Facial, Chest, Genitals}), Industry Analysis Report, Regional Outlook, Application Potential, Price Trends, Competitive Market Share & Forecast, 2020 – 2026," *Global Market Insights* – Report ID: GMI2926 (March 2020), https://www.gminsights.com/industry-analysis/sex-reassignment-surgery-market; Grand View Research, "U.S. Sex Reassignment Surgery Market Size, Share & Trends Analysis Report By Gender Transition (Male To Female, Female To Male), And Segment Forecasts, 2020 – 2027" (December 2020), https://www.grandviewresearch.com/industry-analysis/us-sex-reassignment-surgery-market.
[66] Ugalmugle and Swain, "Sex Reassignment Surgery Market Size."
[67] Grand View Research, "U.S. Sex Reassignment Surgery Market Size, Share & Trends Analysis."
[68] "Sex Reassignment Surgery Market – Growth, Trends, COVID-19 Impact, and Forecasts (2022 – 2027)." *Mordor Intelligence* (2021), https://www.mordorintelligence.com/industry-reports/sex-reassignment-surgery-market
[69] Ibid.

Center (Boston, MA), Cleveland Clinic (Cleveland, OH), CNY Cosmetic & Reconstructive Surgery (Syracuse, NY), and Plastic Surgery Group Rochester (Rochester, NY).[70]

One surgical team specializing in gender-transition has recently described the current growth rate of people seeking medical transition in these terms:

> The landscape of gender dysphoria has changed dramatically in recent years secondary to increased societal acceptance, legislative changes, and medical providers' increased awareness of the associated psychosocial burden associated with the diagnosis . . . . To accommodate the expanding demand for gender-affirmation surgery, academic medical centers specializing in these procedures are gradually emerging. Advancing surgical techniques in the setting of rising patient demand encourage plastic surgeons to increasingly provide high-quality health care to this diverse patient population in an effort to optimize psychosocial functioning and minimize the burden of gender dysphoria.[71]

Another recent study proposes that the number of people seeking medical transition procedures is significantly higher than the actual surgical numbers themselves suggest, due to inaccessibility factors such as the relative lack of surgeons doing gender-related surgeries and/or their geographic proximity, as well as "exclusionary insurance policies."[72]

2. Factors Associated with the Growth in Gender Transition

There are a number of complex inter-related factors involved in the increase in people seeking transition-related medical care. These include the following:

a. The Rising Rates of People Who Report Experiencing Gender Dysphoria and/or Trans Identity

[70] Grand View Research, "U.S. Sex Reassignment Surgery Market Size, Share & Trends Analysis."
[71] Jason M. Weissler, Brian L. Chang, Martin J. Carney, David Rengifo, et al., "Gender-Affirming Surgery in Persons with Gender Dysphoria," *Plastic and Reconstructive Surgery* 141/3 (2018), 388e-396e; doi: 10.1097/PRS.0000000000004123. Weissler, et al. have noted: "To accommodate the expanding demand for gender-affirmation surgery, academic medical centers specializing in these procedures are gradually emerging." Jason M. Weissler, Brian L. Chang, Martin J. Carney, David Rengifo, et al., "Gender-Affirming Surgery in Persons with Gender Dysphoria," *Plastic and Reconstructive Surgery* 141/3 (2018), 388e-396e; doi: 10.1097/PRS.0000000000004123.
[72] A. T. Feldman, A. Chen, G. Poudrier, et al., "How Accessible Is Genital Gender-Affirming Surgery for Transgender Patients with Commercial and Public Health Insurance in the United States? Results of a Patient-Modeled Search for Services and a Survey of Providers," *Sexual Medicine* 8/4 (2020), 664–72.

To being, the number of people reporting gender dysphoria and/or trans identification has sky-rocketed in recent years. Throughout the 20th century, trans prevalence rates were almost exclusively grounded in clinic-based data. However, in recent years, surveys of self-reporting samples from non-clinical, geographically-based populations are increasingly becoming the preferred method of calculating the number of trans identified people.[73] Not surprisingly, population-based studies have found a much higher prevalence rate than clinic-based studies. For example, a Massachusetts study based on data collected between 2007 - 2009 found a transgender prevalence rate of 0.5%.[74] A 2014 study surveying 19 U.S. states and the territory of Guam calculated a prevalence rate of 0.53%.[75] Extrapolating from this data to the U.S. as a whole, it was estimated that the 2014 U.S. transgender prevalence rate was 0.6% or about 1.4 million people.

The sub-population representing the most dramatic increases in trans prevalence rates is that of children and adolescents.[76] Regarding this steep increase in prevalence rates, researchers are using terms like "substantial," "unprecedented," and "simply staggering."[77] One team of researchers has found that the years 2004 – 2007 marked a key shift in adolescent rate

[73] M. B. Deutsch, "Making It Count: Improving Estimates of the Size of Transgender and Gender Nonconforming Populations," *LGBT Health* 3 (2016), 181-5.
[74] K. J. Conron, G. Scott, G. S. Stowell, and S. J. Landers, "Transgender Health in Massachusetts: Results from a Household Probability Sample of Adults," *American Journal of Public Health* 102/1 (2012), 118-22.
[75] H. P. Crissman, M. B. Berger, L. F. Graham, and V. K. Dalton, "Transgender Demographics: A Household Probability Sample of U.S. Adults," *American Journal of Public Health* 107/2 (2017), 213-15.
[76] M. D. Connolly, M. J. Zervos, C. J. Barone, C. C. Johnson, and C. L. M. Joseph. "The Mental Health of Transgender Youth: Advances in Understanding," *Journal of Adolescent Health* 59 (2016), 489-95; M. M. Johns, R. Lowry, J. Andrzejewski, L. C. Barrios, Z. Demissie, T. McManus, et al., "Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students — 19 States and Large Urban School Districts, 2017," *Morbidity and Mortality Weekly Report (MMWR)* 68/3 (2019), 67-71; R. Kaltiala-Heino, P. Carmichael, N. de Graff, K. Rischel,L. Frisén, L. Suomalainen, and A. Wahre, "Time Trends in Referrals to Child and Adolescent Gender Identity Services: A Study in Four Nordic Countries and the UK," *Nordic Journal of Psychiatry* 74/7 (2019), 1-5; H. Wood, S. Sasaki, S. J. Bradley, D. Singh, S. Fantus, A. Owen-Anderson, A. Di Giacomo, J. Bain, and K. J. Zucker, "Patterns of Referral to a Gender Identity Service for Children and Adolescents (1976-2011): Age, Sex Ratio, and Sexual Orientation," *Journal of Sex and Marital Therapy* 39 (2013), 1-6.
[77] W. P. Bouman, A. L. C. de Vries, and G. T'Sjoen, "Gender Dysphoria and Gender Incongruence: An Evolving Inter-disciplinary Field," *International Review of Psychiatry* 28/1 (2016), 1-4; N. M. de Graaf, G. Giovanardi, C. Zitz, and P. Carmichael, "Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009-2016)," *Archives of Sexual Behavior* (April 25, 2018), doi:10.1007/s10508-018-1204-9. Note: The data on trans youth prevalence rates that follows is drawn from my prior study: Paul Rhodes Eddy, "Reflections on the Debate Concerning the Desistance Rate among Young People Experiencing Gender Dysphoria," *Center for Faith, Sexuality & Gender* (posted: April 2020; updated: June 2021), 110 pp; http://centerforfaith.com/sites/default/files/desistance_document_-_v._3.pdf.

increases.[78] This increase appears to be a transnational phenomenon. A recent UK study reports on the "unprecedented increase in referrals of gender-diverse young people seeking professional help."[79] Using data from the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDYQ–AA), a Finnish study found "[a]mong the boys 2.2% and among the girls 0.5% displayed potentially clinically significant gender dysphoria."[80] A Canadian community-based study using the Gender Identity Questionnaire for Children (GIQC) – a parent-report questionnaire covering a range of gender characteristics of children – found that "2.3% of boys and 2.8% of girls showed GNC levels comparable to those of children referred clinically for gender dysphoria."[81]

Several studies have sought to ascertain transgender prevalence rates among children and adolescents by using school-based surveys. A 2017 German study found that among those who participated in the nationally representative "Health Behaviour in School-aged Children" Hamburg survey, "4.1% of the adolescents' responses were rated as variant in gender experience and 3.0% as nonconforming in expression."[82] In the U.S., one of the more significant school surveys was conducted by the Minnesota Department of Education in 2016 among 9th and 11th graders. Over 80,000 students were surveyed. Researchers found that 2,168 – or 2.7% of the students identified as transgender (3.6% assigned/natal females and 1.7% assigned/natal males).[83] This study also found that, while a higher rate of racial/ethnic minority students identified as transgender, the rates were similar among metropolitan and non-metropolitan student populations. Compared to previous estimates of transgender identity among adolescents,

[78] K. J. Zucker, S. J. Bradley, A. Owen-Anderson, S. J. Kibblewhite, and J. Cantor, "Is Gender Identity Disorder in Adolescents Coming Out of the Closet?," *Journal of Sex and Marital Therapy* 34/4 (2008), 287-90 (here 288).
[79] de Graaf, et al., "Sex Ratio in Children and Adolescents."
[80] M. Sumia, N. Lindberg, M. Työläjärvi, and R. Kaltiala-Heino, "Current and Recalled Childhood Gender Identity in Community Youth in Comparison to Referred Adolescents Seeking Sex Reassignment," *Journal of Adolescence* 56 (2017), 34-39 (here 34).
[81] A. I. van der Miesen, A. N. Nabbijohn, A. Santarossa, and D. P. VanderLaan, "Behavioral and Emotional Problems in Gender-Nonconforming Children: A Canadian Community-Based Study," *Journal of the American Academy of Child and Adolescent Psychiatry* 57/7 (2018), 491-99 (here 491).
[82] I. Becker, U. Ravens-Sieberer, V. Ottova-Jordan, and M. Schulte-Markwort, "Prevalence of Adolescent Gender Experiences and Gender Expression in Germany," *Journal of Adolescent Health* 61/1 (2017), 83-90
[83] M. E. Eisenberg, G. L. Gower, B. J. McMorris, G. N. Rider, G. Shea, and E. Coleman, "Risk and Protective Factors in the Lives of Transgender/ Gender Nonconforming Adolescents," *Journal of Adolescent Health* 61/4 (2017), 521-26; G. N. Rider, B. J. McMorris, A. L. Gower, E. Coleman, and M. E. Eisenberg, "Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study," *Pediatrics* (2018), doi: 10.1542/peds.2017-1683.

the 2.7% prevalence rate in this Minnesota study is unusually high. Recently, one team of researchers has commented on the implications of this fact:

> Although the Minnesota study is an outlier in its high prevalence rates, it is among the most recent and targets a younger demographic than other prevalence studies, and thus may be indicative of future trends in TGNB identity prevalence.[84]

Perhaps the most astounding finding to date emerged from a 2015-2016 UCLA study, which found that 27 percent – that is, about 796,000 – of California youth, ages 12 to 17, reported *they are viewed by others* as gender nonconforming at school.[85] With regard to the wider U.S., the estimates of two studies published in 2015 and 2017 – taken together – suggest that between 0.7% and 3.2% of young people now identify as "transgender."[86] However, an even more recent study, published in 2021 and based on a 2018 survey of youth within the Pittsburgh public school district, found that 9.2% of the students identified as gender-diverse.[87]

b. Ongoing Advancements in Transition-Related Medical Procedures

A second factor influencing the rise in medical gender transition is the ever-increasing sophistication and success – especially in terms of safety, functionality and aesthetics – of transition-related surgical procedures.[88] A range of medical transition follow-up studies over several decades have consistently found that physiological and sexual functioning, along with aesthetically pleasing results (e.g., lack of scarring, authentic looking outcomes for chest and

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[84] I. T. Nolan, C. J. Kuhner, and G. W. Dy, "Demographic and Temporal Trends in Transgender Identities and Gender Confirming Surgery," *Translational Andrology and Urology* 8/3 (2019), 184-90 (here 184).

[85] B. D. M. Wilson, S. K. Choi, J. L. Herman, T. L. Becker, and K. J. Conron, *Characteristics and Mental Health of Gender Nonconforming Adolescents in California: Findings from the 2015-2016 California Health Survey* (Los Angeles: The Williams Institute and UCLA Center for Health Policy Research), http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1706.

[86] J. L. Herman, A. R. Flores, T. N. Brown, B. D. Wilson, and K. J. Conron, *Age of Individuals Who Identify as Transgender in the United States* (Los Angeles: Williams Institute, 2017), 2; B. D. M. Wilson, and A. Kastanis, "Sexual and Gender Minority Disproportionality and Disparities in Child Welfare: A Population-based Study," *Children and Youth Services Review* 58 (2015), 12.

[87] Kacie M. Kidd, Gina M. Sequeira, Claudia Douglas, Taylor Paglisotti, David J. Inwards-Breland, Elizabeth Miller, and Robert W. S. Coulter, "Prevalence of Gender-Diverse Youth in an Urban School District," *Pediatrics* 147/6 (2021), e2020049823. doi: 10.1542/peds.2020-049823. On this study, see also Kacie Kidd, "Nearly 10% of youth in one urban school district identify as gender-diverse, new study finds," *The Conversation* (June 3, 2021), https://theconversation.com/nearly-10-of-youth-in-one-urban-school-district-identify-as-gender-diverse-new-study-finds-161640.

[88] A number of studies have found that functionality and aesthetics/cosmesis are "the factors most correlated with post-operative satisfaction." Rayisa Hontscharuk, Brandon Alba, Alireza Hamidian Jahromi, and Loren Schechter. "Penile Inversion Vaginoplasty Outcomes: Complications and Satisfaction," *Andrology* 9 (2021), 1732-43 (p. 1740).

genital surgeries, etc.), are key factors related to reported post-operative satisfaction.[89] It is not surprising, then, that advancements in transition-related surgical procedures would be correlated with an increase in the number of trans people requesting such procedures. A steady international flow of publications – from textbooks to summary articles – has served to keep the field abreast of the ever-evolving dimensions, and the ever-increasing surgical improvements, of various transition-related procedures.[90]

Over the years, much of the attention has focused on the development of ever-more effective procedures involving genital – or bottom – surgery.[91] For MtF surgeries, this involves various techniques for the creation of a neovagina, typically using either a penile skin inversion procedure – which is considered the "gold standard" technique – or (as a secondary alternative) a pedicled intestinal transplant.[92] As a well-known Serbian research team explains, when it comes to vaginoplasty, "[m]any operative procedures have been described but none is ideal. Therefore,

[89] E.g., M. W. Ross and J. A. Need, "Effects of Adequacy of Gender Reassignment Surgery on Psychological Adjustment: A Follow-up of Fourteen Male-to-Female Patients," *Archives of Sexual Behavior* 18 (1989), 145-53; Friedemann Pfäfflin, "Regrets After Sex Reassignment Surgery." *Journal of Psychology & Human Sexuality* 5/4 (1993), 69–85; C. Klein and B. B. Gorzalka, "Sexual Functioning in Transsexuals Following Hormone Therapy and Genital Surgery: A Review (CME)," *Journal of Sexual Medicine* 6/11 (2009), 2922–39; F. Vedovo, L. Di Blas, F. Aretusi, M. Falcone, C. Perin, N. Pavan, et al., "Physical, Mental and Sexual Health Among Transgender Women. A comparative Study Among Operated Transgender and Cisgender Women in a National Tertiary Referral Network," *Journal of Sexual Medicine* 18/5 (2021), 982-89.

[90] E.g., R. Rossi Neto, F. Hintz, S. Krege, H. Rübben, and F. vom Dorp, "Gender Reassignment Surgery - A 13 Year Review of Surgical Outcomes," *International Brazilian Journal of Urology* 38/1 (2012), http://dx.doi.org/10.1590/S1677-55382012000100014; J. U. Berli, Knudson, L. Fraser, V. Tangpricha, R. Ettner, F. M. Ettner, et al., "What Surgeons Need to Know About Gender Confirmation Surgery When Providing Care for Transgender Individuals: A Review," *JAMA Surgery* 152/4 (2017), 394-400; Hembree, et al., "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons"; Schechter, *Surgical Management of the Transgender Patient*; Ettner, et al., eds, *Principles of Transgender Medicine and Surgery*; Djordjevic and Bizic, "Sexual Reassignment Surgery: Male to Female"; Monstrey, et al., "Sexual Reassignment Surgery: Female to Male"; Selvaggi and J. Beliringer, "Gender Reassignment Surgery: An Overview"; Gennaro Selvaggi, Christopher J. Salgado, Stan Monstrey, and Miroslav Djordevic, "Gender Affirmation Surgery," *Hindawi - BioMed Research International* (2018), 1768414, https://doi.org/10.1155/2018/1768414; Leonid Poretsky and Wylie C. Hembree, eds., *Transgender Medicine: A Multidimensional Approach* (New York: Humana/Springer Nature, 2019); Mark Fisher, Mark Smith and Adam D. Perry, "Gender Confirmation Surgery," in Poretsky and Hembree, eds., *Transgender Medicine*, 183-96.

[91] Miroslav L. Djordjevic, "Gender Confirmation Surgery," in *Female Pelvic Surgery*, 2nd ed.; ed. F. Firoozi (New York: Springer, 2020 [2015]), 343-56; Mang L. Chen, Polina Reyblat, Melissa M. Poh, and Amanda C. Chi, "Overview of Surgical Techniques in Gender-Affirming Genital Surgery," *Translational Andrology and Urology* 8/3 (2019), 191-208.

[92] M. Bizic, V. Kojovic, D. Duisin, D. Stanojevic, S. Vujovic, A. Milosevic, G. Korac, and M. L. Djordjevic, "An Overview of Neovaginal Reconstruction Options in Male to Female Transsexuals," *Scientific World Journal* (2014), art. 638919, p. 2; http://dx.doi.org/10.1155/2014/638919.

the search for new, improved solutions continues."[93] Another research team has noted that "[t]here has been an exponential increase in referrals for transmasculine patients seeking genital affirmation surgery."[94] FtM genital procedures typically involve either metoidioplasty (transformation of the clitoris into a penis through testosterone treatment and surgery) or phalloplasty.[95] Increasingly sophisticated penile prosthetics are being developed to enable post-phalloplasty sexual function in trans men.[96]

In addition to top and bottom surgeries, advancements are being made in both facial feminization surgery (FFS) and facial masculinization surgery (FMS).[97] Eric Plemons has observed that, in recent years, FFS has become as – or even more – important than genital surgery for some trans people.[98] Similarly, Alex Dubov and Liana Fraenkel have argued that, in terms of personal and social impact (i.e., the ability to "pass" socially), FFS is more important to many trans women than bottom surgery.[99] The first FFS for a transfeminine person was pioneered in 1983 by Douglas Ousterhout, a craniofacial surgeon based in San Francisco.[100] Ousterhout was also

[93] Ibid., 1.
[94] D. Jolly, C. A. Wu, E. R. Boskey, et al., "Is Clitoral Release Another Term for Metoidioplasty? A Systematic Review and Meta-Analysis of Metoidioplasty Surgical Technique and Outcomes," *Sexual Medicine* 9/1 (2021), 100294. doi: 10.1016/j.esxm.2020.100294. See Dean Kotula, *The Phallus Palace: Female to Male Transsexuals* (Los Angeles: Alyson, 2002).
[95] See ibid.; M. Rashid and M. Tamimy, "Phalloplasty: The Dream and the Reality," *Indian Journal of Plastic Surgery* 46/3 (2013), 283-93; Monstrey, et al., "Sexual Reassignment Surgery: Female to Male."
[96] S. A. Rooker, K. S. Vyas, E. C. DiFilippo, et al., "The Rise of the Neophallus: A Systematic Review of Penile Prosthetic Outcomes and Complications in Gender-Affirming Surgery," *Journal of Sexual Medicine* 16/5 (2019), 661–72
[97] Jordan C. Deschamps-Braly, "Facial Gender Confirmation Surgery: Facial Feminization Surgery and Facial Masculinization Surgery," *Clinics in Plastic Surgery* 45/3 (2018), 323-31; Nick, Esmonde, Alireza Najafian, Amy Penkin, and Jens Urs Berli, "The Role of Facial Gender Confirmation Surgery in the Treatment of Gender Dysphoria," *Journal of Craniofacial Surgery* 30/5 (2019), 1387-92.
[98] Eric Plemons, *The Look of a Woman: Facial Feminization Surgery and the Aims of Trans-Medicine* (Durham, NC: Duke University Press, 2017).
[99] Alex Dubov and Liana Fraenkel, "Facial Feminization Surgery: The Ethics of Gatekeeping in Transgender Health," *American Journal of Bioethics* 18/12 (2018), 3-9.
[100] Eric D. Plemons, "Description of Sex Difference as Prescription for Sex Change: On the Origins of Facial Feminization Surgery," *Social Studies of Science* 44/5 (2014), 657–79; Jordan C. Deschamps-Braly, "Approach to Feminization Surgery and Facial Masculinization Surgery: Aesthetic Goals and Principles of Management," *Journal of Craniofacial Surgery* 30/5 (2019), 1352-58; Deschamps-Braly Clinic, "History of Facial Feminization & Gender Confirmation Surgery," https://deschamps-braly.com/facial-feminization-surgery/history-ffs/. On FFS, see also Douglas K. Ousterhout, *Facial Feminization Surgery: A Guide for the Transgendered Woman* (Omaha, NB: Addicus, 2009); A. L. Callen, R. K. Badiee, A. Phelps, V. Potigailo, E. Wang, S. Lee, et al., "Facial Feminization Surgery: Key CT Findings for Preoperative Planning and Postoperative Evaluation," *American Journal of Roentgenology* 217/3 (2021), 709-17.

instrumental in pioneering FMS. In 2017, for example, Ousterhout's team announced the first facial masculinization procedure that included the augmentation of an Adam's apple.[101]

Another area of transition-related surgical advancement involves the voice. Studies have shown that how trans people perceive their own voice – as well as how others perceive it – affects their reported quality of life.[102] In earlier years, the only way of adjusting voice quality was through hormones and/or voice/speech therapy.[103] Eventually, phonosurgical procedures – both feminizing and masculinizing – were added to this set of options.[104]

In her critique of the idea of the trans woman, the British second-wave feminist, Germaine Greer, once wrote:

> No so-called sex-change has ever begged for a uterus-and-ovaries transplant; if uterus-and-ovaries transplants were made mandatory for [trans] women they would disappear overnight.[105]

It turns out that Greer's intuitions on this matter were, to say the least, not entirely correct. In 1931, Lili Elbe, one of the very first people to undergo complete MtF SRS, had a uterine transplant procedure as part of the final surgical process – leading to an infection which ended her life. Today, 90 years later, at the frontier of transition-related medicine is the possibility of successful uterine transplant surgery.

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[101] Deschamps-Braly, et al., "First Female-to-Male Facial Confirmation Surgery with Description of a New Procedure for Masculinization of the Thyroid Cartilage (Adam's Apple)." On FMS, see also Farah Sayegh, David C. Ludwig, Mona Ascha, Krishna Vyas, Afaaf Shakir, Jeffrey W. Kwong, et al., "Facial Masculinization Surgery and its Role in the Treatment of Gender Dysphoria," *Journal of Craniofacial Surgery* 30/5 (2019), 1339-46.
[102] A. B. Hancock, J. Krissinger, and K. Owen, "Voice Perceptions and Quality of Life of Transgender People," *Journal of Voice* 25/5 (2011), 553-58; K. Neumann and C. Welzel, "The Importance of Voice in Male-to-Female Transsexualism," *Journal of Voice* 18/1 (2004), 153–67; Seth O. Watt, Konstantin O. Tskhay, and Nicholas O. Rule, "Masculine Voices Predict Well-Being in Female-to-Male Transgender Individuals," *Archives of Sexual Behavior* 47/4 (2018), 963-72.
[103] M. S. Irwig, K. Childs, and A. B. Hancock, "Effects of Testosterone on the Transgender Male Voice," *Andrology* 5 (2017), 107-12.
[104] Ian T. Nolan, Shane Morrison, Omotayo Arowojolu, Christopher S. Crowe, Jonathan P. Massie, Richard K. Adler, et al., "The Role of Voice Therapy and Phonosurgery in Transgender Vocal Feminization," *Journal of Craniofacial Surgery* 30/5 (2019), 1368-75.
[105] Germaine Greer, "Pantomime Dames," in *The Whole Woman* (New York: Anchor, 1999).

In 2015, the first live birth following uterine transplantation was reported.[106] By 2018, uterine transplant surgery was being identified as a "rapidly expanding field."[107] That same year, a leading group of surgeons specializing in gender transition stated that this development is the first step toward the day when trans women will be able to give birth.[108] More recently, another group of researchers has noted several anatomical challenges to a trans woman being able to give birth via a uterine transplant. Nonetheless, they conclude: "While some degree of surgical adaptation is necessary, none of these barriers seem insurmountable."[109] They go on to point out that, since "many [transgender men] seeking hysterectomy are young and healthy, they represent a possible group of volunteers for uterus donation" to trans women seeking a uterine transplant.[110] According to one trans woman who has written about this new possibility of giving birth to a child, about half of the trans women she knows desire that experience.[111]

To summarize this second factor influencing the rising rates of medical transition: Ongoing advancements related to transition-related surgical procedures – in terms of safety, functionality and aesthetic outcomes – has made medical transition an increasingly attractive option for trans people. In light of these developments, some are now calling for transition-related medicine to become part of the required medical school curriculum.[112] In the near future, it appears that

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[106] M. Brännström, L. Johannesson, H. Bokström, N. Kvarnström, J. Mölne, P. Dahm-Kähler, et al., "Livebirth After Uterus Transplantation," *Lancet* 385/9968 (2015), 607-16.
[107] M. Brännström, L. P. Dahm-Kähler, R. Greite, J. Mölne, C. Diaz-Garcia, and S. G. Tullius, "Uterus Transplantation: A Rapidly Expanding Field," *Transplantation* 102/4 (2018), 569-77.
[108] Marta R. Bizic, Milos Jeftovic, Slavica Pusica, Borko Stojanovic, Dragana Duisin, Svetlana Vujovic, Vojin Rakic, and Miroslav L. Djordjevic, "Gender Dysphoria: Bioethical Aspects of Medical Treatment," *Biomed Research International* (2018), 9652305, p. 4; doi: 10.1155/2018/9652305.
[109] Alireza Hamidiani Jahromi, Sydney R. Horen, Amir H. Dorafshar, Michelle L. Seu, Asa Radix, Erica Anderson, et al., "Uterine Transplantation and Donation in Transgender Individuals: Proof of Concept," *International Journal of Transgender Health* 22/4 (2021), 349-59 (p. 349). See also Vikram G. Mookerjee and Daniel Kwan, "Uterus Transplantation as a Fertility Option in Transgender Healthcare," *International Journal of Transgender Health* 21/2 (2020), 122-24.
[110] Jahromi, et al., "Uterine Transplantation and Donation in Transgender Individuals," 349. See M. Carbonnel, L. Karpel, B. Cordier, P. Pirtea, and J. M. Ayoubi, "The Uterus in Transgender Men," *Fertility & Sterility* 116/4 (2021), 931-35.
[111] Jane Fae, "Pregnancy for trans women is around the corner – as an older trans woman, I couldn't be happier," *Independent* (February 18, 2019), https://www.independent.co.uk/voices/trans-pregnancy-transgender-womb-transplant-women-uterus-transphobia-motherhood-a8784536.html.
[112] Vishnu R. Mani, Sebastian C. Valdivieso, Adel Hanandeh, Aleksandr Kalabin, Alexius Ramcharan, and Brian Donaldson, "Transgender Surgery - Knowledge Gap among Physicians Impacting Patient Care," *Current Urology* 15/1 (2021), 68-70. Relatedly, see also Loren S. Schechter, "Gender Confirmation Surgery: A New Frontier in Plastic Surgery Education," *Plastic and Reconstructive Surgery* 138/4 (2016), 784e-85e; doi: 10.1097/PRS.0000000000002594.

pioneering technologies, including uterine transplantation and the promise of childbirth, will only further fuel the demand for transition-related medical interventions.

c. The Growing Cultural Awareness and Acceptance of Trans People

A third factor fueling the increased interest in gender transition is the remarkable cultural awareness – and increasing acceptance – of the trans-identified people. Among the factors associated with this growing cultural acceptance, the internet and various media platforms have played a highly significant role, particularly among younger people. To briefly focus on just one dimension of this – that of television and related media: In June 2014, *Time Magazine* proclaimed that our culture had reached a "Transgender Tipping Point." The cover photo captured an image of Laverne Cox, a transgender actress starring in the popular show "Orange is the New Black." 2014 also brought the Amazon comedy-drama "Transparent," a web series involving an aging father who comes out as a transgender woman. On April 24, 2015, the high-profile 20/20 interview of Caitlyn Jenner was aired. Three months later Jenner was featured on the cover of *Vanity Fair*, and the reality TV series "I am Cait" was launched. And in July 2015, the reality show "I Am Jazz" – featuring trans teen Jazz Jennings – was launched. Five years later, in 2020, Jesse James Keitel became the first nonbinary actor to play a transfeminine character on primetime television in the ABC show "Big Sky."[113]

Research has found that television narratives portraying trans persons in a positive light serve to influence audience attitudes in a sympathetic direction.[114] One study on the representation of trans people in television from 2008 to 2014 reported that "television has begun to evolve in a manner that relies less on a standardized narrative and one-dimensional characterization of transgender people."[115]

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[113] Max Gao, "Nonbinary actor Jesse James Keitel on groundbreaking 'Big Sky' role: Keitel, who plays a transfeminine musician and sex worker in the ABC drama, is the first nonbinary actor to play a nonbinary series regular on primetime TV," *NBC News* (December 1, 2020), https://www.nbcnews.com/feature/nbc-out/nonbinary-actor-jesse-james-keitel-groundbreaking-big-sky-role-n1249521.

[114] Traci K. Gillig, Erica l. Rosenthal, Sheila T. Murphy, and Kate Langrall Folb, "More Than a Media Moment: The Influence of Televised Storylines on Viewer's Attitudes toward Transgender People and Policies," *Sex Roles* 78 (2018), 515-27.

[115] Jamie C. Capuzza and Leland C. Spencer, "Regressing, Progressing, or Transgressing on the Small Screen? Transgender Characters on U.S. Scripted Television Series," *Communications Quarterly* 65/2 (2017), 214-30 (p. 214). Interestingly, one qualitative study involving interviews with eight trans people who volunteered to be part of a television documentary about trans experience found that "the experience of being mirrored through the group

Reflecting on the cultural gains for trans people between the years 2014 and 2019, trans woman and Harvard literary critic and poet, Stephanie Burt, writes of

> the apotheosis of Laverne Cox; pop stars coming out as genderqueer (Sam Smith) and rock stars transitioning (Laura Jane Grace); the rise of trans books by trans authors for trans readers (especially in poetry and young adult fiction, notably Rachel Gold, April Daniels, and Cameron Awkward-Rich). Multiple trans people serve as elected and appointed government officials (Virginia's Danica Roem). Trans supporting characters appear in mainstream comic books and show up regularly on TV, sometimes even in roles that aren't entirely about their trans identities . . . . The struggle for recognition, for economic security, and for mere personal safety, is hardly over — too many of us live in poverty, and in fear of anti-trans violence. But it's hard not to feel that, for trans people in the U.S., 2019 beats 2014.[116]

Another researcher of American media images of LGBTQ people summarized her findings with the phrase: "Queer is the New Cool."[117]

A number of people working in transition-related medical fields have proposed that this growing cultural awareness and acceptance is one important factor in the relatively recent rise in medical transition procedures.[118] For example, many professionals working with trans youth have attributed the exponential rise in clinical referral rates primarily to the "significant progress towards the acceptance and recognition of transgender and gender diverse people in our

process during filming and the audience's response to the TV series, which was very positive, appeared to be associated with an attenuation in the urgency with which planned body modifications were being discussed post-TV screenings." Alessandra Lemma, "Research Off the Couch: Re-visiting the Transsexual Conundrum," *Psychoanalytic Psychotherapy* 26 (2012), 263-81 (p. 263).

[116] Stephanie Burt, "*Transparent*'s Greatest Trans Legacy Is How Quickly It Grew Irrelevant," *Vulture* (September 26, 2019), https://www.vulture.com/2019/09/transparents-trans-legacy-is-how-quickly-it-grew-irrelevant.html. Of course, not all of the data on trans acceptance shows a positive trajectory. See e.g., Spencer Harvey, "GLAAD's 2019 Accelerating Acceptance Index: Results Show Further Decline in LGBTQ Acceptance among Americans Ages 18-34," *GLAAD.org* (June 24, 2019), https://www.glaad.org/blog/glaad%E2%80%99s-2019-accelerating-acceptance-index-results-show-further-decline-lgbtq-acceptance-among.

[117] Vanessa Campagna, "Queer is the New Cool: Mass Media Images of LGBT America," in *Lesbian, Gay, Bisexual, and Transgender Americans at Risk: Problems and Solutions*, vol. 2: *Adults, Generation X, and Generation Y*, ed. Chuck Stewart (Santa Barbara, CA: Praeger, 2018), 159-80.

[118] E.g., Nolan, et al., "Demographic and Temporal Trends in Transgender Identities and Gender Confirming Surgery"; Jason M. Weissler, Brian L. Chang, Martin J. Carney, David Rengifo, et al., "Gender-Affirming Surgery in Persons with Gender Dysphoria," *Plastic and Reconstructive Surgery* 141/3 (2018), 388e-396e; doi: 10.1097/PRS.0000000000004123

society."[119] On a personal level, the experience of Kate Hutchinson reflects this proposal. Hutchinson originally came out as trans in the 1990s. But she later decided to detransition due to the discrimination she faced. More recently, she decided to retransition – both socially and medically – largely because of the "greater visibility and acceptance of trans people" she had witnessed over the intervening years.[120] Moreover, a recent market forecast of SRS in the coming years observes that "[t]he growing acceptance of the transgender population . . . . [is] expected to increase the demand for sex reassignment surgeries during the forecast period [i.e., 2020-2027]."[121]

d. The Increasing Visibility of Nonbinary Gender Identities

A fourth factor is the increasing visibility of *nonbinary gender identities* and, with this, an awareness of new forms of medical transition that correspond to nonbinary sensibilities. Over the last few years, the trans experience(s) – which for years had been understood in predominantly "gender binary" terms – has proliferated and diversified to include an ever-growing number of gender-diverse experiences and identities.[122] This has led, for example, to a range of new *nonbinary* gender expressions and identities (e.g., agender, genderqueer, gender-bending; gender-fluid, maverique, maxigender, novosexual, pangender, faesari, cenrell, etc.). In fact, studies are finding that 1/3 or more of trans people identify with some expression of nonbinary gender identity.[123] This new cultural awareness and embrace of nonbinary gender identities has

[119] "GIDS Referrals Increase in 2017/18," Tavistock and Portman NHS Foundation Trust **(**May 17, 2018), https://tavistockandportman.nhs.uk/about-us/news/stories/gids-referrals-increase-201718/ (here quoting the director of the UK's Gender Identity Development Service, Polly Carmichael).
[120] Alla Braidwood, "I detransitioned because of transphobia, but I always knew I am a woman. Now I'm living as my authentic self," *inews* (May 1, 2019), https://inews.co.uk/opinion/comment/i-detransitioned-because-of-discrimination-but-i-always-knew-i-am-a-woman-now-im-living-as-my-authentic-self-286290.
[121] Grand View Research, "U.S. Sex Reassignment Surgery Market Size, Share & Trends Analysis."
[122] Rob Cover, *Emergent Identities: New Sexualities, Genders and Relationships in a Digital Era* (New York: Routledge, 2019); J. S. Hyde, R. S. Bigler, D. Joel, C. C. Tate, and S. M. van Anders, "The Future of Sex and Gender in Psychology: Five Challenges to the Gender Binary," *American Psychologist* 74/2 (2019), 171-93.
[123] E.g., Aaron S. Breslow, Hailey Wojcik, Robert Cox, Jr., Nathaniel M. Tran, and Melanie E. Brewster, "Toward Nonbinary Nuance in Research and Care: Mapping Differences in Gender Affirmation and Transgender Congruence in an Online National U.S. Survey," *Transgender Health* 6/3 (2021), 156-63 (p. 157); Denton Callander, Christy E. Newman, Martin Holt, Shoshana Rosenberg, Dustin T. Duncan, Mish Pony, et al., "The Complexities of Categorizing Gender: A Hierarchical Clustering Analysis of Data from the First Australian Trans and Gender Diverse Sexual Health Survey," *Transgender Health* 6/2 (2021), https://doi.org/10.1089/trgh.2020.0050.

also been fueled by advocates of *queer theory*, who call for the transgression of conventional categories – such as the *gender binary* – as a path toward liberation.[124]

With the recognition of nonbinary gender identities has come an increasing awareness among transition-related medical providers of the range of medical procedures now being considered by nonbinary people.[125] Related to this, Jen Hastings, et al. write:

> Medical interventions [for nonbinary people] may include pubertal suppression, hormones, and surgeries, which are best reviewed by individual physical effects rather than with "masculinizing" or "feminizing" terminology. Individualized goals may be supported by estrogen, testosterone, or a combination of both.[126]

Another research team has explicitly called upon gender clinicians to be prepared to support non-binary/genderqueer clients who identify as agender, pangender, etc. in their requests for medical intervention (hormones; surgery) in order to either "remove obvious markers" of any sex/gender or who "wish to combine such markers" in creative ways.[127] The former option – known as *gender-nullification surgery* (or M/FtN) – is sometimes chosen by people who identify as

[124] For helpful introductions to queer theory from various – and, at points, sometimes conflicting – perspectives, see Kath Browne and Catherine J. Nash, eds., *Queer Methods and Methodologies: Intersecting Queer Theories and Social Science Research* (reprint ed.; New York: Routledge, 2016 [2010]); Lisa Duggan, "Making It Perfectly Queer," *Socialist Review* 22/1 (1992), 11-32; Noreen Giffney, "Introduction: The 'q' Word," in *Ashgate Research Companion to Queer Theory*, eds. Noreen Giffney and Michael O'Rourke (Burlington, VT: Ashgate, 2009), 1-16; Annamarie Jagose, *Queer Theory* (New York: New York University Press, 1996); E. Patrick Johnson and Mae G. Henderson, eds., *Black Queer Studies: A Critical Anthology* (Durham, NC: Duke University Press, 2005); Ki Namaste, "The Politics of Inside/Out : Exploring Queer Theory, Poststructuralism, and a Sociological Approach to Sexuality," *Sociological Theory* 12/2 (1994), 220-231; Bruno Perreau, *Queer Theory: The French Response* (Stanford: Stanford University Press, 2016); Mari Ruti, *The Ethics of Opting Out: Queer Theory's Defiant Subjects* (New York: Columbia University Press, 2017); Nikki Sullivan, *A Critical Introduction to Queer Theory* (New York: New York University Press, 2003); Robyn Wiegman and Elizabeth A. Wilson, eds., *Queer Theory without Antinormativity* (Durham, NC: Duke University Press, 2015).

[125] Christina Richards, Walter Pierre Bouman, Leighton Seal, Meg John Barker, Timo O. Nieder, and Guy T'Sjoen, "Non-binary or Genderqueer Genders," *International Review of Psychiatry* 28/1 (2016), 95-102; J. Hastings, B. Callum, M. Wolfe, A. Jimenez, and C. St. Amand, "Medical Care for Nonbinary Youth: Individualized Gender Care Beyond a Binary Framework," *Pediatric Annals* 50/9 (2021), e384-90. https://doi.org/10.3928/19382359-20210818-03; Joz Motmans, Timo O. Nieder, and Walter Pierre Bouman, "Transforming the Paradigm of Nonbinary Transgender Health: A Field in Transition," *International Journal of Transgenderism* 20/2-3 (2020), 119-25. The WPATH's SOC-8 will reportedly have a new chapter dedicated to non-binary identities. From explicitly queer theory perspectives, see also Dean Spade, "Mutilating Gender," in Stryker and Whittle, eds., *Transgender Studies Reader*, 315-32; J. Horncastle, "Busting Out: Happenstance Surgery, Clinic Effects, and the Poetics of Genderqueer Subjectivity," *TSQ* 5/2 (2018), 251-67.

[126] Hastings, et al., "Medical Care for Nonbinary Youth."

[127] Richards, et al., "Non-binary or Genderqueer Genders," 99.

neutrois, nullo or eunuch, and involves the removal of all genitalia that could appear to be either male or female.[128]

A related nonbinary medical intervention being sought by some youth involves long-term puberty suppression via the extended use of puberty blockers. Here, a primary motivation is the desire to retain a more androgynous-looking body that better fits with a nonbinary person's sense of not being either fully male or female. By taking puberty blockers over the long-term, puberty is potentially avoided entirely, and more of a pre-pubertal physical appearance can be maintained on into adulthood. A research team associated with the Royal Children's Hospital and the Murdoch Children's Research Institute in Melbourne, Australia, and headed up by Ken Pang, is leading the way in exploring the possibilities, risks, and ethics associated with this nonbinary medical pathway.[129]

e. The Increasing Number of Children and Adolescents Choosing to Transition

A fifth factor that will likely continue to fuel the rise in overall medical transition procedures involves the increasing number of young children who are being socially transitioned, of pre-pubescent children who are being put on puberty blockers, and of ever younger adolescents who are accessing medical transition interventions.

To begin here, a bit of backstory. For most of the 20th century, children who experienced GD had only one treatment path prior to becoming a legal adult – namely, various forms of behavioral and/or psychotherapy.[130] Beginning in the mid-1990s, publications began to appear from a

[128] See Neutrois, www.neutrois.com; Align Surgical Associates, "Nullification," https://www.alignsurgical.com/non-binary/nullification/; M. Hermann and A. Thorstenson, "A Rare Case of Male-to-Eunuch Gender Dysphoria," *Sexual Medicine* 3/4 (2015), 331-33; Kevin J. Hsu, "Erotic Target Identity Inversions in Male Furries, Adult Baby/Diaper Lovers, and Eunuchs" (PhD dissertation; Northwestern University, 2019).

[129] Ken C. Pang, Lauren Notini, Rosalind McDougall, Lynn Gillam, Julian Savulescu, Dominic Wilkinson, et al, "Long-term Puberty Suppression for a Nonbinary Teenager," *Pediatrics* 145/2 (2020), e20191606. doi: 10.1542/peds.2019-1606; L. Notini, B. D. Earp, L. Gillam, R. J. McDougall, J. SavulescuJ, M. Telfer, and K. C. Pang, "Forever Young? The Ethics of Ongoing Puberty Suppression for Non-binary Youth," *Journal of Medical Ethcis* 46/11 (2020), 743-52; L. Notini, K. C. Pang, M. Telfer, and R. J. McDougall, "'No One Stays Just on Blockers Forever': Clinicians' Divergent Views and Practices Regarding Puberty Suppression for Nonbinary Young People," *Journal of Adolescent Health* 68/6 (2021), 1189-96.

[130] E.g., R. Green, L. Newman, and R. Stoller, "Treatment of Boyhood Transsexualism: An Interim Report of Four Years' Experience," *Archives of General Psychiatry* 26 (1972), 213-17; Richard Green, *The "Sissy Boy Syndrome" and the Development of Homosexuality* (New Haven: Yale University Press, 1987); Kenneth J. Zucker and Susan J.

research team in the Netherlands that signaled the development of a new approach – most commonly referred to today as the *Dutch* – or *Watchful Waiting* – model.[131]

Key aspects of the Dutch/Watchful Waiting model's treatment approach for young people experiencing gender dysphoria include: (1) the use of puberty blockers (GnRHa) in the early stages of puberty (i.e., around age 12) to prevent the "development of irreversible sex characteristics of the unwanted sex," and to provide additional time for the child to decide whether to pursue a gender transition or to live as their natal sex.[132] (2) For those who decide to pursue a gender transition, cross-sex hormone therapy can begin at age 16. (3) For those who wish to pursue irreversible transition-related surgeries, they are required to wait until they become a legal adult. (4) Finally, for children under the age of 12 who experience gender dysphoria, a stance of "watchful waiting" on the part of parents and others is encouraged – that is, on one hand, "there is no active effort to lessen the gender dysphoria or cross-gender behavior."[133] On the other hand, neither is there any action taken to socially transition the child. In essence, this model takes something of a "wait and see" approach with pre-adolescent children, while focusing on helping the family – both the parents and the child – to adjust to the situation in as healthy and positive a way as possible.[134]

Bradley, *Gender Identity Disorder and Psychosexual Problems in Children and Adolescents* (New York: Guilford, 1995).

[131] Key publications from the first decade include: Louis Gooren and Henriette Delemarre-van de Wall, "The Feasibility of Endocrine Interventions in Juvenile Transsexuals," *Journal of Psychology and Human Sexuality* 8/4 (1996), 69-74; Peggy T. Cohen-Kettenis and Stephanie H. M. van Goozen, "Sex Reassignment of Adolescent Transsexuals: A Follow-up Study," *Journal of the American Academy of Child and Adolescent Psychiatry* 36 (1997), 263-71; Peggy T. Cohen-Kettenis and Stephanie H. M. van Goozen, "Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent," *European Child and Adolescent Psychiatry* 7/4 (1998), 245-48; H. A. Delemarre-van de Waal and P. T. Cohen-Kettenis, "Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects," *European Journal of Endocrinology* 155/Suppl 1 (2006), S131–S137. doi:10.1530/ eje.1.02231; Peggy T. Cohen-Kettenis, Henriette A. Delemarre-van de Waal, and Louis J. G. Gooren, "The Treatment of Adolescent Transsexuals: Changing Insights," *Journal of Sexual Medicine* 5 (2008), 1892-97. For a very helpful summary of the Dutch model, see Annelou L. de Vries and Peggy T. Cohen-Kettenis, "Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach," in *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion*, eds. J. Drescher and W. Byne (New York: Routledge, 2013), 7-26.

[132] Delemarre-van de Waal and Cohen-Kettenis, "Clinical Management of Gender Identity Disorder in Adolescents," S131.

[133] Kenneth J. Zucker, "On the 'Natural History' of Gender Identity Disorder in Children," *Child and Adolescent Psychiatry* 47/12 (2008), 1361-63 (p. 1362).

[134] E.g., Christine Aramburu Alegria, "Gender Nonconforming and Transgender Children/Youth: Family, Community, and Implications for Practice," *Journal of the America Association of Nurse Practioners* 28/10 (2016), 521-27.

In 2007, the Gender Management Service (GeMS) was opened at Boston Children's Hospital – the first interdisciplinary, hospital-based pediatric clinic in the U.S. to provide assessment and medical intervention for gender dysphoric/transgender youth. The founders of GeMS, including psychologist Laura Edwards-Leeper and endocrinologist Norman Spack, explicitly adopted the Dutch model, with Edwards-Leeper being directly trained by Peggy Cohen-Kettenis, one of the Dutch model's founders.[135] As James Cantor has pointed out, "almost all clinics and professional associations in the world use . . . the *watchful waiting* approach to helping gender diverse (GD) children."[136] Up until very recently, that is.

Increasingly a third approach to the treatment of gender dysphoric/transgender children is gaining prominence today, especially in the U.S. – *the Gender Affirmative model* (GAM).[137] To make its contrast with the Watchful Waiting model explicit, Diane Ehrensaft has also dubbed it the "Listen and Act" model.[138] While it shares many of the same broad protocols as the Dutch model, it differs in at least one key area: it explicitly endorses the social transition of gender dysphoric/transgender children at very young ages. The essence of the GAM was presented by Stephanie Brill and Rachel Pepper in their 2008 book, *The Transgender Child*.[139] Near the opening of the book, they answer the question: "How You Can Know a Child is Transgender"

> "Luckily most children are very clear on this subject. When given a choice – boy or girl – most kids feel strongly they are one or the other . . . . When your 18-month-old girl's first words are "me boy" or your 2-year-old son insists he is a girl, and these responses don't

[135] See Laura Edwards-Leeper and Norman P. Spack, "Psychological Evaluation and Medical Treatment of Transgender Youth in an Interdisciplinary 'Gender Management Service' (GeMS) in a Major Pediatric Center," in Drescher and Byne, eds., *Treating Transgender Children and Adolescents*, 27-42; Norman P. Spack, "Transgenderism," *Lahey Clinic Medical Ethics Journal* 12/3 (2005), 1-12.
[136] James Cantor, "Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy," *Journal of Sex and Marital Therapy* 46/4 (2020), 307-13 (p. 309).
[137] Diane Ehrensaft, Shawn V. Giammattei, Kelly Storck, Amy C. Tishelman, and Colton Keo-Meier, "Prepubertal Social Gender Transitions: What We Know; What We Can Learn—A View From a Gender Affirmative Lens," *International Journal of Transgenderism* 19/2 (2018), 251-68; Colt Keo-Meier and Diane Ehrensaft, eds, *The Gender Affirmative Model: An Interdisciplinary Approach to Supporting Transgender and Gender Expansive Children* (Washington, DC: American Psychological Association, 2018); Diane Ehrensaft, *The Gender Creative Child: Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes* (New York: The Experiment, 2016).
[138] Diane Ehrensaft, "Realities and Myths: The Gender Affirmative Model of Care for Children and Youth," in *Current Critical Debates in the Field of Transsexual Studies: In Transition*, ed. O. Gozlan (New York: Routledge, 2018), 102-14 (p. 102).
[139] Stephanie Brill and Rachel Pepper, *The Transgender Child* (San Francisco: Cleis, 2008).

> waver or change over the next few years, you can be pretty sure you have a transgender child."[140]

This passage reflects two of the distinctive features of the GAM: (1) We can know with a high degree of certainty whether or not a young person is a "transgender child"; and (2) it is often possible for a "transgender child" to be identified at an extremely young age. Regarding the first distinctive, the GAM proposes that the test by which we can identify a transgender child is this: If the child is "insistent, persistent, and consistent in their affirmation of a cross-gender identity," we are justified in concluding that they are a transgender child.[141] In Diane Ehrensaft words: "Children at a young age, both cisgender and transgender, can definitively know their gender."[142]

The second distinctive can be clearly seen in the TransYouth Project. The TransYouth Project, launched in 2013, is the largest North American study of more than 350 socially-transitioned transgender children in the US and Canada. The children recruited for the study were *between the ages of three and twelve*, and the project plans to track them for 20 years.[143] A 2018 study related to the TransYouth Project focused on the sub-cohort of three-to-five-year-olds. Kristina Olson – the director of the TransYouth Project – and co-author Anne Fast describe this group of children:

> Thirty-six 3- to 5-year-old transgender children who had socially transitioned . . . participated, including 28 transgender girls (natal males) and 8 transgender boys (natal females). Perhaps not surprisingly, as social transitions often occur later in development, our sample skewed toward the older age of this range, with two 3-year-olds, thirteen 4-

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[140] Ibid., 2.

[141] Hidalgo, et al., "Gender Affirmative Model," 286. This criterion of "insistent, persistent and consistent" has gone on to become a commonplace among gender affirmative advocates. E.g., K. R. Olson, "Prepubescent Transgender Children: What We Do and Do Not Know," *Journal of the American Academy of Child and Adolescent Psychiatry* 55/3 (2016), 155-56 (see 155). More recently, some GAM advocates are raising critical questions about this criterion. E.g., Jack L. Turban and Alex S. Keuroghlian, "Dynamic Gender Presentations: Understanding Transition and 'De-Transition' Among Transgender Youth," *Journal of the American Academy of Child and Adolescent Psychiatry* 57/7 (2018), 451-53.

[142] Diane Ehrensaft, "Exploring Gender Expansive Expression Versus Asserting a Gender Identity," in Keo-Meier and Ehrensaft, eds, *The Gender Affirmative Model*, 37-53. See also James R. Rae, Selin Gülgöz, Lily Durwood, Madeleine DeMeules, Riley Lowe, Gabrielle Lindquist, and Kristina R. Olson, "Predicting Early-Childhood Gender Transitions." *Psychological Science* 30/5 (2019), 669-81.

[143] On the TransYouth Project, see Kristina R. Olson, Lily Durwood, Madeleine DeMeules, and Katy A. McLaughlin, "Mental Health of Transgender Children Who Are Supported in Their Identities," *Pediatrics* 137/3 (2016), e20153223; http://pediatrics.aappublications.org/content/pediatrics/early/2016/02/24/peds.2015-3223.full.pdf; Kristina R. Olson and Selin Gülgöz, "Early Findings from the TransYouth Project: Gender Development in Transgender Children," *Child Development Perspectives* 12/2 (2017), https://doi.org/10.1111/cdep.12268.

> year-olds, and twenty-one 5-year-olds participating. The transgender children were socially transitioned at the time of participation, meaning they were all living as the gender "opposite" of their natal sex . . . . [All of the children met the standard criteria for a full social transition, including] using the pronoun, clothing, and hairstyles associated with the "other" gender.[144]

Inspired by this study of the youngest trans children, another team of researchers have offered proposals for future research regarding the need for better assessments of gender identity in very young children – including both transgender and nonbinary identities.[145]

Moving to older children and adolescents: Once a young person reaches this stage, the GAM largely reflects the Dutch protocol. Puberty blockers are instituted before any irreversible physical changes take place, and eventually HRT is initiated for those children who decide to pursue medical transition. Studies have found that the vast majority of children who are put on puberty blockers eventually go on the medically transition with HRT.[146] And so, under the guidance of the GAM, it seems that increasingly early social transition commonly leads to puberty suppression, which in turn frequently leads to medical transition.

The Trans Youth Care Research Network – the most significant U.S. longitudinal study of children who have opted for puberty blockers and HRT – is currently underway.[147] Launched in 2016, this Trans Youth Care Study (TYCS) is being conducted by four institutions that are leading the way in U.S. trans youth medicine: The Center for Transyouth Health and

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[144] Anne A. Fast and Kristina R. Olson, "Gender Development in Transgender Preschool Children," *Child Development* 89/2 (2018), 620-37 (p. 625).
[145] Christy L. Olezeski, Emily M. Pariseau, Wendy P. Bamatter, and Amy C. Tishelman, "Assessing Gender in Young Children: Constructs and Considerations," *Psychology of Sexual Orientation and Gender Diversity* 7/3 (2020), 293-303.
[146] E.g., Tessa Brik, Lieke J. J. J. Vrouenraets, Martine C. de Vries, and Sabine E. Hannema, "Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria," *Archives of Sexual Behavior* 49/7 (2020), 2611-18; Polly Carmichael, Gary Butler, Una Masic, Tim J. Cole, Bianca L. De Stavola, Sarah Davidson, Elin M. Skageberg, Sophie Khadr, and Russell Viner, "Short-term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK," *PLoS ONE* 16/2 (February 21, 2021), e0243894; https://doi.org/10.1371/journal.pone.0243894.
[147] J. Olson-Kennedy, Y. M. Chan, S. Rosenthal, M. A. Hidalgo, D. Chen, L. Clark, D. Ehrensaft, A. Tishelman, and R. Garofalo, "Creating the Trans Youth Research Network: A Collaborative Research Endeavor," *Transgender Health* 4/1 (2019), 304-12; J. Olson-Kennedy, Y. M. Chan, R. Garofalo, N. Spack, D. Chen, L. Clark, D. Ehrensaft, M. Hidalgo, A. Tishelman, and S. Rosenthal, "Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study," *JMIR Research Protocols* 8/7 (2019), e14434. doi: 10.2196/14434.

Development at Children's Hospital Los Angeles; the Gender Management Service at Boston Children's Hospital; the Child and Adolescent Gender Center Clinic at Benioff Children's Hospital in San Francisco; and the Gender and Sex Development Program at Lurie Children's Hospital of Chicago. As of 2019, a total of 497 youth are enrolled in the TYCS, divided into two cohorts: a cohort who are on puberty blockers (93 youth) and a second cohort who are on HRT (311 youth).

Johanna Olson-Kennedy – one of the most publicly visible researchers in the Trans Youth Care Research Network – and her team have been investigating the effects of medical transition on remarkably young adolescents. Whereas the Dutch protocol advises that children wait until 16-years of age before beginning HRT, Olson-Kennedy's team has explored administering HRT for youth as young as 12.[148] And whereas the Dutch model recommends that transition surgeries be postponed until legal adulthood, Olson-Kennedy's team has investigated whether chest surgery should be available to minor-aged children – concluding that "professional guidelines and clinical practice should consider patients for chest surgery based on individual need rather than chronologic age."[149]

As this survey of treatment approaches for youth experiencing GD reveals, there is continued debate among professionals as to the best model to adopt. A 2015 study by several of the leading Dutch researchers concluded that – despite the rapidly growing trend toward medical interventions for adolescents who experience GD –

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[148] J. Olson-Kennedy, V. Okonta, L. F. Clark, and M. Belzer, "Physiologic Response to Gender-Affirming Hormones among Transgender Youth," *Journal of Adolescent Health* 62/4 (2018), 397-401.

[149] J. Olson-Kennedy, J. Warus, V. Okonta, M. Belzer, and L. F. Clark, "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts," *JAMA Pediatrics* 172 (2018), 431-36 (p. 431). See also Simone Mahfouda, Julia K. Moore, Aris Siafarikas, Timothy Hewitt, Uma Ganti, Ashleigh Lin, and Florian D. Zepf, "Gender-affirming Hormones and Surgery in Transgender Children and Adolescents," *Lancet Diabetes & Endocrinology* 7/6 (2019), 484-98.

Others, of course, are concerned with this GAM-related trend. See e.g., Alison Clayton, "The Gender Affirmative Treatment Model for Youth with Gender Dysphoria: A Medical Advance or Dangerous Medicine?," *Archives of Sexual Behavior* (November 22, 2021), https://doi-org.ezproxy.bethel.edu/10.1007/s10508-021-02232-0 [online prior to print]; Roberto D'Angelo, "Psychiatry's Ethical Involvement in Gender-affirming Care," *Australasian Psychiatry* 26/5 (2018), 460-63; Lauren L. Baker, "True Autonomy/False Dichotomies? Genderqueer Kids and the Myth of the Quick Fix," *American Journal of Bioethics* 19/2 (2019), 63-65; Michael Laidlaw, Michelle Cretella, and G. Kevin Donovan, "The Right to Best Care for Children Does Not Include the Right to Medical Transition," *American Journal of Bioethics* 19/2 (2019), 75-77; David Pilgrim and Kirsty Entwistle, "GnRHa ('Puberty Blockers') and Cross Sex Hormones for Children and Adolescents: Informed Consent, Personhood and Freedom of Expression," *New Bioethics* 26/3 (2020), 224-37.

> in actual practice, no consensus exists whether to use these early medical interventions . . . . Strikingly, the [current] guidelines are debated both for being too liberal and for being too limiting. Nevertheless, many treatment teams using the guidelines are exploring the possibility of lowering the current age limits. As long as debate remains . . . and only limited long-term data are available, there will be no consensus on treatment.[150]

Nonetheless, the number of proponents of the GAM – or of the abandonment of any medical model that would subject transition-related decisions of children and their parents in any way to the "gate-keeping" constraints associated with professional psychological evaluation – is rapidly growing.[151] In making the case for both social and medical transition at increasingly younger ages – along with the argument that "transgender adolescents should have the legal right to access puberty-blocking treatment without parental approval" – it seems that this tendency toward the GAM will naturally fuel the rising rates of medical transition.[152] At the same time, there is a clear tendency among GAM advocates to down-play the importance of detransition as a phenomenon and to minimize – both quantitatively (i.e., the statistics) and qualitatively (i.e., the subjective impact) – the reported experience(s) of detransitioners.[153]

f. The Movement Toward an Informed Consent Model of Transition-Related Medicine

A sixth factor is related to the growing cultural trend to depathologize gender dysphoria and trans experience(s). Taking a cue from the gay liberation movement of the early 1970s, many trans activists and allies have adopted what Christoph Hanssmann has referred to as "the ranging politics of depathologizing regimes of trans health."[154] In this sense, Margaret Nichols suggests

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[150] L. J. Vrouenraets, A. M. Fredriks, S. E. Hannema, P. T. Cohen-Kettenis, and M. C. de Vries, "Early Medical Treatment of Children and Adolescents with Gender Dysphoria: An Empirical Ethical Study," *Journal of Adolescent Health* 57/4 (2015), 367–73 (p. 367).

[151] E.g., Erik Schneider, "Transition and Childhood: Questioning the Medical Approaches," *Current Critical Debates in the Field of Transsexual Studies: In Transition*, ed. O. Gozlan (New York: Routledge, 2018), 158-66.

[152] Maura Priest, "Transgender Children and the Right to Transition: Medical Ethics When Parents Mean Well but Cause Harm," *American Journal of Bioethics* 19/2 (2019), 45-59.

[153] E.g., K. R. MacKinnon, F. Ashley, H. Kia, J. S. H. Lam, Y. Krakowsky, and L. E. Ross, "Preventing Transition 'Regret': An Institutional Ethnography of Gender-Affirming Care Assessment Practices in Canada," *Social Science and Medicine* 291 (2021), 114477, doi: 10.1016/j.socscimed.2021.114477; Kristina R. Olson, Lily Durwood, Rachel Horton, Natalie M. Gallagher, and Aaron Devor, "Gender Identity 5 Years After Social Transition," *Pediatrics* 150/2 (2022), e2021056082.

[154] Christoph L. Hanssmann, "Care in Transit: The Political and Clinical Emergence of Trans Health" (PhD diss.; University of California, San Francisco, 2017), 33-34. Importantly, Hanssmann goes on to note that "[m]ost discussions of trans depathologization persistently and insufficiently compare it to gay and lesbian psychiatric depathologization. Precisely because of this analogical reflex, it is important to examine [other] seemingly more elusive connections" (p. 130). He goes on (pp. 130-32) to discuss two additional influences: feminist health critiques of pathologization as politicization, and disability activism.

that, politically speaking, trans people have become the "new homosexuals."[155] Queer theorist and social commentator D. L. Schultz succinctly captures this strategic conviction:

> Activism should aim toward the complete removal of transsexuality in the DSM, just as the work of gay rights activists advocated for the total removal of homosexuality from the DSM. Trans activists should disrupt APA meetings just like gay activists did in the 1970s. Trans psychologists should come out to increase trans visibility within psychiatric institutions, just like gay, lesbian, and bisexual psychologists came out during gay rights activism.[156]

One of the natural consequences of this strategic shift toward depathologization is a move away from the need for a stringent psychological assessment and additional criteria (depending upon the procedure), prior to obtaining medical transition. For example, WPATH's current SOC-7 advises the following criteria for those seeking transition-related genital surgery (i.e., metoidioplasty or phalloplasty for FtM patients and for vaginoplasty for MtF patients): (1) documentation of persistent gender dysphoria; (2) two independent referrals for surgery by qualified mental health professionals; (3) demonstrated capacity to make "a fully informed decision and to consent for treatment"; (4) age of legal adulthood; (5) control of any co-existing medical or mental health concerns; (5) one year of HRT (unless not clinically indicated); and (6) one year of real-life experience living in the gender role congruent with the intended medical transition.[157] The SOC-7 goes on to note: "Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional."[158]

This set of criteria is now seen by many as a "gate-keeping" tactic by the medical professions serve to pathologize trans experience and identity. In reaction to this "medical," "diagnostic," or "disease" model," many are adopting an *Informed Consent model* of transition-related treatment.[159] An Informed Consent model "allows for clients who are transgender to access

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[155] Margaret Nichols, "Dreger on the Bailey Controversy: Lost in the Drama, Missing the Big Picture," *Archives of Sexual Behavior* 37 (2008), 476-80 (here p. 476).
[156] D. L. Schultz, "Treating Transsexuality: To Help or to Harm? A History and Critical Analysis of How Transsexuality has been Represented as a Mental Illness and Treated by Psychologists," *medium.com* (January 22, 2019), https://medium.com/@dlshultz/treating-transsexuality-to-help-or-to-harm-4bcae0ea621a.
[157] WPATH, SOC-7, 59-60.
[158] Ibid., 60.
[159] On the informed consent model of trans-related medical treatment, see Sarah L. Schulz, "The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria," *Journal of Humanistic Psychology* 58/1 (2018), 72–92; Madeline B. Deutsch, "Use of the Informed Consent Model in the Provision of

hormone treatments and surgical interventions without undergoing mental health evaluation or referral from a mental health specialist."[160] In the words of James Hughs:

> Transgendered individuals are entitled to access to medical technology not because, as the advocates of the medical model . . . assert, they have a medical condition that demands correction, but because we should respect the right to morphological self-determination. I pin my hopes with John Stuart Mill that we all will be enriched when society helps each of us find our own personal self-expression.[161]

For those who fear that a shift to an Informed Consent model will likely lead to a significant growth in the number of people who report post-transition unhappiness, trans woman Andrea Long Chu writes:

> Transition doesn't have to make me happy for me to want it. Left to their own devices, people will rarely pursue what makes them feel good in the long term. Desire and happiness are independent agents. As long as transgender medicine retains the alleviation of pain as its benchmark of success, it will reserve for itself, with a dictator's benevolence, the right to withhold care from those who want it . . . . Nothing, not even surgery, will grant me the mute simplicity of having always been a woman. I will live with this, or I won't. That's fine. The negative passions — grief, self-loathing, shame, regret — are as much a human right as universal health care, or food. There are no good outcomes in transition. There are only people, begging to be taken seriously.[162]

Contrary to Chu and others, there are, of course, a number of people who are concerned about the potentially negative consequences of moving to an Informed Consent model.[163] Some argue that the current state of research is such that solid, evidence-based data on long-term medical transition outcomes – especially for children – is simply lacking. And where such data is lacking, then *truly informed* consent is not possible.[164] To this concern, others add that, especially under the growing hegemonic pressure of the GAM, many trans clients are never given a fully-orbed

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Cross-sex Hormone Therapy: A Survey of the Practices of Selected Clinics," *International Journal of Transgenderism* 13/3 (2012), 140-46.

[160] Schulz, "Informed Consent Model of Transgender Care," 72.

[161] James Hughs, "Beyond the Medical Model of Gender Dysphoria to Morphological Self-Determination," *Lahey Clinic Medical Ethics Journal* (Winter 2006), https://ieet.org/index.php/IEET/more/hughes20060401.

[162] Andrea Long Chu, "My New Vagina Won't Make Me Happy, And It Shouldn't Have To," *New York Times* (November 28, 2018), https://www.nytimes.com/2018/11/24/opinion/sunday/vaginoplasty-transgender-medicine.html.

[163] On the challenge of balancing the competing values in play, see Riki Lane, "'We Are Here to Help': Who Opens the Gate for Surgeries?," *TSQ* 5/2 (2018), 207-27.

[164] Juan Carlos D'Abrera, Roberto D'Angelo, George Halasz, Shirley Prager, and Philip Morris, "Informed Consent and Childhood Gender Dysphoria: Emerging Complexities in Diagnosis and Treatment," *Australasian Psychiatry* 28/5 (2020), 536-38; Madeleine Kearns, "The grim reality of gender reassignment," *Spectator / Australia* (November 14, 2021), https://spectator.com.au/2021/11/the-grim-reality-of-gender-reassignment/

presentation of the complete range of options for addressing gender dysphoria.[165] This has led to the concern that "in many settings informed consent is a perfunctory process creating the risk of uninformed consent."[166] There is also the growing question of what to do under an Informed Consent model when parents and children disagree about whether the child should pursue medical transition or not.[167] And from the other side of the spectrum, some are concerned that what is being presented as a liberating Informed Consent model is, in fact, just a more subtle version of the old, paternalistic medicalized model.[168]

In any case, it appears that there is a growing trend toward gender clinics around the world adopting an Informed Consent model.[169] In fact, it is anticipated that WPATH's new Standards of Care version 8 (SOC-8) – due out in 2022 – will itself move toward an Informed Consent

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[165] Stephen B. Levine, "Informed Consent for Transgendered Patients," *Journal of Sex and Marital Therapy* 45/3 (2019), 218-29; Joshua Franklin, "The Social Context of Adolescents' Right to Transition," *American Journal of Bioethics* 19/2 (2019), 65-66; David Pilgrim and Kirsty Entwistle, "GnRHa ('Puberty Blockers') and Cross Sex Hormones for Children and Adolescents: Informed Consent, Personhood and Freedom of Expression," *New Bioethics* 26/3 (2020), 224-37.

A number of researchers are now arguing that a new approach is needed – what some are calling an *Exploratory model*. See e.g., Anastassis Spiliadis, "Toward a Gender Exploratory Model: Slowing Things Down, Opening Things Up, and Exploring Identity Development," *Metalogos* 35 (2019), file:///C:/Users/16514/Downloads/TowardsaGenderExploratoryModelslowingthingsdownopeningthingsupandexploringidentitydevelopment.pdf; Anna Churcher Clarke and Anastassis Spiliadis, "'Taking the Lid of the Box': The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties," *Clinical Child Psychology and Psychiatry* 24 (2019), 338–52; Roberto D'Angelo, Ema Syrulnik, Sasha Ayad, Lisa Marchiano, Dianna Theadora Kenny, and Patrick Clarke, "One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria," *Archives of Sexual Behavior* 50/1 (2021), 7-16; Marcus Evans, "Freedom to Think: The Need for Thorough Assessment and Treatment of Gender Dysphoric Children*," *BJPsych Bulletin* (July 21, 2020), 1-6. doi:10.1192/bjb.2020.72. On the need for healthy dialogue between the various treatment models, see Bernadette Wren, "Ethical Issues Arising in the Provision of Medical Interventions with Gender Variant Children and Adolescents," *Clinical Child Psychology and Psychiatry* 24/2 (2019), 203–22; idem, "Polarizing debates around gender dysphoria are deeply damaging for young people – I've seen it firsthand," *The Independent* (April 13, 2019), https://www.independent.co.uk/voices/transgender-young-children-hospital-medical-treatment-identity-support-a8868256.html.

[166] Levine, "Informed Consent for Transgendered Patients," 218.

[167] S. Dubin, M. Lane, S. Morrison, A. Radix, U. Belkind, C. Vercler, and D. Inwards-Breland, "Medically Assisted Gender Affirmation: When Children and Parents Disagree," *Journal of Medical Ethics* 46 (2020) 295–299.

[168] steph m. shuster, "Becoming a Legal Proxy: The Unintended Consequences of Informed Consent in Transgender Medicine," in *The Research Handbook on Gender, Sexuality, and Law*, eds. C. Ashford and A. Maine (Northampton, MA: Edward Elgar, 2020), 232-43; idem, "Performing Informed Consent in Transgender Medicine," *Social Science & Medicine* 226 (2019), 190-97.

[169] E.g., Jaco Erasmus, "Monash Gender Clinic: Overview of the Current Model of Care," *Australasian Psychiatry* 28/5 (2020), 533-35; Bethany A. Jones, Nicola Brewin, Christina Richards, Marnix Van Eijk, Alex Stephenson-Allen, and Jon Arcelus, "Investigating the Outcome of the Initial Assessment at a National Transgender Health Service: Time to Review the Process?," *International Journal of Transgenderism* 18/4 (2017), 427-32.

model.[170] In light of these things, it seems likely that the growing trend toward the adoption of an Informed Consent model will serve to add further impetus to the rising rates of medical transition.

g. The Increasing Financial Accessibility of Transition-Related Medical Treatment

A final factor is the increasing number of people who are able to access transition-related medical interventions. A significant dynamic here is the shifting trend in health insurance companies' policies to providing coverage for transition-related medical procedures. One milestone in this shift occurred in 2014, when the U.S. Department of Health and Human Services (HHS) review board ruled that Medicare would pay for gender-related medical procedures.[171] The HHS's 2016 decision, related to the Affordable Care Act, that "hospitals, clinics, and other health-care providers cannot discriminate against patients on the basis of gender identity" provided further impetus in this direction.[172] In 2021, it was announced that the U.S. Department of Veterans Affairs would begin offering gender transition surgery to trans vets.[173] In addition, researchers continue to explore avenues of medical transition that will reduce costs and, in the process, encourage more insurance companies to provide coverage.[174] Each of these signs point toward increasingly accessible pathways to medical transition within the U.S. context. And so, considered together, the cumulative effects of these seven factors suggest that medical gender transition rates are destined to rise on into the future.

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[170] As suggested in Joz Motmans, Timo O. Nieder, and Walter Pierre Bouman, "Transforming the Paradigm of Nonbinary Transgender Health: A Field in Transition," *International Journal of Transgenderism* 20/2-3 (2020), 119-25 (p. 121).

[171] Department of Health and Human Services – Departmental Appeals Board, Appellate Division NCD 140.3. Transsexual Surgery Docket No. A-13-87, Decision No. 2576 (May 30, 2014), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

[172] Emma Green, "The Federal Government Quietly Expands Transgender Rights," *The Atlantic* (May 16, 2016), https://www.theatlantic.com/politics/archive/2016/05/department-of-health-and-human-services-transgender-rights/482934/.

[173] Leo Shane III, "VA to offer gender surgery to transgender vets for the first time," *Military Times* (June 19, 2021), https://www.militarytimes.com/veterans/2021/06/19/va-to-offer-gender-surgery-to-transgender-vets-for-the-first-time/.

[174] E.g., Johanna Olson-Kennedy, Laer H. Streeter, Robert Garofalo, Yee-Ming Chan, and Stephen M. Rosenthal, "Histrelin Implants for Suppression of Puberty in Youth with Gender Dysphoria: A Comparison of 50 mcg/Day (Vantas) and 65 mcg/Day (SupprelinLA)," *Transgender Health* 6/1 (2021), 36-42.

II. Detransition Today:
Skirmishes at the Intersection of Experience, Science & Politics

A. An Overview

Because detransition inevitably involves issues of interest to certain academic disciplines – i.e., matters related to everything from sociology and gender studies to psychology and medicine – it is a subject that naturally courts scholarly attention and research. The scope of interest in detransition, however, does not stop there. Drawn into the wider vistas of popular culture, the topic of detransition has migrated from the spheres of personal experience and academic research into the vortex of political debate and the culture war.[175] In this sense it mirrors other highly polarizing nodes within the wider cultural debate surrounding transgender experience and identity: e.g., the so-called "bathroom debate," the desistance debate, and the treatment model debate regarding youth who experience gender dysphoria.[176]

The last of these issues – i.e., the debate about how best to respond to minor-aged children who experience gender dysphoria – is particularly divisive in Western culture today. It divides the academic world, where several different models of treatment are being pursued. Recently, it appears that the tensions between the Watchful Waiting model and the Gender Affirmative model are reaching a new level of intensity.[177] This debate even divides the adult trans

[175] On the concept of culture war and its contemporary Western expression from different perspectives, see James Davison Hunter, *Culture Wars: The Struggle to Define America* (New York: Basic Books, 1991); Andrew Hartman, *A War for the Soul of America: A History of the Culture Wars* (Chicago: University of Chicago Press, 2015); Bradley Campbell and Jason Manning, *The Rise of Victimhood Culture: Microaggressions, Safe Spaces, and the New Culture Wars* (New York: Palgrave Macmillan, 2018); Mark J. Cherry, *Sex, Family, and the Culture Wars* (New York: Routledge, 2016); Darel E. Paul, "Culture War as Class War: How Gay Rights Enforce Elite Power," *First Things* (August 2018), https://www.firstthings.com/article/2018/08/culture-war-as-class-war.

[176] I have considered the desistance debate in detail within a separate study. See Paul Rhodes Eddy, "Reflections on the Debate Concerning the Desistance Rate among Young People with Gender Dysphoria," *Center for Faith, Sexuality & Gender* (posted: April 2020; updated: June 2021), 110 pp., http://centerforfaith.com/sites/default/files/desistance_document_-_v._3.pdf. Increasingly, medical and psychological researchers and clinicians explicitly see their roles as also inherently encompassing social/political activism. E.g., Gibran Omar Rodriguez de los Reyes and David Collict. "'It's Not Only about Clinical Tools but also Our Role as Agents of Social Change': Implementing a LGBT Competency Training for Future Mental Health Practitioners in Mexico." *Journal of Homosexuality* 69/2 (2022), 230-53.

[177] E.g., Laura Edwards-Leeper and Erica Anderson, "The mental health establishment is failing trans kids: Gender-exploratory therapy is a key step. Why aren't therapists providing it?," *Washington Post* (November 24, 2021), https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/; Jesse Singal, "A Response to Grac Lavery, Part I: On 'Gender Affirmative' Care And 'Watchful Waiting' And Where They Really Differ."

community itself.[178] Mark Regnerus and Brad Vermurlen have recently conducted the first study that examines attitudes toward medical transition for adolescents experiencing gender dysphoria using nationally representative data in the U.S. context.[179] They found that such factors as "[h]igher fertility, race/ethnicity (in this case, black), sex (male), and heterosexual self-identity were each robustly associated with disapproval." They also found that "a range of religion measures were statistically significant (toward disapproval), with "evangelical [Christian] self-identification" being the most significant.[180] They conclude that

> [t]hese findings . . . led us to consider perspectives on medical transitions for adolescents as fitting the "culture war" framework, largely polarized between a "progressive" worldview of bodily autonomy and an "orthodox" worldview of bodily integrity.[181]

It is also important to note that the migration of these debates from academic contexts into popular culture is not a one-way street. The forces of political polarization and culture war within the wider culture in turn influence the very academic atmosphere in which further research is conducted. This dynamic is becoming one of increasing concern among some sex researchers who are aware that everything from volunteer bias and social desirability bias among survey populations to explicit political bias among researchers themselves only adds to the current reputational problems of the social sciences as they attempt to address the "replication crisis" and other disciplinary concerns.[182]

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medium.com (January 18, 2019), https://medium.com/@jesse.singal/a-response-to-grace-lavery-part-i-on-gender-affirmative-care-and-watchful-waiting-and-where-a17a1c0dd53c.

[178] E.g., Scott Newgent, "We Need Balance When It Comes to Gender Dysphoric Kids: I Would Know," *Newsweek* (February 9, 2021), https://www.newsweek.com/we-need-balance-when-it-comes-gender-dysphoric-kids-i-would-know-opinion-1567277. Relatedly, see Corrina Cohn, "What I Wish I'd Known When I Was 19 and Had a Sex Reassignment Surgery," *Washington Post* (April 11, 2022), https://www.washingtonpost.com/opinions/2022/04/11/i-was-too-young-to-decide-about-transgender-surgery-at-nineteen/

[179] Mark Regnerus and Brad Vermurlen, "Attitudes in the U.S. Toward Hormonal and/or Surgical Interventions for Adolescents Experiencing Gender Dysphoria," *Archives of Sexual Behavior* (January 28, 2022), https://doi.org/10.1007/s10508-021-02214-2 [online ahead of print].

[180] Ibid.

[181] Ibid.

[182] See e.g., J. Michael Bailey, "How to Ruin Sex Research," *Archives of Sexual Behavior* 48/4 (2019), 1007-11; Katrina N. Bouchard, Jeremy G. Stewart, Stephanie C. Boyer, Ronald R. Holden, and Caroline F. Pukall, "Sexuality and Personality Correlates of Willingness to Participate in Sex Research," *Canadian Journal of Human Sexuality* 28/1 (2019), 26-37; Bruce M. King, "The Influence of Social Desirability on Sexual Behavior Surveys: A Review," *Archives of Sexual Behavior* 51/3 (2022), 1495-1501; J. Den Haese and B. M. King, "Oral-Genital Contact and the Meaning of 'Had Sex': The Role of Social Desirability," *Archives of Sexual Behavior* 51/3 (2022), 1503-08; Joseph R. Cimpian, "Classification Errors and Bias Regarding Research on Sexual Minority Youths," *Educational Researcher* 46/9 (2017), 517-29. These concerns will be addressed in more detail below.

The politicization of detransition has been fueled by cultural activists on both sides of the wider transgender debate. In addition, the various forms of mass media have acted both as the primary arena of engagement and as an accelerant of the polarization itself. On one side of the cultural divide are the socially conservative/traditional voices that point to the phenomenon of detransition as a clear example of the inevitable negative fallout that now accompanies the widespread societal embrace of the gender affirmative paradigm.[183] On the other side, socially liberal/progressive activists warn that the conservative fascination with detransition is simply a transphobic political tactic designed to limit transgender people's access to life-saving gender affirming medical procedures.[184]

For conservative thinkers, trans activists' presentation of detransition as "as a vanishingly rare phenomenon and the object of faux concern from conservatives who instrumentalise it to restrict access to transition" is seen as the inexcusable "minimization" of the "potential severity of the consequences faced by detransitioners," and one that "necessitates scrutiny of the current treatment protocols for trans-identifying children."[185]

On the replication crisis, see J. W. Clegg and K. L. Slaney, "Introduction to the Special Section: 'Psychology's Replication Crisis,'" *Journal of Theoretical and Philosophical Psychology* 39/4 (2019), 199-201; Bradford J. Wiggins and Cody D. Christopherson, "The Replication Crisis in Psychology: An Overview for Theoretical and Philosophical Psychology," *Journal of Theoretical and Philosophical Psychology* 39/4 (2019), 202–17; B. A. Nosek, T. E. Hardwicke, H. Moshontz, A. Allard, K. S. Corker, A. Dreber, et al., "Replicability, Robustness, and Reproducibility in the Psychological Sciences," *PsyArXiv* (February 9, 2021), https://doi.org/10.31234/osf.io/ksfvq.

[183] E.g., Ryan T. Anderson, "Detransitioners Tell Their Stories," in *When Harry Became Sally: Responding to the Transgender Moment* (New York: Encounter, 2018), 49-76; Caroline ffiske, "The Divided States of Transgenderism," *Conservative Woman* (January 14, 2020), https://www.conservativewoman.co.uk/the-divided-states-of-transgenderism/; Gregory Slysz, "'Bamboozled' transitioners should turn to the law," *Conservative Woman* (April 18, 2020), https://www.conservativewoman.co.uk/bamboozled-transitioners-should-turn-to-the-law/.

[184] GenderGP, "Detransition, Exploring the Facts and Exploding the Myths." *GenderGP* (June 21, 2021), https://www.gendergp.com/detransition-exploring-the-facts-and-exploding-the-myths/; German Lopez, "The Debate about Transgender Children and 'Detransitioning' is Really about Transphobia," *Vox* (August 9, 2016), https://www.vox.com/2016/8/9/12404246/transgender-children-detransitioning-transphobia; Julia Serano, "Desistance, Detransition, and Disinformation: A Guide for Understanding Transgender Children Debates," *Medium* (August 2, 2016), https://medium.com/@juliaserano/detransition-desistance-and-disinformation-a-guide-for-understanding-transgender-children-993b7342946e.

[185] Ellen Pasternack and Emily Weater, "Transitioning to a Medical Scandal," *The Critic* (November 2020), https://thecritic.co.uk/issues/november-2020/transitioning-to-a-medical-scandal/.

For trans activists and their socially progressive allies, the conservatives' presentation of transition regret is riddled with "myths,"[186] fueled by "transantagonistic attitudes,"[187] and leads to "serious real-world consequences, from misguided policy proposals to social stigma."[188] From this perspective, the proliferation and framing of stories about detransition within the mainstream media functions as a moment of "moral panic" designed "to question gender-affirmative medical care for trans people and support heightened psychiatric gatekeeping and medical regulation of trans-related healthcare."[189]

Wherever one happens to stand on this issue, the climate of culture war inevitably tempts us to attribute unethical motives to those on the "other side." In such an atmosphere, it is easy to interpret the publicly stated moral concerns of one's cultural enemy as disingenuous rhetoric that only shrouds their myopic political agenda or, perhaps, their unstated sinister intent. Thus, to conservative sensibilities, the transgender activists and physicians who champion access to trans medical care, while "undoubtedly" including "some well-meaning individuals," have nonetheless "caused such horrific mental and physical trauma to so many vulnerable people bamboozled into making decisions that they were in no position to make," with "many" of them being motivated by the desire "to pursue their political agenda or to make financial gain."[190] Resonating with these concerns, conservative social analyst Ryan Anderson emphasizes the plight of those who detransition:

> Activists claim to represent the best interests of all those with discordant gender identities, insisting that their policies and treatment protocols are the only ethical ones, and that other approaches lead to depression and suicide. Popular media outlets are happy to report on the people who seem to find contentment with sex reassignment procedures. We seldom hear the voices of people who discover that hormones and surgery were not

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[186] Brynn Tannehill, "Myths About Transition Regrets," *Huffington Post* (February 2, 2016), http://www.huffingtonpost.com/brynn-tannehill/myths-about-transition-regrets_b_6160626.html; Amber Roberts, "Dispelling the Myths About Trans People 'Detransitioning,'" *Vice* (November 17, 2015), https://www.vice.com/en/article/kwxkwz/dispelling-the-myths-around-detransitioning.

[187] Florence Ashley, "The Importance of an Appropriate Understanding of the Literature," *BJM* (March 10, 2019), https://www.bmj.com/content/364/bmj.l245/rr-5.

[188] Liam Knox, "Media's 'detransition' narrative is fueling misconceptions, trans advocates say: They say the current narrative makes "transition regret" seem more common than it is and contributes to misconceptions about transgender people in general," *nbcnews.com* (December 19, 2019), https://www.nbcnews.com/feature/nbc-out/media-s-detransition-narrative-fueling-misconceptions-trans-advocates-say-n1102686.

[189] Van Slothouber, "(De)trans Visibility: Moral Panic in Mainstream Media Reports on De/retransition," *European Journal of English Studies* 24/1 (2020), 89-99 (here p. 90).

[190] Slysz, "'Bamboozled' transitioners should turn to the law."

> the answer but often the source of new problems . . . . In this light, it's dismaying that the people who found more problems after transitioning would be ignored or even attacked by transgender activists. Women who transition and then detransition can be special targets for hate.[191]

Conversely, in the eyes of many trans activists and their allies, the conservatives' stated concern about detransition, "while seemingly about the welfare of children, actually aims to deny *all* trans people the right to gender-affirming care."[192] Julia Serano expresses the concern of many within the trans community about approaching the topic of detransition in an unbiased and open-handed fashion:

> In a perfect world, we would be able to have open and honest discussions about detransitioning, viewing it in terms of a personal decision based on individual's well being. But unfortunately, purveyors of the cisgender-people-turned-transgender trope insist on citing the existence of such people (and occasionally exploiting their personal stories) to forward trans-antagonistic and trans-suspicious agendas . . . . I would love to see more support from trans communities (and from health providers) for people who choose to detransition. But this isn't going to be easy so long as people who adhere to the cisgender-people-turned-transgender trope continue to use such individuals as political pawns.[193]

And so, viewed from either side of the political divide, it can appear that the opposing camp merely treats people who detransition with a nonchalant instrumentalism, as useful pawns to be strategically deployed[194] – or, alternatively, as threatening characters to be strategically ignored if not entirely denied – all for the seemingly greater ethical good.

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[191] Anderson, *When Harry Became Sally*, 48, 73.
[192] Van Slothouber, "(De)trans Visibility," 96.
[193] Serano, "Desistance, Detransition, and Disinformation." This concern is common within the trans community and among their allies. E.g., u/Albamc35, "TERFs like to use the 'high detransition' argument to invalidate trans people. Fortunately, I have managed to compile a huge amount of data debunking this," https://www.reddit.com/r/GenderCynical/comments/hpcfe9/terfs_like_to_use_the_high_detransition_argument/ Samantha Allen, "Why Was the Media So Quick to Accept Caitlyn Jenner 'Detransition' Rumors? Caitlyn Jenner's rep says she has no plans to transition back to living as a man. Why was the press so eager to report a false story?," *Daily Beast* (May 12, 2016), https://www.thedailybeast.com/why-was-the-media-so-quick-to-accept-caitlyn-jenner-detransition-rumors.
[194] For an example of detransitioners resisting being used for political purposes, see C. Callahan, M. Crash Robinson, E. Rosch, H. Mangelsdorf, A. Schroeder, . . ., K. L. R. "Statement Against the ADF." Detransitioned Women Resist the ADF website (2017), https://detransitionedwomenresistadf.wordpress.com/

A number of people who detransition have expressed frustration at being treated in this politicized manner.[195] In the words of one person:

> Right now, most of the difficulties I face as a detransitioned woman involve how people misperceive me or try to use me. This isn't limited to one group. I've been troubled by how all kinds of people across the political spectrum, including trans people, radical feminists and religious conservatives, view and treat detransitioned women. I hate when people disrespect, tokenize, objectify, or pity me or other detransitioned women, or belittle, deny or exploit our experiences.[196]

Within our highly charged political environment, it is not surprising that certain detransition-related news stories act as spark upon tinder to ignite additional ethical and political concerns. A few examples (mentioned in chronological order) will suffice to illustrate this dynamic.

B. The Caspian – Bath Spa Controversy

In 2017, James Caspian, a student at Bath Spa University in Bath, England, proposed that he write his thesis for a master's degree in counselling and psychotherapy on the topic of detransition. The proposal was reportedly rejected by the university's ethics committee, in part because the topic of detransition could be considered "politically incorrect."[197] The actual ethics committee's report, which was eventually made public by a Canadian news company, does state that "[e]ngaging in a potentially 'politically incorrect' piece of research carries a risk to the University," and that "[a]ttacks on social media may not be confined to the researcher but may involve the University."[198] It also offers several methodological concerns about the proposal. In

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[195] E.g., C. Callahan, M. Crash Robinson, E. Rosch, H. Mangelsdorf, A. Schroeder, et al., "Statement Against the ADF," Detransitioned Women Resist the ADF website (2017), https://detransitionedwomenresistadf.wordpress.com/.

[196] Crashchaoscats, "Follow-up to 'Lost to Follow-up,'" (February 8, 2018), https://tejuina.tumblr.com/post/170662706607/follow-up-to-lost-to-follow-up.
The author of this piece, Ky Schevers, detransitioned and documented the process under the name Crashchaoscats from 2013 to early 2020. It should be noted that, more recently, Schevers has (re-)identified as transmasculine (while using she/her pronouns). She is now critical of the detransition movement she was part of. See Evanj Urquhart, "An 'Ex-Detransitioner' Disavows the Anti-Trans Movement She Helped Spark," *Slate* (February 1, 2021), https://slate.com/human-interest/2021/02/detransition-movement-star-ex-gay-explained.html.

[197] "Bath Spa University 'Blocks Transgender Research,'" *BBC News* (September 25, 2017), https://www.bbc.co.uk/news/uk-41384473.

[198] "Annex 1: Bath Spa University Research Ethics Approval Form" (for James Caspian's research project), https://ici.radio-canada.ca/info/2019/05/transgenre-sexe-detransitionneurs-transition-identite-genre-orientation/img/Lettre/lettre-de-refus.html.

response, Caspian sought to take the matter before the courts – including the European Court of Human Rights (ECHR).[199] Caspian received financial assistance in his four-year legal challenge through a crowd sourcing campaign under the title of "Free Speech Matters," along with the support from the Christian Legal Centre.[200] In the end, the ECHR decided not to hear the case. The Caspian—Bath Spa U. affair has become common fare in news stories and documentaries on the transgender debate.[201] Naturally, commentators and organizations on both sides of the political divide have lined up either for or against Caspian or the University.[202]

C. Bell v. Tavistock

In December 2020, the UK's High Court ruled on a case involving the Tavistock's London-based Gender Identity Development Service (GIDS), the primary UK gender clinic serving gender-nonconforming children. Two claimants – Keira Bell, a 23-year-old former GIDS patient and "Mrs. A," the mother of a 15-year-old GIDS patient with autism who chose to remain anonymous to protect her daughter's identity – sought a court ruling that would legally restrict the GIDS from using puberty blockers and cross-sex hormones in the treatment of minors experiencing gender dysphoria (GD). A central concern of the claimants was that adolescents experiencing GD who come to the GIDS for treatment are often fast-tracked toward a gender transition without being offered an adequate assessment of whether other, less invasive, means of treatment could alleviate the dysphoria. In Bell's words, "I should have been challenged on the proposals or the claims that I was making for myself. And I think that would have made a big

[199] Maggie Baska, "Psychotherapist blocked from studying 'trans regret' takes case to the EU human rights court," *Pink News* (February 9, 2021), https://www.pinknews.co.uk/2021/02/09/james-caspian-transgender-trans-bath-spa-european-court-human-rights/.
[200] Ibid.; James Caspian, "Free Speech Matters," *CrowdJustice* (2019), www.crowdjustice.com/case/free-speech-matters-round2/. See also James Caspian, "My battle with the transgender thoughtpolice: James Caspian on the suppression of his research into people who detransition," *Spiked* (February 22, 2019), https://www.spiked-online.com/2019/02/22/my-battle-with-the-transgender-thoughtpolice/.
[201] E.g., "Detransitioning: Reversing a Gender Transition," *BBC Newsnight* (November 26, 2019), https://www.youtube.com/watch?v=fDi-jFVBLA8; "The Trans Train" ["Uppdrag Granskning"] *Mission: Investigate* (April 2, 2019), https://www.youtube.com/watch?v=sJGAoNbHYzk; "Trans-Actions: An Exploration of Gender Dysphoria" (2018).
[202] E.g., "James Caspian's Ethics Review Form Posted Online," *TransSafety Network* (February 13, 2021), https://transsafety.network/posts/james-caspian-ethics-review-leaked/; David Scullion, "Banned from Researching Trans: Perceived criticism of trans orthodoxy was too much for one university," *The Critic* (February 17, 2021), https://thecritic.co.uk/banned-from-researching-trans/.

difference as well. If I was just challenged on the things I was saying."[203] The High Court eventually ruled in favor of Bell and Mrs. A.[204]

Detransition enters into this story with Keira Bell herself. Bell explains:

> I was put on puberty blockers at age 16. A year later, I was receiving testosterone shots. When 20, I had a double mastectomy. By then, I appeared to have a more masculine build, as well as a man's voice, a man's beard, and a man's name: Quincy, after Quincy Jones . . . .
>
> But the further my transition went, the more I realized that I wasn't a man, and never would be. We are told these days that when someone presents with gender dysphoria, this reflects a person's "real" or "true" self, that the desire to change genders is set. But this was not the case for me. As I matured, I recognized that gender dysphoria was a symptom of my overall misery, not its cause.
>
> Five years after beginning my medical transition to becoming male, I began the process of detransitioning. A lot of trans men talk about how you can't cry with a high dose of testosterone in your body, and this affected me too: I couldn't release my emotions. One of the first signs that I was becoming Keira again was that—thankfully, at last—I was able to cry. And I had a lot to cry about."[205]

The Bell v. Tavistock decision appears to have had international ripple effects. For example, since the Bell decision – several gender clinics in Sweden, including the renown Karolinska Hospital, have stopped the routine use of puberty blockers and hormones in the treatment of minors who experience GD.[206] Also in the wake of the Bell decision, Finland significantly tightened its guidelines for treating young people experiencing gender dysphoria. This involved stepping away from certain aspects of the WPATH's SOC-7 protocols and more strongly

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[203] Alison Holt, "NHS gender clinic 'should have challenged me more' over transition," *BBC News* (March 1, 2020), https://www.bbc.com/news/health-51676020

[204] For more extensive reflections on the Tavistock's GIDS and this legal case, see Paul R. Eddy and Preston Sprinkle, "Tavistock: A Microcosm of the Debate on How Best to Care for Trans* Kids," Center for Faith, Sexuality & Gender (September 23, 2020), https://www.centerforfaith.com/blog/tavistock-a-microcosm-of-the-debate-on-how-best-to-care-for-trans-kids; Paul R. Eddy and Preston Sprinkle, "The Tavistock Controversy: A Follow-Up Report," Center for Faith, Sexuality and Gender (February 9, 2021), https://www.centerforfaith.com/blog/the-tavistock-controversy-a-follow-up-report.

[205] Keria Bell, "Keira Bell: My Story," *Persuasion* (April 7, 2021), https://www.persuasion.community/p/keira-bell-my-story. For more from Bell on her personal story, see: Keira Bell, "Protect Gender Dysphoric Children from the Affirmation Model." *crowdjustice*, https://www.crowdjustice.com/case/challenge-innate-gender/; Keira Bell and Raquel Rosario Sánchez [interview], "Keira Bell: 'There Was Nothing Wrong with My Body,'" *Woman's Place UK* (November 30, 2020), https://womansplaceuk.org/2020/11/30/keira-bell-there-was-nothing-wrong-with-my-body/

[206] Lisa Nainggolan, "Hormone Tx of Youth with Gender Dysphoria Stops in Sweden," *Medscape* (May 12, 2021), https://www.medscape.com/viewarticle/950964.

emphasizing the place of psychotherapy in such treatment.[207] In the U.S., since the Bell decision a number of state-level legislative efforts have been initiated to reign in medical procedures for young people experiencing GD.[208]

In 2021, a UK appeal court overturned the high court ruling. In response, Bell filed for an appeal to the supreme court.[209] Finally, in May 2022, the supreme court announced that it would not take up a challenge to the appeal court's ruling, stating that Bell's appeal did not "raise an arguable point of law."[210] However, the review of the Tavistock by Dr. Hilary Casss – commissioned by the NHS England in September 2020 – eventually led to Cass's recommendation that the Tavistock be decommissioned and closed. It was announced on July 28, 2022 that the NHS would be following Cass's recommendation "in full," with plans to close the clinic by spring 2023, and to replace it with "regional centres at existing children's hospitals offering more 'holistic care' with 'strong links to mental health services.'"[211] The Bell v Tavistock case continues to serve as another lightening rod in the international debate on childhood GD and the detransition experience.[212]

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[207] "One Year Since Finland Broke with WPATH 'Standards of Care': *Finland prioritizes psychotherapy over hormones, and rejects surgeries for gender-dysphoric minors*," *SEGM* (July 2, 2021), https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors.

[208] Claire Hansen, "Republican State Lawmakers Push Wave of Bills Targeting Transgender Youth," *US News & World Report* (April 9, 2021), https://www.usnews.com/news/national-news/articles/2021-04-09/republican-state-lawmakers-push-wave-of-bills-targeting-transgender-youth.

[209] Haroon Siddique, "Appeal court overturns UK puberty blockers ruling for under-16s," *The Guardian* (September 17, 2021), https://www.theguardian.com/society/2021/sep/17/appeal-court-overturns-uk-puberty-blockers-ruling-for-under-16s-tavistock-keira-bell.

[210] Martin Robinson, "Landmark puberty-blockers ruling will NOT be challenged at Supreme Court: Children under 16 who have gender dysphoria can continue to be given life-changing drugs with GP's consent," *Daily Mail* (May 6, 2022), https://www.dailymail.co.uk/news/article-10789019/Landmark-puberty-blockers-ruling-NOT-challenged-Supreme-Court.html.

[211] Eleanor Hayward and Lucy Bannerman, "Tavistock gender clinic forced to shut over safety fears: Centre accused of rushing vulnerable children into treatment," *The Times* (July 28, 2022), https://www.thetimes.co.uk/article/e1ed2bea-0e63-11ed-93cf-b011fa7fe86b.

[212] E.g., see "WPATH, EPATH, USPATH, AsiaPATH, CPATH, AusPATH, PATHA Response to Bell v. Tavistock Judgment: Statement Regarding Medical Affirming Treatment including Puberty Blockers for Transgender Adolescents," *WPATH*, https://www.wpath.org/media/cms/Documents/Public%20Policies/2020/FINAL%20Statement%20Regarding%20Informed%20Consent%20Court%20Case_Dec%2016%202020.docx.pdf?_t=1608225376; "Bell v Tavistock outcome," *Gendered Intelligence* (December 1, 2020), https://genderedintelligence.wordpress.com/2020/12/01/bell-v-tavistock-outcome/; "UK High Court Ruling on the Use of Puberty Blockers in Gender Dysphoric Minors (Bell v. Tavistock): SGM Position Statement," *Society for Evidence Based Gender Medicine* (December 3, 2020), https://segm.org/UK_HighCourt_Rules_PubertyBlockers_Experimental; "Keira Bell: The High Court hands down a historic judgment to protect vulnerable children," *Transgender Trend* (December 1, 2020), https://www.transgendertrend.com/keira-bell-high-court-historic-judgment-protect-vulnerable-children/.

D. The "60 Minutes" Segment

In May 2021, the CBS weekly news show, "60 Minutes," aired a segment titled "Transgender Healthcare." In this installment, long-time correspondent, Lesley Stahl, reported on challenges – both medical and legal – facing transgender healthcare today. In the course of her investigation, Stahl engaged the issue of people who have detransitioned. In reflecting on her investigation, Stahl said:

> I think we spoke to more people on this story than any other story I can remember reporting on in my whole time at 60 Minutes . . . . We wanted to be thorough. We wanted to be fair. And we wanted to understand every aspect of this story. And it was really focused on health care. That was the primary idea for the story. Health care.[213]

At the same time, Stahl said that she "cannot remember another story she has worked on at 60 Minutes where comments and criticisms began surfacing from advocates before the piece aired."[214] In an interview with Stahl, Alphonso David, an LGBTQ civil rights lawyer and the president of the Human Rights Campaign, told her he had concerns that the report could be "taken out of context [and] could further victimize and marginalize" the transgender community.[215]

Predictably, upon airing of the episode, a firestorm quickly erupted. The very same evening, GLAAD, a leading LGBTQ rights group, tweeted:

> Tonight @60minutes @LesleyRStahl aired a shameful segment fearmongering about trans youth. Parents of trans youth could walk away with the false belief that young people are being rushed into medical transition. This is simply untrue.[216]

In a similar vein, Chase Strangio, deputy director for transgender justice with the American Civil Liberties Union's LGBTQ & HIV Project, tweeted:

> @60Minutes, Lesley Stahl, Alexandra Poolos, and Collette Richards knew exactly the harm they were causing with last night's segment. They knew it was the wrong moment

[213] Keith Zubrow, "Inside the 60 Minutes Report on Transgender Health Care Issues," *CBS News* (May 23, 2021), https://www.cbsnews.com/news/60-minutes-transgender-health-care-issues-2021-05-23/.
[214] Ibid.
[215] Ibid.
[216] https://twitter.com/glaad/status/1396665047645138945.

> and a dangerous, unaccountable and limited angle," he said. "But they did it anyway. That's on all of you.[217]

Media across the political spectrum quickly picked up the story.[218] Many within the trans community weighted in. One commentator clued "60 Minutes" into the fact that "there is no 'both sides-ing'" this issue.[219]

Laura Edwards-Leeper was one of the researchers interviewed in the 60 Minutes segment. In a *Washington Post* essay written six months later, Edwards-Leeper and fellow researcher and trans woman, Erica Anderson, defended people who detransition and called out activist medical practitioners for their politically motivated silencing of detransitioners:

> The pressure by activist medical and mental health providers, along with some national LGBT organizations to silence the voices of detransitioners and sabotage the discussion around what is occurring in the field is unconscionable. Not only is it harmful to detransitioned young people — to be made to feel as if their lived experiences are not valid, the very idea that the gender-transition treatment is meant to remedy — but it will undoubtedly raise questions regarding the objectivity of our field and our commitment to help trans people.[220]

And, thus, the highly polarized – and polarizing – state of the conversation about detransition in our current cultural climate. As one detransition researcher has put it:

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[217] https://twitter.com/chasestrangio/status/1396828255639019524?lang=en

[218] E.g., Rhuaridh Marr, "60 Minutes criticized for 'dangerous' and 'dehumanizing' segment on transgender healthcare: LGBTQ advocates called the segment 'shameful,' 'horrible,' and 'anti-trans propaganda,'" *Metro Weekly* (May 26, 2021), https://www.metroweekly.com/2021/05/60-minutes-criticized-for-dangerous-and-dehumanizing-segment-on-transgender-healthcare/; Lindsay Ellefson, "GLAAD Slams 'Shameful' '60 Minutes' Story on Transgender Youth," *The Wrap* (May 24, 2021), https://www.thewrap.com/glaad-60-minutes-transgender-youth-cbs-news/; Valerie Richardson, "'60 Minutes' hit with backlash from LGBTQ advocates for detransition report: Segment on gender reassignment for minors, young adults raised concerns about lax medical standards," *Washington Times* (May 26, 2021), https://www.washingtontimes.com/news/2021/may/26/60-minutes-backlash-lgbt-advocates-detransitioning/; J. D. Robertson, "Detrans Youth Stories They Didn't Want you to Hear, in 60 Minutes, or Less," *Velvet Chronicle* (May 31, 2021), https://thevelvetchronicle.com/detrans-youth-stories-they-didnt-want-you-to-hear-60-minutes-or-less/; Jennifer Smith, "Lesley Stahl defends CBS 60 Minutes episode about transgender people rushing into treatment then regretting it," *Daily Mail* (May 26, 2021), https://www.dailymail.co.uk/news/article-9621959/Lesley-Stahl-defends-CBS-60-Minutes-episode-transgender-teens-rushed-it.html.

[219] James Factora, "Dear 60 Minutes, There is No 'Both Sides-Ing' Trans Healthcare," *Them* (May 25, 2021), https://www.them.us/story/60-minutes-platforms-detransitioners-trans-healthcare.

[220] Laura Edwards-Leeper and Erica Anderson, "The mental health establishment is failing trans kids: Gender-exploratory therapy is a key step. Why aren't therapists providing it?," *Washington Post* (November 24, 2021), https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/.

> There is no value-neutral, apolitical way to study detrans. Different forms of detrans research are each entangled with different goals, in a way that is constitutive of knowledge production more broadly and cannot be simply reduced to bias.[221]

True enough. A value-neutral, apolitical ground from which to consider detransition is quite likely an imaginary no-man's-land. That being said, when it comes to considering detransition today, there is plenty of room for resisting the temptations of polarizing polemics, partisan point-making, and treating persons who experience detransition as political pawns.[222] Avoiding such things will be among the goals of what follows.

III. Choosing Detransition:
On the History and Experience of Reversing Gender Transition

There is a consensus among researchers that, to date, detransition has been widely neglected as a subject of serious and careful study.[223] It is, therefore, not surprising that a detailed history of detransition has yet to be written. It has been observed that cultural awareness of detransition grew dramatically between 2015 and 2017. During this period, detransitioners increasingly made

[221] Rowan Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine': A Transfeminist Approach to Research on Detransition," *Sociological Review* 68/4 (2020), 800–16 (here p. 803).
[222] For an all-too-rare call to – and example of – a humble and compassionate approach to the wider trans teen debate, see Samuel Paul Veissière, "The Debate on Trans Teens: Compassion Is Needed on All Sides: We need dialogue and common humanity, not polarized thinking," *psychologytoday.com* (December 2, 2018), https://www.psychologytoday.com/us/blog/culture-mind-and-brain/201812/the-debate-trans-teens-compassion-is-needed-all-sides.
[223] See Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 805; Expósito-Campos, "Typology of Gender Detransition," 270, 276-77; Vandenbussche, "Detransition-Related Needs and Support."

their presence known through blogs/vlogs,[224] online support groups,[225] YouTube videos,[226] autobiographical books and essays,[227] and interviews in various media.[228]

While 2015-2017 certainly marked a significant increase in cultural exposure, detransitioners were making their voices heard well before that. For example, they had already been sharing their stories on YouTube for several years.[229] Whether the term "detransition" was used or not, the phenomenon itself has been experienced and/or reported on for decades.[230] In the 20th century, the phenomenon of detransition was often encountered under the category of medical transition "regret." With the rise and development of medical transition procedures in the early-to-mid 20th century, came the possibility that someone who underwent such a transition would

[224] For a list of several detrans blogs/vlogs, see https://www.detransvoices.org/resource-directory/websites-blogs-by-detransitioners-desisters/

[225] E.g., Detrans Canada (https://detranscanada.com/); Detrans Voices (https://www.detransvoices.org/); Detransitioners Anonymous (DetransitionersAnonymous@protonmail.com); Pique Resiliency Project (www.piqueresproject.com); Post Trans (https://post-trans.com/); Sex Change Regret (www.sexchangeregret.com).

[226] E.g., GNC Centric at https://www.youtube.com/c/GNCCentric.

[227] E.g., Walt Heyer, "Transgender Identities are Not Always Permanent," *Public Discourse* (September 27, 2016), http://www.thepublicdiscourse.com/2016/09/17753/; idem, *A Transgender's Faith* (n.p.: CreateSpace, 2015); Charlie McCann, "When girls won't be girls," *1843* (October/November 2017), www.1843magazine.com/features/when-girls-wont-be-girls

[228] E.g., Cari Stella, "In praise of gatekeepers: An interview with a former teen client of TransActive Gender Center," *4thwavenow* (April 21, 2016), https://4thwavenow.com/2016/04/21/in-praise-of-gatekeepers-an-interview-with-a-former-teen-client-of-transactive-gender-center/; Tracy Clark-Flory, "Detransitioning: Going From Male To Female To Male Again," *Vocativ* (June 15, 2015), https://www.vocativ.com/culture/lgbt/detransitioning-male-female-male-again/; Katie Herzog, "The Detransitioners: They Were Transgender, Until They Weren't," *The Stranger* (June 28, 2017), https://www.thestranger.com/features/2017/06/28/25252342/the-detransitioners-they-were-transgender-until-they-werent; Joan McFadden, "Transition Caused More Problems Than It Solved," *The Guardian* (September 16, 2017), https://www.theguardian.com/lifeandstyle/2017/sep/16/transition-caused-more-problems-than-it-solved; "Transgender boy transitioning to life as girl changes his mind," *60 Minutes Australia* (2017), https://www.youtube.com/watch?v=27qjn0v4Av4.

[229] E.g., "My decision to detransition," Y*ouTube* (2010), https://www.youtube.com/watch?v=ZHFV7Upr52M; "mtf transition update, topic: detransition and being yourself," Y*ouTube* (2010), https://www.youtube.com/watch?v=Jpn4fYXghxk.

[230] E.g., Ronald J. Blank, "The Partial Transsexual," *American Journal of Psychotherapy* 35/1 (1981), 107-12; Elsie R. Shore, "The Former Transsexual: A Case Study," *Archives of Sexual Behavior* 13/3 (1984), 277-85; I. R. Marks and D. Mataix-Cols, "Four-year Remission of Transsexualism after Comorbid Obsessive-Compulsive Disorder Improved with Self-Exposure Therapy. Case Report," *British Journal of Psychiatry* 171 (1997), 389-90; I. Marks, R. Green, and D. Mataix-Cols, "Adult Gender Identity Disorder Can Remit," *Comprehensive Psychiatry* 41/4 (2000), 273-75; "Double sex-change patient to sue," *Sydney Morning Herald* (September 16, 2004), https://www.smh.com.au/national/double-sex-change-patient-to-sue-20040916-gdjqtj.html; Julie Bindel, "I changed for all the wrong reasons, and then it was too late," *The Sunday Telegraph* (December 15, 2003); idem, "Mistaken Identity," *The Guardian* (May 23, 2007), https://www.theguardian.com/lifeandstyle/2007/may/23/healthandwellbeing.health; Jill Stark, "Sex-change clinic 'got it wrong,'" *Sydney Morning Herald* (May 31, 2009), https://www.smh.com.au/national/sexchange-clinic-got-it-wrong-20090530-br3u.html; Lindsay Pieper, "Mike Penner 'or' Christine Daniels: The U.S. Media and the Fractured Representation of a Transgender Sportswriter," *Sport in Society* 18 (2015), 186-201; Brian Belovitch, *Trans Figured: My Journey from Boy to Girl to Woman to Man* (New York: Simon & Schuster, 2018).

later come to regret it.[231] From the early 1950s onward, cases of transition regret and/or the desire to detransition were being regularly reported in the medical literature.[232] An early longitudinal study of transition outcomes, published in 1961, reported that one of the five cases involved a natal male who had surgically transitioned and – following a failed vaginoplasty – eventually returned to socially presenting as a man.[233] In his 1966 book, *The Transsexual Phenomenon*, Harry Benjamin also mentions a case of transition regret and anticipated detransition.[234]

Since 2017, the detransition community has continued to experience increasing visibility and apparent growth. Similar to other sexual and gender minority groups, connections within the detransition community have taken place primarily in the online world of internet groups and social media. For example, the rapid expansion of the detransition community is reflected in the exponential growth in membership of the r/detrans subreddit over the last few years. (Re)launched in late 2017, by 2020 it had grown from 100 to over 6,000 members. One year later (November 2021), its membership had exploded to 23,000. Six months following, membership was over 34,000.[235]

A host of detransition support groups have sprung up around the world, with names like Detrans Advocacy Network, Detrans Canada, Detrans Canada Highway, Detrans Voices, Detransition Info, Detransitioners Anonymous, Post Trans, the Pique Resiliency Project, and the Gender Care

[231] We will return to the issue of transition regret below to consider it in more detail.
[232] E.g., David O. Cauldwell, *Sex Transmutation – Can One's Sex be Changed?* (Girard, KS: Haldeman-Julius, 1951); F. Battig, "Beitrag zur Frage des Transvestitismus," Dissertation (Zurich: Buchdruckerei Fluntern, 1952); Eugene De Savitsch, *Homosexuality, Transvestism and Change of Sex* (London: Heinemann Medical Books, 1958); John Hertz, Karl G. Tillinger, and Axel Westman, "Transvestism: Report on Five Hormonally and Surgically Treated Cases," *Acta Psychiatrica Scandinavia* 37/4 (1961), 283-94 (p. 286); G. Hofer, "Transvestitismus," *Fortschritte der Neurologie - Psychiatrie* 29 (1961), 1-33; Harry Benjamin, "Clinical Aspects of Transsexualism in the Male and Female," *American Journal of Psychotherapy* 18 (1964), 458–69; J. B. Randell, "Preoperative and Postoperative Status of Male and Female Transsexuals," in Green and Money, eds., *Transsexualism and Sex Reassignment*, 355-81; Jan Wålinder and Inga Thuwe, *A Social-Psychiatric Follow-up Study of 24 Sex-Reassigned Transsexuals* (Gotcborg : Akademiforlaget, 1975).
[233] Hertz, et al., "Transvestism: Report on Five Hormonally and Surgically Treated Cases," 286.
[234] Harry Benjamin, *The Transsexual Phenomenon* (New York: Julian, 1966), 124.
[235] https://www.reddit.com/r/detrans/. Regarding membership, r/detrans states: "Our subreddit is reserved for detransitioners/desisters and those questioning their own transition; your user flair must clearly indicate that you fall into this group."

Consumer Advocacy Network.[236] One such group succinctly expresses two of the key benefits to detransitioners of an online support group: "As an association, we will have the power of our membership while keeping individuals safely anonymous."[237] Some within the online community of detransistioners have embraced the salamander (using the lizard emoji) – a reptile with the ability to grow back lost body parts – as their mascot.[238]

A number of parent support groups critical of the gender affirmative approach to children who experience GD have forged connections with detransitioners.[239] Professional associations that support detransitioners in one way or another have also recently been birthed. For example, the International Association of Therapists for Desisters and Detransitioners (iatdd), launched in 2020, is an international group of therapists committed to "working together to better understand the needs and challenges faced by desisting and detransitioning people."[240] And the Gender Dysphoria Alliance (GDA), birthed in 2021, includes two detransitioned females – GNC Centric and Sinead Watson – on its advisory board.[241]

This rise in the growth and visibility of the detrans community within the last few years has brought with it increasing media coverage. Articles on the topic – from across the spectrum of

[236] A number of these groups have produced written resources for the detrans community. E.g., Post Trans, *Gender Detransition: A Path Toward Self-Acceptance*, https://files.cargocollective.com/c523136/01_Post-Trans_Booklet_EN.pdf.
[237] Detrans Canada Highway, Twitter.com/DetransCnd.
[238] Laura Dodsworth, "The Detransitioners," *Medium* (August 18, 2020), https://medium.com/@barereality/the-detransitioners-72a4e01a10f9.
[239] E.g., 4thWaveNow, Transgender Trend, and Genspect.
[240] https://iatdd.com/
[241] https://www.genderdysphoriaalliance.com

viewpoints – regularly continue to appear.[242] A number of recent documentary films, podcasts and television segments have also explored the experience of detransition.[243]

In 2019, the first-ever detransition conference was held. The sold-out event – titled "Detransition: The Elephant in the Room. Medical Ethics in the Age of Gender Identity" – was held in Manchester, England on November 30, 2019, and hosted over 200 attendees.[244] The

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[242] E.g., Dodsworth, "The Detransitioners";
Brooke Kato, "What it's like to detransition your gender as a 'masculine trans man,'" *New York Post* (January 26, 2022), https://nypost.com/2022/01/26/what-its-like-to-detransition-your-gender-as-a-masculine-trans-man/; B. Lane, "Regretful 'detransitioners' on rise," *The Australian* (October 14, 2019), https://www.theaustralian.com.au/nation/regretful-detransitioners-on-rise/news-story/627a9cc0f42d700be7dfab435c0522a9; Sally Lockwood, "'Hundreds' of young trans people seeking help to return to original sex," *skynews.com* (October 5, 2019), https://news.sky.com/story/hundreds-of-young-trans-people-seeking-help-to-return-to-original-sex-11827740; German Lopez, "The Debate about Transgender Children and 'Detransitioning' is Really about Transphobia," *Vox* (August 9, 2016), https://www.vox.com/2016/8/9/12404246/transgender-children-detransitioning-transphobia; Lisa Marchiano, "The Ranks of Gender Detransitioners are Growing. We Need to Understand Why," *quillette.com* (January 2, 2020), https://quillette.com/2020/01/02/the-ranks-of-gender-detransitioners-are-growing-we-need-to-understand-why/; Amber Roberts, "Dispelling the Myths About Trans People 'Detransitioning,'" *Vice* (November 17, 2015), https://www.vice.com/en/article/kwxkwz/dispelling-the-myths-around-detransitioning; Robertson, "Detrans Youth Stories They Didn't Want you to Hear, in 60 Minutes, or Less"; Sally Robertson, "Hundreds of trans people regret changing their gender, says trans activist," *News – Medical Life Science* (October 7, 2019) , https://www.news-medical.net/news/20191007/Hundreds-of-trans-people-regret-changing-their-gender-says-trans-activist.aspx; Nathan J. Robinson, "Why the Panic Over Trans Kids?," *Current Affairs* (April 30, 2021), https://www.currentaffairs.org/2021/04/why-the-panic-over-trans-kids; Jesse Singal, "It Would Be So Easy For Liberal Outlets To Do A Better Job Covering Gender Dysphoria," jessesingal.substack.com (February 5, 2019), https://jessesingal.substack.com/p/it-would-be-so-easy-for-liberal-outlets; "Portrait of a Detransitioner as a Young Woman," *The Economist* (November 6, 2021), https://www.economist.com/united-states/2021/11/06/portrait-of-a-detransitioner-as-a-young-woman.

[243] E.g., "What Is Gender Detransition? Changing Your Mind About Changing Your Body," *Unspeakable Podcast* (2021), https://podcasts.apple.com/us/podcast/what-is-gender-detransition-changing-your-mind-about/id1524832743?i=1000554667519; Nicolas Pollock, "'I Wanted to Take My Body Off': Detransitioned," *The Atlantic* (June 18, 2018), https://www.theatlantic.com/video/index/562988/detransitioned-film/; "Detransitioned: The Lives of Carey Callahan" ["Reversing a Gender Transition"], (2018), https://www.youtube.com/watch?v=V6V0p3_bd6w; "Detransitioning: Reversing a Gender Transition," *BBC Newsnight* (November 26, 2019), https://www.youtube.com/watch?v=fDi-jFVBLA8; Silas Gonzalez, Silas. "DETRANSITION," *YouTube* (June 24, 2019), https://youtu.be/j7rtj6xtThU; "I Want My Gender Back: Transgender People Who Regretted Changing Sex," *RT documentary* (2018), https://www.youtube.com/watch?v=-pxxBQm114k; "The Trans Train" ["Uppdrag Granskning"] *Mission: Investigate* (released April 2, 2019), https://www.youtube.com/watch?v=sJGAoNbHYzk;
BBC, "The Detransitioners: She2He2She," *BBC News: The Documentary* (May 10, 2020), https://www.bbc.co.uk/sounds/play/w3ct0hyy; Zubrow, "Inside the 60 Minutes Report on Transgender Health Care Issues."

[244] Dorothy Cummings McLean, "At world's first gender 'detransition' conference, women express regret over drugs, mutilation," *LifeSiteNews* (December 2, 2019), https://www.lifesitenews.com/news/at-worlds-first-gender-detransition-conference-women-express-regret-over-drugs-mutilation/; Liv Bridge, "Detransitioners are living proof the practices surrounding "trans kids" need to be questioned," *Feminist Current* (January 9, 2020), https://www.feministcurrent.com/2020/01/09/detransitioners-are-living-proof-the-practices-surrounding-trans-kids-need-be-questioned/. For a transcript from the conference, see Thomasin Pick, transcript of the "Detransition: The Elephant in the Room" conference. Manchester, UK, November 30, 2019; available at: https://08e98b5f-7b7a-40c9-a93b-8195d9b9a854.filesusr.com/ugd/305c8f_34b673d3097c4df88bf9b9e8f6ed1006.pdf?index=true.

conference was co-sponsored by The Detransition Advocacy Network (TDAN) and the feminist collective Make More Noise. The primary voice behind the UK-based TDAN was Charlie Evans, who lived as a FtM trans person for a decade before her detransition back to female.[245] Since the arrival of the covid pandemic in 2020, both Evans and TDAN have suffered a low profile in terms of online/social media presence, which has caused speculation among both supporters and critics.[246]

At one point or another over the last few years, other detransitioners have also emerged as high-profile voices, including Keira Bell,[247] Carey Callahan,[248] Cat Cattinson,[249] CrashChaosCats,[250]

[245] Claire Heuchan, "I Am No Less of a Woman: Charlie Evans Interview," *afterellen.com* (January 23, 2020), https://www.afterellen.com/general-news/574936-charlie-evans-interview; Charlie Evans, "Detransition Advocacy Network at WHRC," *YouTube* (October 27, 2019), https://www.youtube.com/watch?v=9I7hS3qrwXQ; Lockwood, "'Hundreds' of young trans people seeking help to return to original sex."
[246] Gemma Stone, "Where is The Detransition Advocacy Network Now?," *Medium* (April 23, 2021), https://medium.com/@notCursedE/where-is-the-detransition-advocacy-network-now-f01ec9c9682d.
[247] Bell, "Keira Bell: My Story"; idem, "Protect Gender Dysphoric Children from the Affirmation Model"; Bell, Keira, and Raquel Rosario Sánchez [interview], "Keira Bell: 'There Was Nothing Wrong with My Body.'"
[248] Carey Callahan, "Unheard Voices of Detransitioners," in *Transgender Children and Young People*, ed. Heather Brunskell-Evans and Michele Moore (Newcastle upon Tyne, UK: Cambridge Scholars, 2018), 166-80; idem, "The Game Plan for when Transition Hasn't Worked Out." *Medium* (April 20, 2019), https://mariacatt42.medium.com/the-game-plan-for-when-transition-hasnt-worked-out-29bf52bc7908. Callhoun is featured in the documentaries "Detransitioned: The Lives of Carey Callahan"; and "'I Wanted to Take My Body Off': Detransitioned."
[249] Sienna Mae Heath and Cat Cattinson, "Cat Cattinson: A California Woman's Detransition Story," *Free the People: Leaving the Left for Liberty* - Episode 12 (May 5, 2022), https://freethepeople.org/cat-cattinson-a-california-womans-detransition-story-leaving-the-left-for-liberty-ep-12/
[250] Crashchaoscats, "An open letter to Julia Serano from one of the detransitioned people you claim to 'support'." (August 8, 2016). https://sandradodd.com/transgender/crash; idem, "Lost to Follow-up/How Far Can You Follow Me?" (2017) [no longer available; site deleted by author]; idem, "Follow-up to 'Lost to Follow-up,'" (February 8, 2018), https://crashchaoscats.wordpress.com/2018/02/08/follow-up-to-lost-to-follow-up/ (no longer available at the original link; site deleted by author); available at https://tejuina.tumblr.com/post/170662706607/follow-up-to-lost-to-follow-up. Again, the detransitioned author who wrote under the pseudonym of CrashChaosCats, Ky Schevers, has more recently (re-)identified as transmasculine (while using she/her pronouns), and has written several pieces critiquing the detransition movement she once participated in. See e.g., Ky Schevers, "Detransition as Conversion Therapy: A Survivor Speaks Out," *An Injustice!* (December 21, 2020), https://aninjusticemag.com/detransition-as-conversion-therapy-a-survivor-speaks-out-7abd4a9782fa; Urquhart, "An 'Ex-Detransitioner' Disavows the Anti-Trans Movement She Helped Spark."

Chloe Cole,[251] GNC Centric (Ben/Benji),[252] Ritchie Herron,[253] Walt Heyer,[254] Helena Kerschner,[255] Grace Lidinsky-Smith,[256] Max Robinson,[257] James Shupe,[258] Cari Stella,[259] and

[251] "Chloe Cole: Testimony in Louisiana," https://www.facebook.com/InternationalPartnersforethicalcare/videos/chloe-cole-testimony-in-louisiana/412402700331012/; Michael Cook, "Chloe's story: puberty blockers at 13, a double mastectomy at 15," *mercatornet.com* (July 25, 2022), https://mercatornet.com/chloe-cole-gender-transition/80073/.

[252] GNC Centric is a Toronto-based detransitioned female whose YouTube channel features both personal videos and interviews with other detransitioners. See https://www.youtube.com/channel/UCTY0IumyDAKe--wcRyL_Avg/videos?disable_polymer=1. GNC Centric is also on the advisory board of the Gender Dysphoria Alliance (GDA).

[253] Ritchie Herron, "Transitioning was 'the biggest mistake of my life': Ritchie Herron interview," *YouTube*, https://www.youtube.com/watch?v=jSYL7eiPM-E; Sanchez Manning, "'My first thought as I came round was Oh God! What have I done?': Man suing the NHS over trans surgery he bitterly regrets has bravely waived anonymity to share his ordeal," *Daily Mail* (June 25, 2022), https://www.dailymail.co.uk/news/article-10953157/Man-suing-NHS-trans-surgery-regrets-bravely-waived-anonymity-share-ordeal.html.

[254] Walt Heyer, "I Was a Transgender Woman," *Public Discourse* (April 1, 2015), https://www.thepublicdiscourse.com/2015/04/14688/; idem, "Transgender Identities are Not Always Permanent"; idem, *A Transgender's Faith*; idem, *Trans Life Survivors* (n.p.: Bowker Identifier Services, 2018).

[255] "Helena: A Detransition Story," *Unsafe Space podcast* (May 5, 2021), https://www.podchaser.com/podcasts/unsafe-space-4317/episodes/episode-0562-deprogrammed-hele-90823127; Helena Kerschner, "At What Cost? Trans Healthcare, Manipulated Data, and Self-Appointed Saviors," *Medium* (August 5, 2020), https://medium.com/@helenakerschner/at-what-cost-trans-healthcare-manipulated-data-and-self-appointed-saviors-dc81c4be7ae2.

[256] Grace Lidinsky-Smith, "There's No Standard for Care When it Comes to Trans Medicine," *Newsweek* (June 25, 2021), https://www.newsweek.com/theres-no-standard-care-when-it-comes-trans-medicine-opinion-1603450; Kaelan Deese, "Woman who spoke about detransition responds to 'unfair' backlash from transgender activists," *Washington Examiner* (May 27, 2021), https://www.washingtonexaminer.com/news/woman-spoke-60-minutes-detransition-responds-backlash-transgender-activists. Some of Lidinsky-Smith's other pieces can be found at her substack site Hormone Hangover: https://hormonehangover.substack.com/.

[257] Max Robinson, *Detransition: Beyond Before and After* (Mission Beach, Queensland, AU: Spinifex, 2021). On Robinson see also McCann, "When girls won't be girls."

[258] James Shupe, "I Was America's First 'Nonbinary' Person. It Was All a Sham," *Daily Signal* (March 10, 2019), https://www.dailysignal.com/2019/03/10/i-was-americas-first-non-binary-person-it-was-all-a-sham/; idem, "My New Life After Transgender Despair," *Daily Signal* (February 10, 2020), https://www.dailysignal.com/2020/02/10/my-new-life-after-transgender-despair/; Bruce Bawer, "A Transgender Hero Breaks Ranks," *P J Media* (February 13, 2019), https://pjmedia.com/news-and-politics/bruce-bawer-2/2019/02/13/a-transgender-hero-breaks-ranks-n63759.

[259] See her YouTube channel at https://www.youtube.com/channel/UChCA_LScK33yNsiq0BIAa2g/videos?view=0. See also Cari Stella [interview], "In praise of gatekeepers: An interview with a former teen client of TransActive Gender Center," *4thwavenow* (April 21, 2016), https://4thwavenow.com/2016/04/21/in-praise-of-gatekeepers-an-interview-with-a-former-teen-client-of-transactive-gender-center/; idem, "Why I detransitioned and what I want medical providers to know (USPATH 2017)," *YouTube* (February 6, 2017), https://www.youtube.com/watch?v=Q3-r7ttcw6c (this video was done by request for the detransition mini-symposium at USPATH 2017).

Sinead Watson.[260] Along with others, Keira Bell helped inaugurate Detrans Awareness Day on March 12, 2021.[261]

2021 also brought the publication of the best-selling book *Detransition, Baby: A Novel*, which served to bring additional light – and ignite further conversation – on detransition.[262] Written by Torrey Peters, a trans woman, the storyline of *Detransition, Baby* revolves around the character of Reese, a 35-year-old trans woman living in Brooklyn, and her ex-, Ames, a former trans woman who has detransitioned. The press generated by the release of this book has been remarkable. The book is already being developed for television, with Peters serving as an executive-producer and writing the pilot episode.[263] One reviewer announced that it is "already entering the canon of trans culture."[264] The *Rolling Stone* review proclaimed it "the most subversive book of the year," and presents Peters as the "voice of a new queer generation."[265] According to this reviewer, its "subversive radicalism" lies in the manner in which it depicts trans women – and, one could add, the phenomenon of detransition – "in a casual way."[266] In the words of another reviewer:

> in refusing to avoid the sore spots of trans life, Peters offers a lucidity that would be impossible if her only goal were to inspire sympathy. She is refreshingly uninterested in persuading the public of the bravery and nobility of trans people, and lets them be as dysfunctional as anyone else.[267]

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[260] Sinead Watson, "Sinead Watson, detransitioned woman, on devastating impact of gender clinic's 'affirmative model,'" *YouTube* (May 22, 2021), https://www.youtube.com/watch?v=oyMbTd1crgs; idem, "Sinead Watson – detransitioner from Scottland." *Dialogue Not Expulsion*, https://www.dialoguenotexpulsion.org/nlc-vs-ggp/testimony/Sinead_Watson--detransitioner; idem, "Transition and Detransition: A conversation between sisters," *4thWaveNow* (February 26, 2021), https://www.transgendertrend.com/transition-detransition-conversation-between-sisters/. Watson serves as an advisor to both Genspect and the Gender Dysphoria Alliance (GDA).

[261] https://www.detransawareness.org/; https://twitter.com/klbfax/status/1369626591081328641?lang=en; Jo Bartosch, "The first ever Detransition Awareness Day is today Friday 12th March," *Gay and Lesbian News* (March 12, 2021), https://lesbianandgaynews.com/2021/03/the-first-ever-detransition-awareness-day-is-this-friday-12th-march/.

[262] Torrey Peters, *Detransition, Baby: A Novel* (New York: One World, 2021).

[263] Portwood, "Torrey Peters on Publishing the Most Subversive Book of the Year."

[264] Amanda Armstrong-Price, "Semi-Plausible Histories: On Torrey Peter's 'Detransition, Baby,'" *Los Angeles Review of Books* (July 16, 2021), https://www.lareviewofbooks.org/article/semi-plausible-histories-on-torrey-peterss-detransition-baby/.

[265] Jerry Portwood, "Torrey Peters on Publishing the Most Subversive Book of the Year," *Rolling Stone* (July/August 2021), https://www.rollingstone.com/culture/culture-features/detransition-baby-book-torrey-peters-1193653/.

[266] Ibid.

[267] Crispin Long, "The Insider Insights of 'Detransition, Baby,'" *The New Yorker* (January 31, 2021), https://www.newyorker.com/books/page-turner/the-insider-insights-of-detransition-baby.

In this sense, Torrey Peters, along with Andrea Long Chu[268] and others, can be considered part of a new generation, even a "second wave," of trans writers who willingly and open-handedly explore issues within the range of trans experience(s) – including detransition – that others consider to be ideologically or politically off-limits.

IV. Detransition Studies: The Current State of Research

As mentioned above, one of the few things that everyone seems able to agree on is that there has been very little attention devoted to academic research on detransition. This observation is reflected in the fact that many academic publications on transgender experience and/or GD contain little-to-no mention of detransitioners or their experiences. For example, the 2021 book, *Transgender and Gender Diverse Health Care: The Fenway Guide* – an up-to-date publication of 350 pages – contains no chapter on detransition, nor does the term appear in its index.[269] Proactive avoidance of the topic of detransition has characterized some professional contexts. For example, in 2017, the Philly Trans Health Conference decided to cancel a panel on detransition that had been planned. In a statement, the conference promoters communicated that the "difficult decision" to cancel this panel – along with a second panel that was to be devote to alternative ways to dealing with GD – "ultimately came down to the level of heated conversation and controversy surrounding the two workshops."[270] Perhaps most surprisingly, the WPATH's *Standards of Care* – the most widely recognized set of guidelines for the medical care of trans persons in the world today – contains no section on detransition in its current version (SOC-7). And – despite the fact that vast majority of gender surgeons surveyed report that they hope the

[268] Andrew Long Chu, "On Liking Women," *n+1* (Winter 2018), https://nplusonemag.com/issue-30/essays/on-liking-women/; idem, "My New Vagina Won't Make Me Happy"; idem, *Females* (New York: Verso, 2019); Andrea Long Chu and Emmett Harsin Drager, "After Trans Studies," *TSQ* 6/1 (2019), 103–16.
[269] Alex Keuroghlian, Jennifer Potter, and Sari L. Reisner, eds., *Transgender and Gender Diverse Health Care: The Fenway Guide* (New York: McGraw Hill, 2021).
[270] Katie Herzog, "Philly Trans Health Conference Cancels Sessions on Detransitioning," *thestranger.com* (August 30, 2017), https://www.thestranger.com/slog/2017/08/30/25382933/philly-trans-health-conference-cancels-sessions-on-detransitioning.

SOC-8 would include such a chapter [271] – the currently posted list of anticipated chapters does not include one on detransition.[272]

Given the remarkable dearth of detransition-oriented scientific research, the detrans community itself, along with its allies, have stepped in to begin the initial spadework. Pablo Expósito-Campos – one of the very few serious academic researchers of detransition – explains the situation:

> Despite not being a genuinely novel phenomenon from a historical perspective . . . . 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, parent reports, informal surveys carried out by detransitioners, media outlets, support groups, documentaries, case studies, and the experiences of clinicians who work with this cohort.[273]

For example, the first two significant surveys of detransitioners were conducted by people within the detrans community itself. The first of these, coordinated by Cari Stella and conducted in August 2016, is based on the self-reports of 203 detransitioned females recruited from social media sites including Tumblr and private detransitioner Facebook groups.[274] Hailey Mangelsdorf coordinated the other survey in 2017, which involved the self-reports of 211 detransitioned females recruited through social media, and focused on mental health issues.[275] Several of the very few academic researchers now exploring detransition have made use of one or both of these surveys in their work.[276]

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[271] Sara Danker, Sasha K. Narayan, Rachel Bluebond-Langner, Loren S. Schechter, and Jens U. Berli, "Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries," *Plastic and Reconstructive Surgery – Global Open* 6/95 (September 2018), 189, doi: 10.1097/01.GOX.0000547077.23299.00.
[272] https://www.wpath.org/soc8/chapters (i.e., as of May 2022).
[273] Expósito-Campos, "Typology of Gender Detransition," 270.
[274] Cari Stella, "Female Detransition and Reidentification: Survey Results and Interpretation" [Post], *Tumblr* (September 3, 2016), https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey.
[275] Hailey [Mangelsdorf], "Survey of co-morbid mental health in detransitioned females: Analysis and results," *Re-sister* (2017), https://desisterresister.wordpress.com/2017/01/11/survey-of-co-morbid-mental-health-in-detransitioned-females-analysis-and-results/. In 2017, Mangelsdorf also conducted an online survey of 359 non-transitioned females who experience gender dysphoria, which inquired about management strategies they use to ease their dysphoria. See Hailey Mangelsdorf, "Female/AFAB Dysphoria Management Survey – Analysis and Results" (2017), https://docs.google.com/document/d/1nc5X96PwzyfIfpvKi8RQR5t9AQe9SVl76aWZL30rVLY/edit.
[276] Expósito-Campos, "Typology of Gender Detransition"; Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine'"; Vandenbussche, "Detransition-Related Needs and Support"; Lisa Littman, "Individuals Treated for

Another result of the lack of research is the statistical data gap regarding actual numbers and demographics of detransitioned people. In September 2021, a project titled Detransition Count was launched to explore these questions. Led by "an online community of concerned parents, professionals, and adult transexuals," the stated goal is to "start tracking detransitioned communities in order to better understand detransitioned experiences and develop support networks for detransitioners."[277]

While the detransition community and its allies have been at the forefront of calling for, and initiating research into, detransition experience(s), a few academic researchers have begun to seriously engage the question. In 2017 – the same year that the Philly Trans Health Conference cancelled its panel on detransition – the United States Professional Association for Transgender Health (USPATH), the U.S. affiliate of WPATH, held a conference at UCLA that hosted a panel featuring several detransitioned people themselves, including Cari Stella and Joel Nowak.[278]

In 2018, the results of a survey of gender surgeons were made public. The survey found that 88% of gender surgeons believe the next edition of WPATH's Standards of Care (SOC 8) "should include a chapter on detransition."[279] In the same year, a number of books and articles on the treatment of GD/transgender people were published that directly – and often sympathetically – addressed detransition.[280] Importantly, among the authors were trans affirmative voices that were

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Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners," *Archives of Sexual Behavior* 50/8 (2021), 3353-69.

[277] https://detranscount.wixsite.com/website.

[278] See the videos done by request for the detransition mini-symposium at USPATH 2017: Cari Stella, "Why I detransitioned and what I want medical providers to know (USPATH 2017)," *YouTube* (February 6, 2017), https://www.youtube.com/watch?v=Q3-r7ttcw6c; Joel Nowak, "Detransition: Normalizing the Conversation," *YouTube* (February 3, 2017), https://www.youtube.com/watch?v=S5LjG-t8xGM. For more on Nowak, see Clark-Flory, "Detransitioning: Going From Male To Female To Male Again." Also in 2017, J. Graham presented "Detransition, Retransition: What Providers Need to Know" at the Advancing Excellence for Transgender Health conference (Boston, MA, October 13-15, 2017).

[279] Danker, et al., "Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries."

[280] E.g., Sarah Boslaugh, *Transgender Health Issues* (Santa Barbara, CA: ABC-CLIO, 2018), 42-44; Az Hakeem, ed., "'I Changed My Sex, Then Changed My Mind,'" in *TRANS: Exploring Gender Identity and Gender Dysphoria* (Nottinghamshire, UK: Trigger, 2018), ch. 19; Jack L. Turban, Jeremi Carswell, and Alex S. Keuroghlian, "Understanding Pediatric Patients Who Discontinue Gender-affirming Hormonal Interventions," *JAMA Pediatrics* 172 (2018), 903–04; Turban and Keuroghlian, "Dynamic Gender Presentations," 451-53; Eric Yarbrough, "Transition and Detransition," in *Transgender Mental Health* (Washington, DC: American Psychiatric Association, 2018), 129-42; Alexander Yoo, "Transition Regret and Detransition," in *Lesbian, Gay, Bisexual and Transgender*

asking hard questions about the poor treatment that many detransitioned people have received from the wider trans community and its allies. For example, regarding people who experience transition regret and detransition, Alexander Yoo writes:

> Assuming the accuracy of the oft-cited "less than 5 percent" figure (keeping in mind the lack of consistency defining "detransition" or "transition regret"), how does one reconcile the dismissive phrases (e.g., "almost negligible," "irrelevant") used to describe this group of people? Additionally, how does one reconcile the passionate hatred these detransitioners encounter in everyday interactions with their former communities, with their families, and on popular internet hubs with the idea that identifying as LGBTQ+ (the + sign represents everyone else who does not conform to cisgender norms) means respecting individuality? What is behind the dismissiveness implied by citing the "rarity" of "transition regret" (never mind that most studies do not address nonsurgical transition regret)? What is the root of this dismissive attitude toward those who struggle with continued dysphoria, regret, and related issues? This observation merits study and discussion: the very real intolerance by members of the trans community against those experiencing regret or who have in some form detransitioned.[281]

It is the years 2020 and 2021 – the dawning of the third decade of the 21st century – that mark a significant step forward for serious academic research on detransition. In October 2021, the annual meeting of the American Academy of Child and Adolescent Psychiatry included a set of presentations on transition regret and detransition.[282] More importantly, during this two-year period, a remarkable number of studies on, or related to, detransition were published.[283] Notably,

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Americans at Risk: Problems and Solutions, Vol 2: *Adults, Generation X and Generation Y*, ed. Chuck Stewart (Santa Barbara, CA: Praeger, 2018), 181-91.

[281] Yoo, "Transition Regret and Detransition," 189.

[282] For the titles and abstracts, see Jack L. Turban and Peter T. Daniolos, "Transgender Youth: Understanding 'Detransition,' Non-Linear Gender Trajectories, and Dynamic Gender Identities," *Journal of the American Academy of Child & Adolescent Psychiatry* 60/10 Supp. (2021), S3; Aron Janssen, Ann Lurie and Robert H. Lurie, "Understanding Gender 'Detransition' With and Without Regret," *Journal of the American Academy of Child & Adolescent Psychiatry* 60/10 Supp. (2021), S4; Andrea Giedinghagen, "Quantitative Perspectives on 'Detransition' and Transition Regret," *Journal of the American Academy of Child & Adolescent Psychiatry* 60/10 Supp. (2021), S4; Thwin Myint, "Nonlinear Gender Trajectories and Detransition Without Regret," *Journal of the American Academy of Child & Adolescent Psychiatry* 60/10 Supp. (2021), S4.

[283] Antonio Becerra Fernandez, "Disforia de genero/incongruencia de genero: Transicion y detransicion, persistencia y desistencia [Gender dysphoria/gender incongruence: Transition and detransition, persistence and desistence]," *Endocrinologıa, Diabetes y Nutricion* 67/9 (2020), 559-61; Catherine Butler and Anna Hutchinson, "Debate: The Pressing Need for Research and Services for Gender Desisters/Detransitioners," *Child and Adolescent Mental He*alth 25/1 (2020), 45-47; Leia K. Cain and Julianna C. Velasco, "Stranded at the Intersection of Gender, Sexuality and Autism: Gray's Story," *Disability & Society* 36/3 (2021), 358-75; Kirsty Entwistle, "Debate: Reality Check – Detransitioners' Testimonies Requires Us to Rethink Gender Dysphoria," *Child and Adolescent Mental Health* 26/1 (2021), 15-16; Susan Evans and Marcus Evans, "Detransitioners," in *Gender Dysphoria: A Therapeutic Model for Working with Children, Adolescents and Young Adults* (Oxfordshire, UK: Phoenix, 2021), ch. 3; Expósito-Campos, "Typology of Gender Detransition"; ibid, "Gender Detransition in Spain: Concept and Perspectives," *Endocrinología, Diabetes y Nutrición* (April 10, 2021), S2530-0164(21)00080-X [online pub ahead of print]; Pablo Expósito-Campos, Marcelino Gómez-Balaguer, Felipe Hurtado-Murillo, Rosa García-Moreno, and Carlos Morillas-

some of these appeared in journals known for their support of a gender affirmative approach to trans experience – a sign that detransition is slowly becoming a phenomenon of study distinct, if never entirely separable, from the politicization of the culture war. Several of these studies break new ground regarding definitions and terminology, data (both quantitative and qualitative), and the framing of detransition itself. A number of proposals and insights drawn from these key studies will now be considered.

A. Defining "Detransition" and Related Concepts

As Rowan Hildebrand-Chupp reminds us, there simply "is no value-neutral, apolitical way to study detrans."[284] The inevitable politicization involved in detransition research is wrapped up in the very terminology used to describe people's experiences. For example, "a set of terms that is affirming to participants from transgender communities could be offputting to participants from detransition communities, and vice versa."[285] Nonetheless, Hildebrand-Chupp rightly asserts that respecting "the struggles of people who detransition, who identify as detransitioners, and who

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Ariño, "Medical Detransition Following Transgender Identity Reaffirmation: Two Case Reports," *Sexual Health* (October 12, 2021), SH21089, https://www.publish.csiro.au/SH/justaccepted/SH21089; R. Hall, L. Mitchell, and J. Sachdeva, "Access to Care and Frequency of Detransition Among a Cohort Discharged by a UK National Adult Gender Identity Clinic: Restrospective Case-note Review," *BJPsych Open* 7/6 (2021), e184. doi:10.1192/bjo.2021.1022; Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine'"; Littman, "Survey of 100 Detransitioners"; Lisa Marchiano, "Gender Detransition: Ainnon Case Study," *Journal of Analytical Psychology* 66/4 (2021), 813-32; MacKinnon, et al., "Preventing Transition 'Regret,'"; M. Pazos Guerra, M. Gomez Balaguer, M. Gomes Porras, F. Hurtado Murillo, E. Solá Izquierdo, and C. Morillas Arino, "Transexualidad: Transiciones, detransiciones y arrepentimientos en España [Transsexuality: Transitions, Detransitions and Regrets in Spain]," *Endocrinología, Diabetes y Nutrición* 67/9 (2020), 562-67; M. Pazos Guerra, M. Gómez Balaguer, F. Hurtado Murillo, E. Solá Izquierdo, and C. Morillas Arino, "Reply to: 'Gender Detransition in Spain: Concept and Perspectives,'" *Endocrinologia, Diabetes y Nutricion* (May 21, 2021), DOI: 10.1016/j.endinu.2021.01.008 [online pub ahead of print]; Jack L. Turban, Stephanie S. Loo. Anthony N. Almazan, and Alex S. Keuroghlian, "Factors Leading to 'Detransition' Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis," *LGBT Health* 8/4 (2021), https://doi.org/10.1089/lgbt.2020.0437; Vandenbussche, "Detransition-Related Needs and Support" (originally published online ahead of print in 2021).
Several unpublished undergraduate and graduate studies on detransition also appeared during these two years. E.g., Pablo Expósito-Campos, "Destransición de género: Una historia de vida [Gender Detransition: A Life-story]," M.A. thesis (University of Granada, 2020); Faye Gear, "A Thematic Analysis of Detransitioners' Experience and Development." B. A. honors thesis (University of Western Ontario, 2021); Wilma Karlsson, "De-transition: En Netnografisk undersökningsstudie av unga kvinnors upplevelser kring sin De-transition [De-transition : A Netnographic study of young women's experiences of their De-transition]," B. A. thesis (Linnaeus University, 2021).

[284] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 803.

[285] Ibid., 813.

have negative transition experiences necessitates considering their experiences as real, distinct, and worthy of study in their own right."[286]

The terminological problems in the field of detransition research stem not only from its politicization. The sheer lack of significant research itself is a related factor. Pablo Expósito-Campos writes:

> [T]he 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 . . . . The absence of systematic research around detransition has given rise to inconsistencies in its conceptual use and application, adding to the unclarity and confusion.[287]

In this section, a number of terminological proposals related to detransition will be considered.

As Elie Vandenbussche has observed: "To date there has been little agreement on a definition of the word 'detransition.'"[288] Again, this fact is explained both by the political and polarizing nature of the question itself and the consequent lack of systematic study necessary for definitional consensus. Most briefly put, "detransition" refers to halting or, in some sense, reversing a prior gender transition and/or transgender identification. We find this type of definition offered in several of the recent studies:

- "Detransition is the act of stopping or reversing a gender transition."[289]
- "'Detransition' [is] a process through which a person discontinues some or all aspects of gender affirmation.[290]

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[286] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 813. Hildebrand-Chupp goes on propose a way forward for detransition research that may help to minimize some of the types of concern reflected in the study by Turban, et al. mentioned above. The proposal involves distinguishing between two different research goals: preventing detransition vs. supporting people who detransition. Hildebrand-Chupp (811-12) explains: "Research on preventing detrans will almost certainly be used to argue for restricting access to transition-related care or for other interventions designed to reduce the likelihood of detrans . . . . Research on supporting detrans could enable a variety of interventions designed to help detrans people . . . . To put it differently, research on preventing detrans constructs detrans as a matter of risk, whereas research on supporting detrans constructs detrans as a matter of inclusion." For a critical reflection on Hildebrand-Chupp's "supporting vs. preventing" typology from a practical clinical perspective, see Expósito-Campos, "Typology of Gender Detransition," 276.
[287] Expósito-Campos, "Typology of Gender Detransition," 270, 276-77.
[288] Vandenbussche, "Detransition-Related Needs and Support," 1602.
[289] Littman, "Survey of 100 Detransitioners," 3353.
[290] Turban, et al., "Factors Leading to 'Detransition,'" 273.

- "Detransition is . . . a descriptive verb that refers to the act of returning in some way to a pre-transition state."[291]
- Detransition "broadly describes people returning to live in their original gender role, following a process of transition."[292]
- "Detransitioning refers to a process whereby, after initiating gender transition, an individual discontinues, reverses, or re-directs the course of their transition."[293]
- "Detransition refers to a change in gender role and/or the cessation of medical transition (e.g., hormonal treatment)."[294]

But with a bit of probing, we quickly find that things are more complex than this. The range of reports from those who experience detransition require us to develop more terminological nuance. First, just as there are several different potential dimensions to gender transition, so detransition can reflect these various dimensions. *Medical detransition* involves the process of halting or reversing the medical aspects of one's transition – e.g., halting or changing hormone therapy, choosing to undergo reversal surgeries, etc. *Social detransition* involves the process of reversing or in some way changing the social aspects of one's transition, commonly to re-identify with one's natal/assigned sex – e.g., returning to one's pre-transition name and/or pronouns, gender presentation, etc. *Legal detransition* involves reversing or in some way changing the legal aspects of one's transition – e.g., reversing or changing one's sex/gender status on official governmental documents (driver's license, passport, etc.), typically to reflect a pre-transition status.

Second, as several researchers have proposed, there is an important distinction to be made between two different types of detransition. Hildebrand-Chupp's articulates these two types of detransition experience by making a distinction

> between detransition as act and detransition as identity; becoming a detransitioner involves a fundamental shift in one's subjective understanding of oneself, an

[291] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 802.
[292] Hall, et al., "Access to Care and Frequency of Detransition," 1.
[293] MacKinnon, et al., "Preventing Transition 'Regret,'" 2.
[294] S. K. Narayan, R. Hontscharuk, S. Danker, J. Guerriero, A. Carter, G. Blasdel, R. Bluebond-Langner, R. Ettner, A. Radix, L. Schechter, and J. U. Berli, "Guiding the Conversation – Types of Regret after Gender-Affirming Surgery and Their Associated Etiologies," *Annals of Translational Medicine* 9/7 (2021), 605, p. 9; https://doi.org/10.21037/atm-20-6204.

> understanding that is constructed within these communities. Knowing a person's medical history would give no insight into whether that person had detransitioned in this sense, because it refers to a specific way of making meaning out of the experience of detransition.[295]

Expósito-Campos's analysis reflects a similar fundamental distinction:

> The term "detransition" has been used to describe two types of situations. In the first, a person stops identifying as transgender 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.[296]

Expósito-Campos goes on to propose a typology to address this situation. He distinguishes two main types of detransitions: what he calls "core" or "primary" detransition as opposed to "non-core" or "secondary" detransitions.[297] He explains:

> 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 . . . .
>
> 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 . . . . 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.[298]

Because of this potentially equivocal use of the term detransition – and in light of the fact that the very term "detransition" has "been used controversially and disparagingly with regard to surgical transition" and, as used in this context, has often failed "to honor the spectrum of reasons why patients may undergo reversal surgery," some now argue that the term detransition

[295] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 802.
[296] Expósito-Campos, "Typology of Gender Detransition," 271.
[297] Ibid.
[298] Ibid., 272, 273.

"should not be used to describe the process of surgical reversal."[299] However, choosing to discontinue and/or reverse medical/surgical (and/or other forms of) transition is well within the semantic range of how the term "detransition" is used in most contexts today. The recent distinctions and typologies offered by Hildebrand-Chupp, Expósito-Campos, and others provide insights into how we can continue to use the term "detransition" and its cognates in careful and nuanced fashion without having to artificially limit its semantic range and utility.

For example, several scholars have proposed that we reserve the term "detransitioner" (or even "detransitioned woman/man") for those who understand their detransition experience in terms of "an identity and community who share this identity."[300] From this perspective, "becoming a detransitioner involves a fundamental shift in one's subjective understanding of oneself, an understanding that is constructed within these communities."[301] Vandenbussche helpfully elaborates:

> The term "detransitioner" . . . refer[s] to someone who possibly underwent some of these medical and/or social detransition steps and, more importantly, who identifies as a detransitioner. It is important to add this dimension, because the act of medical/social detransition can be performed by individuals who did not cease to identify as transgender and who do not identify as detransitioners or as members of the detrans community. Furthermore, some individuals might identify as detransitioners after having ceased to identify as trans, while not being in a position to medically or socially detransition due to medical or social concerns.[302]

One can see that this specified use of "detransitioner" correlates quite well with Expósito-Campos's concept of core/primary detransition. Following this recent pattern, in this study the term "detransitioner(s)" will be reserved individuals or communities who identify as such. The word/phrase "(people who) detransition" will be used for the wider category of people who – for whatever reason – choose to halt or reverse their gender transition.

Additional terminological proposals have been made recently – some more helpful than others. These include:

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[299] Narayan, et al., "Guiding the Conversation – Types of Regret after Gender-Affirming Surgery and Their Associated Etiologies," 9.
[300] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 802.
[301] Ibid.
[302] Vandenbussche, "Detransition-Related Needs and Support," 1603.

1. Detransition vs. Desistance

Although some scholars conflate the terms detransition and desistance as synonyms,[303] they are more commonly – and more helpfully – used to refer to distinctive phenomena. Expósito-Campos offers a proposal regarding this distinction:

> The difference between both concepts is twofold. First, desistance, as it has been described in the literature, involves the remission of GD . . . , 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.[304]

While Expósito-Campos' explanation is helpful generally speaking, his two criteria for an iron-clad distinction are not without exceptions. First, concerning his claim that detransition does not involve the "remission of GD": While this is often true, it is also the case that a number of people report that remission of GD is one of the motivating factors in their detransition (more on this below). Second, regarding his claim that "desistance occurs without there being a gender transition process": Again, while this is often the case, it is not always so. For example, children can experience a social transition at a relatively young age and then subsequently experience the desistance of their gender dysphoria. And so, while making a distinction between desistance and detransition is helpful, the criteria by which we demarcate these two phenomena are not always as clear and consistent as we might like.

2. Detransition vs. Reidentified

Hildebrand-Chupp clarifies:

> Some detransitioners draw a distinction between being 'detransitioned' and being 'reidentified'. The former can refer to someone who medically transitioned and then medically detransitioned, while the latter can refer to someone who may only have socially transitioned, or who only ever identified as transgender but did not change their name, pronouns, or presentation. As a result, sometimes the term 'detransitioned/ reidentified' is used to include both groups, but the term 'detransitioned' is also sometimes used as an umbrella term.[305]

[303] E.g., Kristina R. Olson, Lily Durwood, Rachel Horton, Natalie M. Gallagher, and Aaron Devor, "Gender Identity 5 Years After Social Transition," *Pediatrics* 150/2 (2022), e2021056082.
[304] Expósito-Campos, "Typology of Gender Detransition," 273.
[305] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 802.

In this study, "detransitioned/detransitioner" will be used in this second sense, i.e., as umbrella terms.

3. Detransition vs. Transition Regret

Although these two phenomena are commonly correlated in people's experience, they are conceptually – and sometimes experientially – distinct. Again, Expósito-Campos:

> [C]linicians 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 . . . . Detransition processes are as multiple and diverse as transition processes, so clinicians must avoid applying a homogeneous prism of interpretation.[306]

Ami Kaplan explains further by offering examples:

> Certainly a person who has made a gender transition can have certain regrets that are not extreme enough to cause them to wish to de-transition. The WPATH Standards of Care notes that "cases are known of persons who have received hormone therapy and sex reassignment surgery who later regretted their inability to parent genetically related children". Other less extreme regrets can involve loss of certain benefits or privileges commonly associated with one gender or another.[307]

Regarding "transition regret" itself, Hildebrand-Chupp has rightly pointed out that there is real ambiguity attached to this phrase and the phenomena behind it. To address this problem, Hildebrand-Chupp offers a helpful proposal that centers on the idea of *negative transition experience*:

> the broad term *negative transition experience* (NTE) [captures] a range of negative subjective evaluations of one's own transition or some aspect of it . . . . Though research on NTEs has often used narrower terms, like 'regret' and 'dissatisfaction', it seems likely that many NTEs do not fit within these concepts. For example, a number of detransitioners have described grief as a crucial aspect of their detransition experience . . . . NTEs can be associated with a variety of aspects of transition: physical, psychological, economic and social . . . . NTEs can shift over time, emerging, subsiding, or changing form. The decision to detransition is not defined by any particular subjective experience. Thus, no one concept, including 'regret', should be the *a priori* term used to describe transition. It is imperative for researchers to recognise that negative transition experiences are not synonymous with the act of detransition or with identifying as a detransitioner.[308]

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[306] Expósito-Campos, "Typology of Gender Detransition," 275.
[307] Ami B. Kaplan, "Posts from the 'post-transition' Category," *Transgender Mental Health*, https://tgmentalhealth.com/category/post-transition/.
[308] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 803 (emphasis added).

Going forward, this study will make use of Hildebrand-Chupp's concept of negative transition experience (NTE) as an umbrella category that contains sub-phenomena such a transition dissatisfaction, transition regret, etc.

4. Detransition vs. Retransition

Although some use the terms detransition and retransition as synonyms,[309] others use the term *retransition* to refer to "the act or process of transitioning again after having detransitioned at some previous point."[310] This will be the definition of retransition used in this study. There are a number of potential motivating factors for people who choose to retransition.[311] Making use of his typology of core/primary vs. non-core/secondary detransition, Expósito-Campos observes that for people who fall within the non-core/secondary category, detransition often has "a temporary character . . . , and the likelihood of future retransitioning may be higher, given that the underlying identitarian motivation to transition—be it socially or medically—remains."[312] One of the most high-profile retransitioners in recent years is Ky Schevers, who formerly wrote as a detransitioner under the pseudonym CrashChaosCats.[313]

5. "Detransition" recast as "Nonlinear Gender Exploration/Trajectory" reflective of "Dynamic Gender Identities"

More recently, reflecting concerns with the language and concept of detransition within certain sectors of the trans community, some gender affirmative scholars have expressed their hesitancy

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[309] E.g., Olson, et al., "Gender Identity 5 Years After Social Transition."
[310] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 802.
[311] For examples of retransition, see Lee Leveille, "I'm A Trans Person That Helped Found a 'Detransition Advocacy' Organization," *thatweirdolee.medium.com* (January 18, 2021), https://thatweirdolee.medium.com/im-a-trans-person-that-helped-found-a-detransition-advocacy-organization-57d18572be32; Mallory Moore, "Lee Leveille on backlash over retransitioning," *twitter* (January 1, 2022), https://twitter.com/Chican3ry/status/1477324895390515205; Helen Weathers, "Top London lawyer changed gender three times," *Daily Mail* (March 31, 2017), https://www.nzherald.co.nz/lifestyle/top-london-lawyer-changed-gender-three-times/WOEMFCEM7VKWBMPSLM4GVCIMZQ/.
[312] Expósito-Campos, "Typology of Gender Detransition," 273.
[313] See Schevers, "Detransition as Conversion Therapy"; Ky Schevers, "Risks/harms of ideological detransition/'alternative treatments for gender dysphoria," *Reclaiming Trans* (June 20, 2021), https://reclaimingtrans.wordpress.com/2021/06/20/risks-harms-of-ideological-detransition-alternative-treatments-for-gender-dysphoria/; idem, "Telling the Whole Story: A Closer Look at the Detrans Women in When Children Say They're Transgender." *Health Liberation Now* (April 3, 2021), https://healthliberationnow.com/2021/04/03/telling-the-whole-story-a-closer-look-at-the-detrans-women-in-when-children-say-theyre-transgender/. See also Urquhart, "An 'Ex-Detransitioner' Disavows the Anti-Trans Movement She Helped Spark."

with even using the term "detransition." For example, in a recent study, Jack Turban and colleagues write:

> [T]he term "detransition" has become less acceptable to TGD [transgender and gender diverse] communities, due to its incorrect implication that gender identity is contingent upon gender affirmation processes. In addition the term "detransition" has at times been conflated with regret, particularly with regard to medical and surgical affirmation, and the delegitimization of an individual's self-knowledge regarding their gender identity. It has subsequently become associated with politically motivated attempts to impede access to gender-affirming care for TGD people. Because this is the term most commonly used in the literature, and the term used in the 2015 U.S. Transgender Survey (USTS) that constitutes the basis of this study, we use the term "detransition" in this article, with the understanding that there is a need for more affirming terminology that has not yet been broadly adopted by TGD communities or in the literature.[314]

As can be seen in this quote itself – as well as the title of the article – their concern with the term *detransition* appears to be reflected in the use of scare quotes surrounding the word when it is used.[315]

In response to this concern with the term detransition, other language is being explored within some gender affirmative circles. One alternative approach in being explored by Jack Turban and colleagues. In a 2018 publication, Turban and Alex Keuroghlian use the phrase "dynamic gender presentations" to introduce their article on detransition.[316] They explain their concern for the dynamic nature of gender identity in the course of challenging the criterion commonly used by gender affirmative clinicians for determining whether a gender variant child is "truly transgender" or not – namely whether the child is "insistent, persistent, and consistent in their affirmation of a cross-gender identity."[317] Turban and Keuroghlian write:

> The term "insistent, persistent, and consistent" is sometime used to describe transgender youth, but gender identity is not always persistent or consistent. Failure to recognize the at-times dynamic nature of gender identity throughout a youth's life does a disservice to those whose evolving gender identity might eventually lead them away from their initial transition.[318]

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[314] Turban, et al., "Factors Leading to 'Detransition,'" 273-74.
[315] I.e., Turban, et al., "Factors Leading to 'Detransition' Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis."
[316] Turban and Keuroghlian, "Dynamic Gender Presentations: Understanding Transition and 'De-Transition' Among Transgender Youth."
[317] Hidalgo, et al., "Gender Affirmative Model," 286. See also K. R. Olson, "Prepubescent Transgender Children: What We Do and Do Not Know," *Journal of the American Academy of Child and Adolescent Psychiatry* 55/3 (2016), 155-56 (p. 155).
[318] Turban and Keuroghlian, "Dynamic Gender Presentations," 452.

Three years later, in October 2021, Jack Turban – along with Peter Daniolos – presented at a session of the 68th Annual Meeting of the American Academy of Child & Adolescent Psychiatry (AACAP) that was dedicated to the topics of transition regret and detransition. The title of their presentation was "Transgender Youth: Understanding 'Detransition,' Non-Linear Gender Trajectories, and Dynamic Gender Identities." In this presentation, they emphasized that

> [g]ender identity is not necessarily static, and for many adolescents, it may evolve over time. Child and adolescent psychiatrists must be aware of the sometimes-dynamic nature of gender identity so that they can support patients through *nonlinear gender trajectories*.[319]

As both this quotation and the title of their presentation demonstrate, Turban and Daniolos are here using the phrases "dynamic gender identities" and "non-linear gender trajectories" to unpack the idea behind the term "detransition." During this 2021 session of the AACAP, they were not alone in doing so. In the same session, Andrea Giedinghagen's presentation had as its stated objective: "to present the existing quantitative literature on the phenomenon of 'detransition,' or nonlinear gender exploration."[320] Similarly, Thwin Myint's presentation at this session used the language of "nonlinear gender trajectories" as a replacement for detransition.[321] And so, as of 2021, it appears that a sector of gender affirming scholarship is in the process of replacing the terminology of "detransition" with the alternative language of "non-linear gender exploration/trajectories" in association with the concept of "dynamic gender identities."

Given the specific concerns they express about the term "detransition," it seems likely that the rhetorical strategy behind this alternative language is to tap into the gender affirmative language game that portrays one's gender identity as the outcome of a benign "gender journey"[322] in

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[319] Turban and Daniolos. "Transgender Youth: Understanding 'Detransition,' Non-Linear Gender Trajectories, and Dynamic Gender Identities" (emphasis added).
[320] Giedinghagen, "Quantitative Perspectives on 'Detransition' and Transition Regret."
[321] Myint, "Nonlinear Gender Trajectories and Detransition Without Regret."
[322] E.g., Baer Karrington, "Defining Desistance: Exploring Desistance in Transgender and Gender Expressive Youth through Systematic Literature Review," *Transgender Health* (May 31, 2021), p. 22; https://doi.org/10.1089/trgh.2020.0129 [online pub prior to print]; Tristan Skye, *Transgender Journey: Real Stories From Around The World* (n.p.: TQ Productions, 2016); Virginia Ramey Mollenkott and Vanessa Sheridan, *Transgender Journeys*, reprint ed. (Eugene, OR: Resource/Wipf & Stock, 2010); Lei Ming, with Lura Frazey, *Life Beyond My Body: A Transgender Journey to Manhood in China* (Oakland, CA: Transgress Press, 2016).

which the person exercises and explores their own "gender creativity."[323] Trans activist Andrea James succinctly captures this perspective in the Welcome section of her website:

> A *gender transition* is just like a trip. You choose: where you want to go; how much time you will take; how much money you will spend. This map will help you choose your route. I want you to buy what is right for you. I also want to help you set goals you can make. Going full-time is your main goal.[324]

For many who embrace this paradigm, detransition is not something to regret, for it is simply one of many potential paths one can choose – each of which contributes to one's own personal "gender quest."[325] From many who hold this perspective, the "idea of de-transitioning is not helpful because even if somebody makes changes again it's a further change onwards, on a journey."[326]

This language game has been crafted over the years by leading gender affirmative clinicians and researchers, including Diane Ehrensaft and Johanna Olson-Kennedy. It has led some of them to speak with a remarkable nonchalance about children as young as 12-years-old undertaking cross-sex hormone therapy or trans identified minor-aged adolescents undergoing double mastectomies and genital/bottom surgery.[327] For example, when asked about this option at a 2018 Gender

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[323] Diane Ehrensaft, "From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy," *Journal of Homosexuality* 59/3 (2012), 337-56; idem, *The Gender Creative Child: Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes* (New York: The Experiment, 2016). For a critical perspective on this approach, see Susan Matthews, "Gender Guides and Workbooks: Understanding the Work of a New Disciplinary Genre," in *Inventing Transgender Children and Young People*, eds. Michele Moore and Heather Brunskell-Evans (Newcastle upon Tyne, UK: Cambridge Scholars, 2019), 218-36.

[324] Andea James, "Academic Exploitation of Sex and Gender Minorities," (2003; 2010), https://www.transgendermap.com/politics/academia/academic-exploitation/.

[325] Rylan J. Testa, Deborah Coolhart, and Jayme Peta, *The Gender Quest Workbook: A Guide for Teens and Young Adults Exploring Gender Identity* (Oakland: New Harbinger, 2015).

[326] Meg-John Barker, cited in "Keira Bell interview: Is Keira 'reconsidering her journey'?," *transgendertrend.com* (January 12, 2021), https://www.transgendertrend.com/keira-bell-interview-reconsidering-journey/.

[327] E.g., J. Olson-Kennedy, J., V. Okonta, L. F. Clark, and M. Belzer, "Physiologic Response to Gender-Affirming Hormones among Transgender Youth," *Journal of Adolescent Health* 62/4 (2018), 397-401; C. Milrod, "How Young it Too Young: Ethical Concerns in Genital Surgery of the Transgender MTF Adolescent," *Journal of Sexual Medicine* 11/2 (2014), 338-46. Related to this, see also S. Mahfouda, J. K. Moore, A. Siafarikas, T. Hewitt, U. Ganti, A. Lin, and F. D. Zepf, "Gender-affirming Hormones and Surgery in Transgender Children and Adolescents," *Lancet Diabetes & Endocrinology* 7/6 (2019), 484-98; A. P. Sansfacon, J. Temple-Newhook, F. Suerich-Gulick, S. Feder, M. L. Lawson, J. Ducharme, et al. on behalf of the Stories of Gender-Affirming Care Team, "The Experiences of Gender Diverse and Trans Children and Youth Considering and Initiating Medical Interventions in Canadian Gender-Affirming Specialty Clinics," *International Journal of Transgenderism* 20/4 (2019), 371-87.

This attitude of seeming nonchalance toward the possibility of future regret regarding significant medical procedures is not unique to the field of medical gender transition. In recent years, the appeal to patient autonomy has fostered a much more tolerant attitude toward potential future regret in medical decision-making. E.g., see P.

Spectrum conference, Olson-Kennedy's response included the following comment: "And here's the other thing about chest surgery, if you want breasts at a later point in your life, you can go and get them."[328]

As noted above, it is clear from first-person reports that there are people who detransition who do not experience regret over their original decision to transition. For such people, it may be that the concept of "nonlinear gender exploration" better reflects their self-understanding of their experience than does the term "detransition." However, it is also clear that there are self-identified detransitioners who experience deep regret about their transition. As we will see below, for this group of people, the idea that their transition was simply a generally benign leg of their overall gender journey does not capture the expressions of pain, anger, and regret associated with their gender transition.

B. Hearing the Voices of the Detransitioned in Detransition Research

Among the most important data-points for detransition research today is the range of experiences among those who have detransitioned. To this point in time, the primary ways of accessing the voices of the people who have detransitioned are through their own publicly available statements; through case studies by clinicians who work with detransitioned people; and through survey-based studies of people who have detransitioned. Data from the first two will be considered together, followed by consideration of six of the most important academic studies to date.

McQueen, "The Role of Regret in Medical Decision-making," *Ethical Theory and Moral Practice* 20 (2017), 1051-65. McQueen (p. 1051) argues that "the very reference to post-treatment regret during medical decision-making is inappropriate" in certain cases, particularly those cases "when the decision concerns a 'personally transformative treatment'" – i.e., "a treatment that alters a person's identity." In McQueen's assessment, "because the treatment is transformative, neither clinicians nor the patient him/herself can ascertain whether post-treatment regret will occur." Under this analysis, McQueen concludes: "Consequently, I suggest, what matters in determining whether to offer a personally transformative treatment is whether the patient has sufficiently good reasons for wanting the treatment at the time the decision is made. What does not matter is how the patient may subsequently be changed by undergoing the treatment."

[328] "Dr. Johanna Olson-Kennedy explains why mastectomies for healthy teen girls is no big deal," *YouTube* (November 5, 2018), https://youtu.be/5Y6espcXPJk.

1. Public Statements and Case Studies

Increasingly, people who detransition are willing to share their personal stories and perspectives publicly.[329] Unfortunately, fear of social retaliation from within certain sectors of the trans community and their allies have led some to share their experiences only from behind the protective anonymity of pseudonym or first-name only.[330] Given the lack of research data, personal anecdotal accounts like these are an important source of access to the voicing of various experiences of people who detransition, as well as their perspectives on the ways they have been treated less than charitably – and the reasons for this. On this issue, one detransitioner has suggested: "The reason the LGBTQ won't acknowledge detransitioners is because they present a conundrum that's damaging to the movement's revolutionary goals:

- if they never actually had gender dysphoria then we need to be intensely scrutinizing the standard for diagnosing gender dysphoria
- if they did have gender dysphoria, but then it went away, we need to question the ethics of prescribing permanent bodily changes for what could be a temporary condition."[331]

[329] E.g., Alia, "A TikToker's journey detransitioning," *Brut*, https://www.brut.media/us/news/a-tiktoker-s-journey-detransitioning-3e9b6d12-caf3-4188-9fd1-59480757931b; Hannah Barnes and Deborah Cohen, "How do I go back to the Debbie I was?," *BBC Newsnight* (November 26, 2019), https://www.bbc.com/news/health-50548473; Ryan Barnes [RivalMaverick], "DETRANSITION: My story, and what I wish I knew," *YouTube* (May 18, 2020), https://www.youtube.com/watch?v=rC7EtIeWrPs; Calvin Fox, "Why I Detransitioned," *YouTube* (March 20, 2019), https://www.youtube.com/watch?v=45IS0aRLGb0; Abel Garcia, "Why Did I Detransition (MtFtM)," *YouTube* (November 23, 2021), https://www.youtube.com/watch?v=jlvmbKyoCCE; Gender Care Consumer Advocacy Network (GCCAN), "Interview with A: On Detransition, Obsessive Thoughts, and 'Really Trans,'" *GCCAN* https://www.gccan.org/blog/interview-with-a-detransition-obsessive-thoughts-and-the-concept-of-really-trans; Hacsi Horváth, "The Theatre of the Body: A detransitioned epidemiologist examines suicidality, affirmation, and transgender identity," *4th Wave Now* (December 19, 2018), https://4thwavenow.com/tag/hacsi-horvath/; Elle Palmer, "Why I Transitioned and Detransitioned," *YouTube* (January 8, 2020), https://www.youtube.com/watch?v=n0pVuZ0CT7Q; Patrick, "Detransition was a Beautiful Process," in Moore and Brunskell-Evans, eds., *Inventing Transgender Children and Young People*, 175-79; Linda Pressly and Lucy Proctor, "Ellie and Nele: From she to he – and back to she again," *BBC World Service, Germany*. (March 10, 2020), https://www.bbc.com/news/stories-51806011; M. Rei, "My detransition: How it happened," *YouTube* (February 7, 2018), https://youtu.be/JUoY15ceUp4; Renee Sullivan, "A Different Stripe: For eight years, Renee Sullivan identified as transgender. Then it got more complicated," *psychologytoday.com* (March 7, 2018), https://www.psychologytoday.com/us/articles/201803/different-stripe?amp; Twitter.com/ftmdetransed and twitter.com/radfemjourney, "Our Voices Our Selves: Amplifying the Voices of Detransitioned Women," in Moore and Heather Brunskell-Evans, eds., *Inventing Transgender Children and Young People*, 167-74.

[330] E.g., GCCAN, "Interview with A"; Patrick, "Detransition was a Beautiful Process."

[331] Restingmyfeet, *Instagram*, https://www.instagram.com/p/CTmxyu6rrgb.

The focus of the following consideration of detransition experiences, as expressed through people's own public statements or clinicians' case studies, is on the range of answers given to the question: *Why did you choose to detransition?*

A common theme found within public statements of detransition relates to the issue of what motivating factors led to the decision to detransition. One has only to search YouTube for "Why I detransitioned" to receive a wide range of video responses to this question.[332] Reasons leading people to detransition can be roughly divided into two categories – *external reasons* and *internal reasons*. *External reasons* involve motivating factors that arise from outside of the person (e.g., social pressures). *Internal reasons* involve motivating factors that arise from within the person themselves (e.g., dissatisfaction with the results of transition). Researchers have noted that, in some cases, "internal factors can be the result of external factors (e.g., self-doubt regarding one's gender identity in response to being persistently misgendered or rejected)."[333]

As one explores detransition statements in various venues, along with clinician case studies and personal reflections on clients who detransition, a number of external reasons for detransition emerge. These include:

- Physical safety – i.e., choosing to detransition as a way of avoiding the threat of aggression and violence that can come with living as a transgender person.[334]
- Social stigma and discrimination – i.e., experiencing rejection and/or discrimination from others because of one's trans identity.[335]
- Social pressure from various sources – i.e., experiencing pressure to detransition from family members, spouse/partner, friends, employers, or other people.[336]

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[332] E.g., Fox, "Why I Detransitioned"; Palmer, "Why I Transitioned and Detransitioned"; Garcia, "Why Did I Detransition (MtFtM)."
[333] Turban, et al., "Factors Leading to 'Detransition,'" 274.
[334] E.g., Devin Pinkston, "Why do people consider de-transitioning? 3 Reasons Why," *YouTube* (December 5, 2017), https://www.youtube.com/watch?v=SZ0-6TC05NE&feature=youtu.be; Sam Riedel, "The Trans People Who Are Detransitioning To Stay Safe In Trump's America," *Medium* (November 20, 2016), https://medium.com/the-establishment/the-trans-people-who-are-detransitioning-to-stay-safe-in-trumps-america-a1486e50a547.
[335] E.g., Ella Braidwood, with Kate Hutchinson, "I detransitioned because of transphobia, but I always knew I am a woman. Now I'm living as my authentic self," *inews* (May 1, 2019), https://inews.co.uk/opinion/comment/i-detransitioned-because-of-discrimination-but-i-always-knew-i-am-a-woman-now-im-living-as-my-authentic-self-286290; Riedel, "Trans People Who Are Detransitioning."
[336] E.g., Robyn Kanner, "I Detransitioned, But Not Because I Wasn't Trans," *The Atlantic* (June 22, 2018), https://www.theatlantic.com/family/archive/2018/06/i-detransitioned-but-not-because-i-+wasnt-trans/563396/;

- Deference to a romantic partner.[337]
- Financial and/or employment challenges – i.e., experiencing difficulty in meeting the financial demands associated with transition (e.g., cross-sex hormones, surgeries, etc.); and/or difficulty holding a job due to stigma associated with a transgender identity.[338]

Similar sources also reveal a number of internal reasons that motivate people toward detransition. These include:

- Dissatisfaction and/or unfulfilled expectations regarding medical transition outcomes – e.g., the inability to socially pass as one's experienced gender (especially for transwomen).[339]
- Medical concerns/complications associated with transition.[340]
- Stress and/or anxiety experienced with the transition process itself.[341]
- Recognition that their GD and/or desire to transition were influenced by mental health conditions and/or personal trauma (e.g., sexual trauma).[342]
- Recognition that their GD and/or desire to transition were influenced by homophobia and/or personal difficulty accepting themselves as lesbian/gay.[343]

Fathima Begum Syed Mohideen, Hizlinda Tohid, Mohd Radzniwan Rashid, Sharifah Najwa Syed Mohamad, Khadijah Hasanah Abang Abdullah, and Hatta Sidi. "Gender Dysphoria and De-Transition to the Biological Gender: A Case 1 Report from a Primary Care Perspective." *Frontiers in Medical Case Reports* 2/3 (2021), 1-6; Devin Pinkston, "De-Transitioning. Why Does it Happen Part 2," *YouTube* (December 17, 2017), https://www.youtube.com/watch?v=ZyLY8IVq88c.

[337] E.g., S. B. Levine and L. Davis, "What I Did for Love: Temporary Returns to the Male Gender Role," *International Journal of Transgenderism* 6/4 (2002).

[338] E.g., Pinkston, "De-Transitioning. Why Does it Happen Part 2."

[339] E.g., GCCAN, "Interview with A"; Pinkston, "Why do people consider de-transitioning? 3 Reasons Why."

[340] E.g., "Portrait of a Detransitioner as a Young Woman"; FrankOmg, "WHY I Transitioned / Detransitioned !!," (December 23, 2016), https://www.youtube.com/watch?v=v4IR2dGhiXM; Horváth, "Theatre of the Body."

[341] E.g., Pinkston, "Why do people consider de-transitioning? 3 Reasons Why."

[342] E.g., Callahan, "Unheard Voices of Detransitioners"; Fox, "Why I Detransitioned";
Sira Korpaisarn and Katherine Modzelewski, "Trans-transgender Female: Gender Identity Reversal Following Irreversible Gender Affirming Surgeries," *Journal of the Endocrine Society* 3/Supp 1 (April-May 2019), MON–195, https://doi.org/10.1210/js.2019-MON-195; Levine, "Transitioning Back to Maleness"; I. R. Marks and D. Mataix-Cols, "Four-year Remission of Transsexualism after Comorbid Obsessive-Compulsive Disorder Improved with Self-Exposure Therapy. Case Report," *British Journal of Psychiatry* 171 (1997), 389-90; Palmer, "Why I Transitioned and Detransitioned"; Sira Korpaisarn and Katherine Modzelewski, "Trans-transgender Female: Gender Identity Reversal Following Irreversible Gender Affirming Surgeries," *Journal of the Endocrine Society* 3/Supp. 1 (2019), MON–195, https://doi.org/10.1210/js.2019-MON-195; Stella, "Why I detransitioned and what I want medical providers to know (USPATH 2017)"; Twitter.com/ftmdetransed and twitter.com/radfemjourney, "Our Voices Our Selves: Amplifying the Voices of Detransitioned Women"; Herzog, "The Detransitioners."

[343] E.g., Callahan, "Unheard Voices of Detransitioners"; Fox, "Why I Detransitioned"; FrankOmg, "WHY I Transitioned / Detransitioned !!"; GNC Centric and Thomasin, "Internalised Homophobia is More Powerful than

- Recognition that their GD and/or transition were rooted in misogyny.[344]
- Recognition that their original trans identification and/or desire to transition were heavily influenced by social media, online communities, peers, etc.[345]
- Questioning one's trans identity after an experience with a romantic partner.[346]
- Religious convictions.[347]
- Desire to become a parent.[348]

A great deal of insight into the variety of detransition experiences are available in these sources. Another important source of insight into detransition is survey-based studies – to which we now turn.

2. Survey-Based Studies Related to Detransition

As noted above, there is little in the way of a reliable database on which to base academic research on detransition. However, among the recent studies, several surveys of people who have

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you Know," (2019), https://www.youtube.com/watch?v=k6Xe2P9c5x0; Pique Resilience Project, "DETRANSITION Q&A (#1)," *YouTube* (February 1, 2019), https://www.youtube.com/watch?v=kxVmSGTgNxI; upperhandMARS, "Desist to exist as Chiara," *YouTube* (2020), https://www.youtube.com/watch?v=rLfTrTRnIRk. See also Dawn DeLay, Carol Lynn Martin, Rachel E. Cook, and Laura D. Hanish, "The Influence of Peers During Adolescence: Does Homophobic Name Calling by Peers Change Gender Identity?," *Journal of Youth and Adolescence* 47/3 (2018), 636-49.

[344] E.g., Robinson, *Detransition*.

[345] E.g., Alia, "A TikToker's journey detransitioning"; FrankOmg, "WHY I Transitioned / Detransitioned !!"; GCCAN, "Interview with A"; Helena Kerschner, "Helena: A Detransition Story," *Unsafe Space podcast* (May 5, 2021), https://www.podchaser.com/podcasts/unsafe-space-4317/episodes/episode-0562-deprogrammed-hele-90823127; Palmer, "Why I Transitioned and Detransitioned"; Pique Resilience Project, https://www.piqueresproject.com/; upperhandMARS, "Desist to exist as Chiara."

[346] E.g., Stephen B. Levine, "Transitioning Back to Maleness," *Archives of Sexual Behavior* 47/4 (2018), 1295-1300; M. Pazos-Guerra, M. Gomez Balaguer, M. Gomes Porras, F. Hurtado Murillo, E. Solá Izquierdo, and C. Morillas Arino, "Transexualidad: Transiciones, detransiciones y arrepentimientos en España [Transsexuality: Transitions, Detransitions and Regrets in Spain]." *Endocrinología, Diabetes y Nutrición* 67/9 (2020), 562-67; Waffling Willow, "FtM Detransition: Why I Detransitioned (Revised Version) + Rant," *YouTube* (August 5, 2020), https://www.youtube.com/watch?v=T1FbX04o4nQ.

[347] E.g., David H. Barlow, Gene G. Abel, and Edward B. Blanchard, "Gender Identity Change in a Transsexual: An Exorcism," *Archives of Sexual Behavior* 6/5 (1977), 387-95; S. Draman, S. Maliya, M. Syaffiq, Z. Hamizah, A. Abdul Hakim, M. R. Razman, "Mak Nyahs and Sex Reassignment Surgery – A Qualitative Study from Pahang, Malaysia," *IIUM Medical Journal Malaysia* 18/1 (2019), https://doi.org/10.31436/imjm.v18i1.223; Laura Perry, *Transgender to Transformed: A Story of Transition That Will Truly Set You Free* (Bartlesville, OK: Genesis, 2019); Walt Heyer, *A Transgender's Faith*; idem, *Trans Life Survivors* (n.p.: Bowker Identifier Services, 2018).

[348] Lara Americo, "I'm a Transwoman Who Detransitioned to Become a Mom: I'd do whatever it takes to have a child with the love of my life," *Them* (May 13, 2018), https://www.them.us/story/im-a-trans-woman-who-detransitioned-to-become-a-mom; Blair White, "I'm detransitioning," *YouTube* (November 21, 2018), https://youtu.be/FZnAsk5vWzE.

detransitioned have either been accessed or conducted. Six of the most important of these survey-based studies will now be described and their key results summarized. As mentioned previously, the first two notable surveys of detransitioners were informal in nature and conducted by two people from within the detrans community itself.

a. Cari Stella, "Female detransition and reidentification: Survey results and interpretation" (2016).[349]

Participants and Parameters

This first survey, coordinated by Cari Stella, was conducted in August 2016. The survey itself included both multiple choice and open-ended questions allowing for individual written responses. Participants included 203 detransitioned females recruited from social media sites including Tumblr, private detransitioner Facebook groups, and the Wordpress blog 4thWaveNow. The survey report states that it was "created for anyone female/AFAB [assigned female at birth] who formerly self-described as transgender. This includes women who transitioned, whether socially and/or medically, and subsequently detransitioned, as well as individuals who still identify as nonbinary or genderfluid, but have desisted from medical or social transition."[350] It goes on to note that "the majority of respondents identified their gender as female. This is significant because it means that the volume of responses is not due to individuals who are still trans-identified but have stopped medical transition."[351] The average length of time from transition to detransition was four years, although several people reported detransitioning ten years or more after their transition. The average age of "com[ing] out as trans and/or start[ing] transitioning"' was 17, and the average age at which participants decided to "stop" was 21.

Survey Results

[349] Cari Stella, "Female Detransition and Reidentification: Survey Results and Interpretation" [Post], *Tumblr* (September 3, 2016), https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey.
[350] Ibid.
[351] Ibid.

The survey queried participants on the nature of their GD by distinguishing "physical sex dysphoria" (i.e., a desire to have male sex characteristics, or remove female ones) and "social dysphoria" (i.e., a desire to be seen and treated by others as a different sex/gender).[352] In response, 12% of participants reported experiencing only social dysphoria, 14% experienced only physical sex dysphoria, and 74% experienced both. The survey report notes that "117 of the participants had medically transitioned. Of these, only 41 received therapy beforehand," which means that "*65%* of these women had no therapy at all before transition."[353] The survey found that "[o]nly 12 respondents identified that they felt they were given adequate counseling and information about transitioning."[354]

In response to the question: "What led you to stop your transition?," respondents were provided with 14 options and were instructed to check all that applied. The two most frequently selected options – and the only two that received over 50% representation – were "Political/ideological concerns" (63%) and "Found alternative ways to cope with dysphoria" (59%). The next five most representative responses were: "Mental health concerns – not hormone related" (30.7%); "Resolved mental health issues which led to dysphoria" (28.7%); "Medical concerns" (26.7%); "Dissatisfied with outcomes of transition – dysphoria not resolved, transition did not/would not change enough" (26.2%); and "Dysphoria resolved itself over time" (22.8%).[355]

Stella goes on to add this observation:

> The three most commonly cited reasons for detransition among trans activists – financial concerns, lack of social support, and institutional discrimination were among the lowest, at 18%, 17%, and 7% – in fact, institutional discrimination was the lowest scoring category.[356]

When asked: "How has stopping transition impacted your dysphoria?," 11% reported their dysphoria was "completely gone," 64.5% said it was "better than transition," 17% that it was the

[352] Ibid.
[353] Ibid. (emphasis in text).
[354] Ibid.
[355] Ibid.
[356] Ibid. This observation should be compared with the sharply contrasting findings of Turban, et al., "Factors Leading to 'Detransition,'" whose study was based on a survey of currently transgender identified people rather than identified detransitioners. For more on Turban, et al., see below.

"same as transition," and 7.5% that it was "worse than transition."[357] Finally, 60% of participants reported "negative" feelings toward their former transition, 23% had "mixed feelings or were not sure," 9% had "neutral" feelings, and 8% had "positive" feelings.[358]

Survey limitations include the fact that it only surveyed female/AFAB detransitioners, and its failure to ascertain the percentages of participants who identify with the detrans sub-categories of "detransitioner" vs. "reidentified."

b. Hailey [Mangelsdorf], "Survey of co-morbid mental health in detransitioned females: Analysis and results" (2017).[359]

Participants and Parameters

This second survey, coordinated by Hailey Mangelsdorf and conducted from November 2 until December 1, 2016, was released in 2017. It involved the self-reports of 211 detransitioned females – defined as "any natal females who had in some way desisted from transition or trans identity" – recruited through social media outlets. The survey focused primarily on detransitioners' co-morbid mental health conditions.

Survey Results

Unfortunately, the results of this survey are no longer publicly available online. However, a couple of researchers have reported on some of its findings. Hildebrand-Chupp writes:

> Hailey states that 22% had taken testosterone or hormone blockers, and 8% had undergone surgery. She asked participants what mental illnesses they had been diagnosed with, if any, following up with an open-ended question: 'Do you feel that any of the

[357] Ibid.
[358] Ibid.
[359] Hailey [Mangelsdorf], "Survey of co-morbid mental health in detransitioned females: Analysis and results," *Re-sister* (2017), https://desisterresister.wordpress.com/2017/01/11/survey-of-co-morbid-mental-health-in-detransitioned-females-analysis-and-results/. In 2017, Mangelsdorf also conducted an online survey of 359 non-transitioned females who experience gender dysphoria, which inquired about management strategies they use to ease their dysphoria. See Hailey Mangelsdorf, "Female/AFAB Dysphoria Management Survey – Analysis and Results" (2017), https://docs.google.com/document/d/1nc5X96PwzyfIfpvKi8RQR5t9AQe9SVl76aWZL30rVLY/edit. Incidentally, in 2017 Mangelsdorf also conducted an informal, online survey of 359 non-transitioned females who experience gender dysphoria, which inquired about management strategies they use to ease their dysphoria. See Hailey Mangelsdorf, "Female/AFAB Dysphoria Management Survey – Analysis and Results" (2017), https://docs.google.com/document/d/1nc5X96PwzyfIfpvKi8RQR5t9AQe9SVl76aWZL30rVLY/edit.

> conditions listed above contributed to your trans identification and/or transition? If so, how?' She reports that a number of participants did draw connections between their gender dysphoria and their experiences with a range of mental health conditions and provides examples from the open-ended responses for each condition.[360]

Vandenbussche notes that Hailey also reported a 15% rate of autism spectrum condition among the participants.[361]

c. Elie Vandenbussche, "Detransition-Related Needs and Support: A Cross-Sectional Online Survey" (2021/2022).[362]

Participants and Parameters

In this third study, Elie Vandenbussche conducted a cross-sectional survey in November and December 2019. The survey included multiple choice and open-ended (write-in) questions. Detransitioners of any age or nationality were invited to take part in the study. Participants were recruited through Post Trans (www.post-trans.com), a platform for female detransitioners, and social media outlets including Facebook, Instagram, Twitter, and a Reddit forum for those who have detransitioned (r/detrans). The stated purpose of this exploratory study was "to offer an overview of the current needs of detransitioners from online detrans communities, which will hopefully serve as a useful basis for further experimental studies around the topic of detransition."[363]

The final sample of participants included 237 people – 217 females (92%) and 20 males (8%), determined by responses to the question: "What sex were you assigned at birth?" The ages of the participants ranged from 13 to 64, with the average age being 25 years. The mean age of females (24.38) was lower than that of males (31.95). Participants came from a range of regions and countries, including the U.S. (51%), Europe (32%), Canada (6%), Australia (5%), and one person from each of the following countries: Brazil, Kazakhstan, Mexico, Russia and South Africa.

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[360] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 808.
[361] Vandenbussche, "Detransition-Related Needs and Support," 1614.
[362] Elie Vandenbussche, "Detransition-Related Needs and Support: A Cross-Sectional Online Survey," *Journal of Homosexuality* 69/9 (2022), 1602-20. This study was originally published online ahead of print in 2021.
[363] Ibid., 1603.

Among the participants, 65% had transitioned both socially and medically, while 31% had only transitioned socially. The average age of participants' social transition was 18 years (17.42 for females; 23.63 for males), and the average age for medical transition was 20.70 years (20.09 for females; 26.19 for males). Of the male detransitioners, 80% underwent hormone therapy, compared to 62% of the females. Of those who medically transitioned, 46% underwent gender affirming surgeries.

The average age of detransition was 22.88 years (22.22 for females; 30 for males), although 14% detransitioned before turning 18. The average length of the transition period (both social and medical) was 4.71 years (4.55 for females; 6.37 for males).[364]

Survey Results

In terms of participant experiences of GD, a significant majority of the sample (84%) reported having experienced both body and social dysphoria, with 8% experiencing only body dysphoria, 6% only social dysphoria, and 2% neither of them. When asked about the quality of the information they received regarding health implications of the transition protocols they were considering, 45% reported not feeling properly informed, 33% said they felt partly informed, 18% felt well informed, and 5% were uncertain.[365]

In response to the question of why they chose to detransition, the most common answer (70%) given was "realized that my gender dysphoria was related to other issues."[366] The next most common set of responses were "health concerns" (62%), "transition did not help my dysphoria" (50%), "found alternatives to deal with my dysphoria" (45%), "unhappy with the social changes" (44%), and "change in political views" (43%). The least common responses were "lack of support from social surroundings" (13%), "financial concerns" (12%) and "discrimination" (10%). Fourteen percent of the respondents added various other reasons, including

> absence or desistance of gender dysphoria, fear of surgery, mental health concerns related to treatment, shift in gender identity, lack of medical support, dangerosity of being trans,

[364] Ibid., 1605.
[365] Ibid., 1606.
[366] Ibid.

> acceptance of homosexuality and gender non-conformity, realization of being pressured to transition by social surroundings, fear of surgery complications, worsening of gender dysphoria, discovery of radical feminism, changes in religious beliefs, need to reassess one's decision to transition, and realization of the impossibility of changing sex.[367]

As mentioned above, the primary purpose of Vandenbussche's study was to determine the current needs of detransitioners as expressed within online detrans communities. The survey divided potential areas of need into medical, psychological, legal and social needs. The findings under each category will now be summarized.

Medical Needs – Vandenbussche reports that the most commonly chosen answer under this category was

> the need for receiving accurate information on stopping/changing hormonal treatment (49%), followed by receiving help for complications related to surgeries or hormonal treatment (24%) and receiving information and access to reversal surgeries/procedures (15%).[368]

Psychological Needs – Vandenbussche reports that "[p]sychological needs appeared to be the most prevalent of all, with only 4% of the respondents reporting not having any."[369] Answers with the highest representation – each above 50% – were: (1) "working on comorbid mental issues related to gender dysphoria and learning to cope with gender dysphoria" (65%); (2) "finding alternatives to medical transition" (65%); "learning to cope with feelings of regret" (60%); (4) "learning to cope with the new physical and/or social changes related to detransitioning" (53%); and (5) "learning to cope with internalized homophobia" (52%). Fourteen percent of the participants added additional (non-listed) answers, including

> trauma therapy, learning how to deal with shame and internalized misogyny, how to cope with rejection from the LGBT and trans communities and how to deal with the aftermath of leaving a manipulative group. Other answers disclosed the need for help recovering from addictive sexual behavior related to gender dysphoria, psychosexual counseling and peer support.[370]

[367] Ibid., 1606-07.
[368] Ibid., 1607.
[369] Ibid., 1608.
[370] Ibid.

A number of respondents reported on the "difficulty of finding a therapist willing and able to look at the factors behind gender dysphoria and to offer alternatives to transitioning."[371]

Legal Needs – Regarding detransition-related legal needs, 55% of the participants reported not having any. The main legal need – expressed by 40% of the respondents – was "changing back legal gender/sex marker and/or name", followed by "legal advice and support to take legal action over medical malpractice" (13%). Five participants (2%) added another answer, such as "employment legal aid and support to take legal action for having been forced to go through a sterilization."[372]

Social Needs – Vandenbussche found that a significant "majority of the respondents reported a need for hearing about other detransition stories" (87%). This response was followed by: "getting in contact with other detransitioners" (76%); and "receiving support to come out and deal with negative reactions" (57%). Fourteen percent of the participants added another response, including "being accepted as female while looking male, help navigating social changes at the workplace, building a new social network, more representation of butch lesbians, real life support and finding a community."[373]

In the "Discussion" section of the study, Vandenbussche writes:

> Detransitioners need platforms and spaces where they can connect with each other and build a community. This point is best illustrated by the following account of one participant: "I found the peer support I received through other detransitioned women to be totally adequate and feel I benefited substantially from learning how to exist without institutional validation."[374]

Vandenbussche also notes that

> [a]round half of the respondents (51%) reported having the feeling of not having been supported enough throughout their detransition, 31% said they did not know and 18% answered that they had received enough support.[375]

[371] Ibid., 1611.
[372] Ibid., 1608.
[373] Ibid.
[374] Ibid., 1615.
[375] Ibid., 1609.

In response to the question of where participants found support, either while transitioning or detransitioning, answers ranged from "online groups/forums/social media" (65% for both transition and detransition); and "friends, partner(s) and family" (64% for detransition; 56% for transition). Only 8% said they "received help from an LGBT+ organization while detransitioning, compared to 35% while transitioning."[376] Notably, only

> 29% reported having received support for their detransition "from the medical professionals that helped them during their transition. In contrast, 38% sought support from a new therapist/doctor. A part of the sample reported not receiving help from anybody for transitioning (8%) and for detransitioning (11%).[377]

This finding is important to consider in light of the fact that *many studies on negative transition experiences (i.e., transition regret, dissatisfaction and/or detransition) rely upon follow-up reports from the medical professionals who assisted with the transition*. We will return to this issue below.

This survey included a qualitative section in which participants could respond to two open-ended questions: "The first one enabled the respondents to write about any additional need that they encountered while detransitioning, while the second asked about the support—or lack of— that they had received."[378] Vandenbussche reports on participant responses:

> Several respondents expressed the need for different types of therapy and counseling for dealing with issues of dissociation, childhood sexual trauma, anorexia, relationship issues and body issues caused by irreversible gender affirming surgeries. A participant also mentioned the importance of help revolving around suicide prevention for those who need it . . . . Others wrote about the need for more information about detransition and a better general understanding of this phenomenon.[379]

Additional responses included:

> the need for therapists to validate the feelings of being harmed by transition that some detransitioners experience, rather than dismissing or opposing them . . . ; the need for non-judgmental medical practitioners . . . ; the need for as much medical autonomy as possible and a total freedom from psychology and psychiatry . . . ; and the need to look into individual experiences and needs without forcing them into a rigid model of transition.[380]

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[376] Ibid., 1608.
[377] Ibid., 1609.
[378] Ibid.
[379] Ibid.
[380] Ibid.

Vandenbussche also found that a

> recurrent theme in the answers was a sense amongst respondents that it was very difficult to talk about detransition within LGBT+ spaces and with trans friends. Many expressed a feeling of rejection and loss of support in relation to their decision to detransition, which lead them to step away from LGBT+ groups and communities.[381]

Vandenbussche concludes her study with the following observations:

> Unfortunately, the support that detransitioners are receiving in order to fulfill these needs appears to be very poor at the moment. Participants described strong difficulties with medical and mental health systems, as well as experiences of outright rejection from the LGBT+ community. Many respondents have expressed the wish to find alternative treatments to deal with their gender dysphoria but reported that it was impossible to talk about it within LGBT+ spaces and in the medical sphere.
>
> These accounts are concerning and they show the urgency to increase awareness and reduce hostility around the topic of detransition among healthcare providers and members of the LGBT+ community in order to address the specific needs of detransitioners.[382]

d. Lisa Littman, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: Survey of 100 Detransitioners" (2021).[383]

Participants and Parameters

This study is based upon a survey that was conducted between December 15, 2016 and April 30, 2017. Recruitment information was posted on various online platforms, including Tumblr, Twitter, Reddit, a private online detransition forum, a closed detransition Facebook group, the professional listservs for the WPATH, the American Psychological Association Section 44, and the SEXNET listserv (i.e., a listserv of sex researchers and clinicians). Littman notes that

> [e]fforts were made to reach out to communities with varied views about the use of medical and surgical transition and recruitment information stated that participation was sought from individuals regardless of whether their transition experiences were positive, negative or neutral.[384]

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[381] Ibid., 1611.
[382] Ibid., 1615-16.
[383] Lisa Littman, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners," *Archives of Sexual Behavior* 50/8 (2021), 3353-69.
[384] Ibid., 3355.

The final participant pool included 100 people surveyed (69 natal females and 31 natal males). The mean age of participants at time of survey was 29.2 years, with natal females (mean age 25.8) being significantly younger than natal males (mean age 36.7). Littman notes that, prior to transitioning, "natal females were more likely to report an exclusively homosexual sexual orientation and natal males were more likely to report an exclusively heterosexual sexual orientation."[385]

Survey Results

Participants reported on their pre-transition mental health diagnoses and traumatic experiences. Results included: depression (natal females 39.1%; natal males 16.1%); anxiety (natal females 31.9%; natal males 16.1%); PTSD (natal females 14.5%; natal males 3.2%); ASC (natal females 13%; natal males 3.2%); bipolar disorder (natal females 13%; natal males 0%); obsessive compulsive disorder (natal females 8.7%; natal males 9.7%); borderline personality disorder (natal females 7.2%; natal males 0%); non-suicidal self-injury prior to onset of GD (natal females 27.5%; natal males 16.1%); experienced a trauma less than one year before the onset of GD (natal females 47.8%; natal males 12.9%).[386] Littman comments: "Because these conditions and events occurred before participants began to feel gender dysphoric, they cannot be considered to be secondary to gender incongruence or transphobia."[387]

Regarding onset of GD: The mean age of GD onset was 11.3 for natal females and 11 for natal males. Among the participants, 56% experienced early-onset of GD and 44% late-onset. Littman notes that "[a]lthough late-onset gender dysphoria in natal females was largely absent from the scientific literature prior to 2012 . . . 55.1% of the natal female participants reported that their gender dysphoria began with puberty or later."[388]

In response to the question of why they chose to transition, the most frequently endorsed responses were: "wanting to be perceived as the target gender" (77.0%); "believing that

[385] Ibid.
[386] Ibid., 3359, Table 2.
[387] Ibid., 3358.
[388] Ibid.

transitioning was their only option to feel better" (71.0%); "the sensation that their body felt wrong the way it was" (71.0%); and "not wanting to be associated with their natal sex" (70.0%). In addition, most participants "believed that transitioning would eliminate (65.0%) or decrease (63.0%) their gender dysphoria and that with transitioning they would become their true selves (64.0%)."[389] Over one-third of the participants (37.4%) experienced some sort of pressure to transition, with "[c]linicians, partners, friends, and society" being named as sources of this pressure.[390] Regarding their pre-transition experiences with clinicians:

> The majority (56.7%) of participants felt that the evaluation they received by a doctor or mental health professional prior to transition was not adequate and 65.3% reported that their clinicians did not evaluate whether their desire to transition was secondary to trauma or a mental health condition.[391]

Regarding participants' transition:

> Most respondents adopted new pronouns (91.0%) and names (88.0%), and the vast majority (97.1%) of natal females wore a binder. Most participants took cross-sex hormones (96.0%) and most natal males took anti-androgens (87.1%). The most frequent transition surgery was breast or chest surgery for natal females (33.3%). Genital surgery was less common (1.4% of natal females and 16.1% of natal males). Natal females took testosterone for a mean duration of 2.0 years (SD=1.6). Natal males took estrogen for a mean duration of 5.1 years (SD=5.9) and anti-androgens for 2.8 years (SD=2.6).[392]

Regarding the length of their transition period, participants reported a mean duration of 3.9 years (natal females 3.2 years; natal males 5.4 years).

Regarding their detransition: Participants reported deciding to detransition at a mean age of 26.4 years old (natal females 23.6 years; natal males 32.7 years). In response to the question of their reasons for detransitioning, 87% selected more than one reason. The most frequently chosen reason for detransition was "My personal definition of female or male changed and I became more comfortable identifying as my natal sex" (natal females 65%; natal males 48.4%). Other commonly chosen reasons included: "I was concerned about potential medical complications from transitioning" (natal females 58%; natal males 29%); "My mental health did not improve while transitioning (natal females 44.9%; natal males 35.5%); "I was dissatisfied by

[389] Ibid.
[390] Ibid., 3360.
[391] Ibid.
[392] Ibid.

the physical results of the transition/felt the change was too much" (natal females 50.7%; natal males 16.1%); "I discovered that my gender dysphoria was caused by something specific (ex, trauma, abuse, mental health condition)" (natal females 40.6%; natal males 32.3%); "My mental health was worse while transitioning" (natal females 39.1%; natal males 29%); "I was dissatisfied by the physical results of the transition/felt the change was not enough" (natal females 31.9%; natal males 35.5%); "I found more effective ways to help my gender dysphoria" (natal females 36.2%; natal males 22.6%); and "My physical health was worse while transitioning" (natal females 30,4%; natal males 35.5%).[393]

Littman notes that "[e]xternal pressures to detransition such as experiencing discrimination (23.2%) or worrying about paying for treatments (17.0%) were less common."[394]

Participants were queried about sources that offered encouragement and support for detransition. Primary sources of encouragement were blogs (37%), Tumblr (35%), and YouTube detransition videos (23%).

In response to the question of what they "considered to have been better ways for them to cope with their gender dysphoria," responses included: "community (44.0%), mindfulness/ meditation (41.0%), exercise (39.0%), therapy (24.0%), trauma work (24.0%), medication to treat a mental health condition (18.0%), and yoga (14.0%)."[395]

Upon analysis of the survey data, several distinct transition and detransition narratives emerged. Most participants (41.0%) expressed multiple narratives in their responses. The majority of the participants (58%) expressed a "gender dysphoria was caused by trauma or a mental health condition" narrative.[396] This was the only one of the thematic narratives expressed by a majority of the participants. The narrative with the least representation (3%) was the "retransition"

[393] Ibid., 3361, Table 5.
[394] Ibid.
[395] Ibid., 3362.
[396] Ibid.

narrative, indicating that the participant "had retransitioned or resumed transition" in some sense.[397]

Several questions queried participants about their post-detransition state of life. In terms of self-identification:

> most participants had returned to identifying solely as their birth sex (61.0%) with an additional 10.0% identifying as their birth sex plus another identification. Fourteen percent of the participants identified solely as nonbinary with an additional 11.0% identifying as nonbinary plus a second identification. Eight percent of the participants identified solely as transgender with an additional 5.0% identifying as transgender plus another identification. Four percent of the responses did not ft into the above categories and were coded as "other."[398]

When asked to reflect upon their current feelings about their own past transgender identification, the following statements were selected in descending order of statistical representation:

> "I thought gender dysphoria was the best explanation for what I was feeling" (57.0%), "My gender dysphoria was similar to the gender dysphoria of those who remain transitioned" (42.0%), "What I thought were feelings of being transgender actually were the result of trauma" (36.0%), "What I thought were feelings of being transgender actually were the result of a mental health condition" (36.0%).[399]

In response to a question concerning their feelings about their own prior transition:

> nearly a third (30.0%) indicated that they wish they had never transitioned while 11.0% indicated they were glad they transitioned. Some (34.0%) selected the statement that transition "was a necessary part of [their] journey" but others (21.0%) indicated that the process of transitioning distracted them from what they should have been doing. Responses about whether transition helped or harmed them were also complicated. While 50.5% selected answers consistent with being both helped and harmed, 32.3% indicated that they were only harmed and 17.2% indicated that they were only helped. The majority of respondents were dissatisfied with their decision to transition (69.7%) and satisfied with their decision to detransition (84.7%).[400]

In regard to transition regret: "At least some amount of transition regret was common (79.8%) and roughly half (49.5%) reported strong or very strong regret. Most respondents (64.6%)

[397] Ibid.
[398] Ibid., 3363.
[399] Ibid.
[400] Ibid.

indicated that if they knew then what they know now, they would not have chosen to transition."[401]

Notably, "*only 24.0% of participants had informed the doctor or clinic that facilitated their transitions that they had detransitioned*."[402] This data-point will have to be factored into the question of detransition prevalence rates, which will be considered below.

The final two studies to be considered below – i.e., Turban, et al., "Factors Leading to 'Detransition'" (2021); and MacKinnon, et al., "Preventing Transition 'Regret'" (2021) – are quite different in nature from the first four studies considered above. The most significant difference is that, whereas the first four studies are based on surveys of people who identified as detransitioners, these final two studies are absent the voices of currently identified deransitioners. Rather they are based, respectively, on a large cohort of people who identified as "transgender" at the time of survey (Turban, et al.); and on data taken from interviews with "11 clinicians, 2 administrators, and 9 trans patients, [and a review of] 14 healthcare documents pertinent to gender- affirming care in Canada" (MacKinnon, et al.).[403] *The significance of this difference can hardly be overstated*. Implications of this stark difference in sample pools will be considered below.

e. Jack L. Turban, Stephanie S. Loo, Anthony N. Almazan, and Alex S. Keuroghlian, "Factors Leading to 'Detransition' Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis" (2021).[404]

Participants and Parameters

This study is based upon a "secondary analysis" of relevant data drawn from the 2015 U.S. Transgender Survey (USTS).[405] The USTS is a cross-sectional, nonprobability survey that involved 27, 715 U.S. adults representing all fifty states, the District of Columbia, American

[401] Ibid., 3363-64.
[402] Ibid., 3363 (emphasis added).
[403] MacKinnon, et al., "Preventing Transition 'Regret,'" 1; on the sample pool, see also pp. 4, 7.
[404] Turban, et al., "Factors Leading to 'Detransition' Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis," *LGBT Health* 8/4 (2021), https://doi.org/10.1089/lgbt.2020.0437.
[405] Ibid., 273.

Samoa, Guam, Puerto Rico, and overseas U.S. military bases. Conducted over a 34-day period in the summer of 2015 by the National Center for Transgender Equality, the USTS was made available as an anonymous, online survey for U.S. adults (18 and older) "who identified as transgender, trans, genderqueer, non-binary, and other identities on the transgender identity spectrum."[406] This study is the largest survey of trans identified people in the U.S. to date, and is a follow-up to an earlier study by the National Center for Transgender Equality, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*.[407]

Although it is a study of the experience of detransition. Turban, et al., as noted previously, express hesitancy with even using the term "detransition," due to the fact that some within the trans community find it objectionable.[408] For the purposes of Turban, et al.'s analysis, the relevant detransition-related questions on the USTS were:
(1) "Have you ever de-transitioned? In other words, have you ever gone back to living as your sex assigned at birth, at least for a while?," with the three possible response to choose from being: "Yes," "No," and "I have never transitioned." Turban, et al. explain how they arrived at their final data pool:

> In total, 10,508 respondents reported that they had never undergone gender affirmation ("transitioned") and were excluded from the analyses. Fifty-six respondents did not answer this question and were also excluded, leaving a sample of 17,151 participants, of whom 2242 (13.1%) responded "Yes," which was coded as a history of detransition.[409]

(2) For those who answered affirmatively, they were then asked: "Why did you de-transition? In other words, why did you go back to living as your sex assigned at birth? (Mark all that apply)." Options that participants were able to choose from included the following:

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[406] Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Motter, and Ma'ayan Anafi, *The Report of the 2015 U.S. Transgender Survey* (Washington, DC: National Center for Transgender Equality, 2016), 23; https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf. The National Center for Transgender Equality is planning to conduct another full-scale U.S. transgender survey in 2022 and is hoping to have more than 40,000 respondents. For more information on the upcoming 2022 USTS, see https://www.ustranssurvey.org/about.
[407] Jaime M. Grant, Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011); http://www.thetaskforce.org/injustice-every-turn-report-national-transgender-discrimination-survey/.
[408] Turban, et al., "Factors Leading to 'Detransition,'" 273-74.
[409] Ibid., 274.

> "pressure from a parent," "pressure from spouse or partner," "pressure from other family members," "pressure from friends," "pressure from my employer," "pressure from a religious counselor," "pressure from a mental health professional," "I had trouble getting a job," "I realized that gender transition was not for me," "I faced too much harassment/discrimination," "It was just too hard for me," or "not listed above (please specify)."[410]

Turban, et al., note that response of "'I faced too much harassment/discrimination' was collapsed into a 'pressure from community or societal stigma' category, [and] 'I realized that gender transition was not for me' was collapsed into a 'fluctuations in identity/desire' category."[411]

As stated above – and a point that Turban, et al. explicitly mention more than once – their study is "is restricted to the examination of detransition among people who subsequently identified as TGD [i.e., transgender and gender diverse]."[412] In fact, within the "limitations" section of their study, they clearly state: "Because the USTS only surveyed currently TGD-identified people, our study does not offer insights into reasons for detransition in previously TGD-identified people who currently identify as cisgender."[413] *In other words, this sub-cohort of the USTS appears to be composed of retransitioners. No one who currently identified as a "detransitioner" – as opposed to "transgender or gender diverse" – was included in this survey*.

Turban, et al. also make it clear in the introductory section of their study that their primary focus of interest is whether those USTS respondents who had ever detransitioned did so *for external or for internal reasons*. It is worth noting that of the 12 possible responses participants could choose from on the USTS for why they chose to detransition, *only one of them* ("I realized that gender transition was not for me") *clearly signaled an internal reason for detransition*. Most of the rest of the list of options was an array of clearly expressed external reasons – seven of which identified various types of external "pressure" to detransition.[414] Comparing the options offered for detransition on the USTS to the reasons most frequently given in the surveys above by actual detrasitioners for why they chose to detransition is instructive. Almost entirely missing from the

[410] Ibid.
[411] Ibid.
[412] Ibid.
[413] Ibid., 279.
[414] James, et al., *Report of the 2015 U.S. Transgender Survey*, 272-73.

USTS option list are the type of reasons most commonly given by detransitioners for their own detransition, such as: "Political/ideological concerns"; "Found alternative ways to cope with dysphoria"; "Realized that my gender dysphoria was related to other issues"; "Transition did not help my dysphoria"; and "My personal definition of female or male changed and I became more comfortable identifying as my natal sex" – each of which was chosen by over 50% of the detransitioners in the surveys summarized above.[415]

Survey Results

Turban, et al. report that, of those currently transgender and gender diverse-identified USTS respondents who had detransitioned

> 82.5% cited at least one external factor. A total of 15.9% of respondents cited at least one internal factor. Of all participants who ever pursued gender affirmation, 10.8% reported lifetime history of detransition due to an external factor and 2.1% reported a lifetime history of detransition due to an internal factor."[416]

Thus, they conclude: "the vast majority reported that their detransition was driven by external pressures."[417]

Regarding those who did report being motivated by internal factors in their decision to detransition, Turban, et al. write:

> A minority of respondents reported that detransition was due to internal factors, including psychological reasons, uncertainty about gender identity, and fluctuations in gender identity. These experiences did not necessarily reflect regret regarding past gender affirmation, and were presumably temporary, as all of these respondents subsequently identified as TGD, an eligibility requirement for study participation. In addition, clinicians ought to note that, as highlighted in the gender minority stress framework, external factors such as stigma and victimization may lead to internal factors including depression and self-doubt regarding one's gender identity.[418]

They note that, for these "individuals, gender identity may evolve in a way that is driven by internal factors, ego-syntonic, and not necessarily a result of societal stigma."[419]

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[415] Drawn from Stella, "Female Detransition and Reidentification"; Vandenbussche, "Detransition-Related Needs and Support"; and Littman, "Survey of 100 Detransitioners."
[416] Turban, et al., "Factors Leading to 'Detransition,'" 276.
[417] Ibid., 273.
[418] Ibid., 277.
[419] Ibid., 276.

Beyond the question of external vs. internal factors, Turban, et al. report that experiencing past episodes of detransition was also associated with "male sex assigned at birth, nonbinary gender identity, [and] bisexual sexual orientation."[420]

Turban, et al. observe that the qualitative portion of the USTS survey, which allowed for write-in responses,

> revealed that the term ''detransition'' holds a broad array of possible meanings for TGD people, including temporarily returning to a prior gender expression when visiting relatives, discontinuing gender-affirming hormones, or having a new stable gender identity.[421]

Turban, et al. also emphasize that the USTS reveals the decision to detransition does not necessarily correlate with the experience of "regretting" one's original decision to transition:

> It is important to highlight that detransition is not synonymous with regret. Although we found that a history of detransition was prevalent in our sample, this does not indicate that regret was prevalent. All existing data suggest that regret following gender affirmation is rare. For example, in a large cohort study of TGD people who underwent medical and surgical gender affirmation, rates of surgical regret among those who underwent gonadectomy were 0.6% for transgender women and 0.3% for transgender men. Many of those identified as having ''surgical regret'' noted that they did not regret the physical effects of the surgery itself but rather the stigma they faced from their families and communities as a result of their surgical affirmation. Such findings mirror the qualitative responses in this study of TGD people who detransitioned due to family and community rejection.[422]

Similar to the prior studies, Turban, et al. acknowledge the overall lack of academic research on detransition, stating that "virtually no rigorous studies have been published about those who detransition."[423] Among other things, they suggest that "future studies are needed to examine specific typologies of detransition in more detail."[424]

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[420] Ibid., 273.
[421] Ibid., 276.
[422] Ibid., 279. The study they cite here as evidence of a low rate of transition regret is: C. M. Wiepjes, N. M. Nota, C. J. M. de Blok, M. Klaver, M. de Vries, A. L. Wensing-Kruger, et al., "The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets," *Journal of Sexual Medicine* 15/4 (2018), 582-90.
[423] Turban, et al., "Factors Leading to 'Detransition,'" 274.
[424] Ibid., 276.

f. K. R. MacKinnon, F. Ashley, H. Kia, J. S. H. Lam, Y. Krakowsky, and L. E. Ross, "Preventing Transition 'Regret': An Institutional Ethnography of Gender-Affirming Care Assessment Practices in Canada" (2021).[425]

Participants and Parameters

Methodologically speaking, this final study is distinct from the others in that it is "[i]nformed by the tenets of institutional ethnography." In their summary description of the discipline/methodology of institutional ethnography, the authors write:

> Institutional ethnography is an empirical, materialist research strategy developed by sociologist Dorothy E. Smith (1987, 2001, 2005). Institutional ethnographers explicate the ruling relations discursively organizing and regulating a particular system. The ruling relations are defined as specialized, technical discourses and power structures which coordinate knowledge, and by consequence, people's social relations . . . . Institutional ethnographers examine people's concerted work practices to reveal how these are mediated by discursive ruling relations, enabling the explication of a system under study.[426]

Their study was conducted between June 2017 and January 2018. Data was drawn from interviews with "11 clinicians, 2 administrators, and 9 trans patients (total n =22)," and the review of "14 healthcare documents pertinent to gender- affirming care in Canada."[427] The trans participants, all adults, were recruited through various social media in the Greater Toronto Area.

Although detransition, along with transition regret, is a central focus of this study, there is mention of only one actual detransitioned person in relation to their data pool, and this by second-hand report:

> To be clear, our sample included nine trans people, eleven clinicians, and two administrators. Of those, one psychologist explicitly discussed a patient who – in the clinician's words – "regretted" surgery and detransitioned. Although no other cases of detransition were discussed in our study, it is possible clinicians we interviewed elected not to disclose these cases, or were not fully aware of each of their patients' long-term transition outcomes.[428]

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[425] K. R. MacKinnon, F. Ashley, H. Kia, J. S. H. Lam, Y. Krakowsky, and L. E. Ross, "Preventing Transition 'Regret': An Institutional Ethnography of Gender-Affirming Care Assessment Practices in Canada," *Social Science and Medicine* 291 (2021), 114477, doi: 10.1016/j.socscimed.2021.114477.
[426] Ibid., 4.
[427] Ibid., 1; see also p. 4.
[428] Ibid., 7.

Survey Results

In their "Findings" section, the authors summarize the analytical results of their study under two headings: (1) "Gender-affirming care: assessing, referring, delaying, or denying trans people"; and (2) "Risk mitigation work in the clinic: preventing transition "regret" and avoiding lawsuits."[429] Under the first category, the authors summarize comments from clinician interviews, in which the clinicians

> described in detail the systematic work practices of assessing rigorously trans people's eligibility for hormones, and in particular, surgeries. To determine eligibility for these medical interventions, clinicians used the DSM to ensure that trans patients met diagnostic criteria for gender dysphoria and fulfilled the WPATH-SOC [i.e., SOC-7] "readiness components."[430]

Under the second category, the authors report that

> clinicians raised concerns surrounding transition regret. While clinicians explained that assessment and referral practices are largely in place to ensure that trans people understand all anticipated risks and benefits of hormones and surgeries, salient to clinicians was the potential risk of malpractice lawsuits in cases of regret.[431]

MacKinnon, et al. report that the nine trans participants

> offered different interpretations of the logics built into the prevailing model of gender-affirming care. Some participants suggested assessments were often too strict and disconnected from the experiences of trans people seeking medical transition.[432]

Guided by an institutional ethnographically-informed interpretation of these findings, MacKinnon, et al. highlight several thematic conclusions. First, they conclude that current standards of assessment for trans people seeking access to transition-related medical care – as exemplified by such things as the WPATH's SOC-7 and the DSM-5's diagnostic criteria for GD – foster an unnecessarily restrictive, "gate-keeping" mentality among gender clinicians; a mentality that is fueled by "cisnormative" and "transnormative" paradigms, along with unreasonable fears of transition regret, detransition, and malpractice lawsuits. In the words of MacKinnon, et al.:

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[429] Ibid., 5-7.
[430] Ibid., 5.
[431] Ibid., 6.
[432] Ibid.

> Strict clinical assessment practices may . . . reflect a projection of cisgender people's priorities and anxieties, rather than the concerns of trans people . . . . We uncovered that clinical work involves applying standard transition "readiness" assessments (e.g., the DSM; the WPATH-SOC) together with additional psychosocial evaluations (e.g., housing status; mental health coping strategies) which are deployed as proxy measures to predict future transition satisfaction/regret . . . . We conclude that the logic organizing clinicians' assessment work reflects cisnormativity and transnormativity in biomedicine.[433]

They elaborate on this institutional ethnographically-oriented interpretation of their data:

> Furthermore, attempts to prevent detransition—vis-`a-vis the transnormative WPATH "gatekeeping model" of strict assessment practices designed to identify only those who "truly" meet eligibility criteria—may create unethical, paternalistic, and dehumanizing practice conditions . . . . Our institutional ethnography reveals that transition assessment practices are coordinated by cisnormative and transnormative ruling relations. Thus, trans patients are treated as a "different type of person that isn't capable" of medical decision-making, as one physician participant noted, and any disclosures of dissatisfaction with surgical outcomes are interpreted through a cisnormative lens of "regret" as evidenced by a trans participant's account. Transnormativity further constructs transition regret or detransition as "life-ending" and trans identity ending, which can be traced to biomedical research categorizing these events as a "negative outcome" or a medical "failure."[434]

A second major theme emphasized by MacKinnon, et al. is that, while both transition "regret and detransitioning are unpredictable and unavoidable clinical phenomena," they are also "exceedingly rare" outcomes, and they "even more rarely [appear] in a 'life-ending' form."[435]

MacKinnon, et al., write:

> Despite no clinical guidance on regret or detransitioning, *and scant evidence that detransitioning is a negative phenomenon*, practices of preventing these outcomes define the gender-affirming care enterprise . . . . Gender-affirming care is predicated on cisnormative binary gender expectations together with transnormative standardized clinical assessments used to distinguish between "legitimate" trans persons from those who clinicians perceive to be more likely to regret transition (e.g., trans people with mental illness). Despite the enterprise of medical transition being built on this assessment work—*and no evidence that regret or detransition are necessarily negative outcomes* caused by medical failures.[436]

[433] Ibid., 7, 8.
[434] Ibid., 3, 7.
[435] Ibid., 1, 7.
[436] Ibid., 3, 4 (emphasis added).

From the perspective of MacKinnon, et al., the combined forces of such things as "clinicians' fears and a society 'obsessed with genitals,'" have fueled "[r]eports of detrans in the mainstream media" which, in turn, have contributed to "a moral panic amongst the public."[437]

To return to MacKinnon, et al.'s claim that transition regret and detransition "rarely [appear] in a 'life-ending' form": The source of their phrase "'life-ending' form" – which they use several times throughout their study to propose that detransition is not as negative an experience as often portrayed – is an interview they did with a trans-identified person who said:

> I think that [genital surgery eligibility criteria] it's [f**ked] up because our society is so obsessed with genitals, and *they think that if someone gets [genital surgery] and they regret it, it's life-ending*. I think their perception of it seems so silly to me because I think it's just based on the fact that as a society we're obsessed with genitals and "oh my god you did this to your genitals?"[438]

As MacKinnon, et al. wrap up their study, the reader is left with a sense of tension. On one hand, they clearly acknowledge that they reject the "dominant detransition narratives" that undergird recommendations for substantive psychological evaluations as part of the required pathway toward gender transition.[439] In their words:

> It must also be stated that our analysis contrasts with dominant detransition narratives amplified by the mainstream media which explicitly endorse stricter psychosocial "readiness" assessments to prevent regretful detransitions . . . .[440]

One example of MacKinnon, et al.'s rejection of study findings based on detransitioners' self-reports (e.g., as seen in the studies above) is their dismissal of reports that detransitioners rarely return to their transition-related health care professional to notify them of their detransition. Based on *the counter-report of a single person* involved with their study, MacKinnon, et al. write:

> It has been asserted that when people detransition, they avoid returning to the same clinician, and by default are counted as a "successful" transition, which contributes to under-reporting (Hildebrand-Chupp, 2020; Marchiano, 2020). However, our analysis contradicts this claim, *given that a detransitioning person returned to the same clinician for an assessment/referral to obtain breast augmentation surgery* . . . .[441]

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[437] Ibid., 7.
[438] Ibid., 6.
[439] Ibid., 7.
[440] Ibid.
[441] Ibid (emphasis added).

On the other hand, after having challenged the "dominant detransition narratives" at a number of points, MacKinnon, et al. then go on to state: "This is not to suggest that clinicians' worries of regret or detransition are invalid."[442] While this acknowledgement is intriguing, the authors do not provide any content to this claim. Rather, they simply follow it with:

> To be clear, our sample included nine trans people, eleven clinicians, and two administrators. Of those, one psychologist explicitly discussed a patient who – in the clinician's words – "regretted" surgery and detransitioned. Although no other cases of detransition were discussed in our study, it is possible clinicians we interviewed elected not to disclose these cases, or were not fully aware of each of their patients' long-term transition outcomes.[443]

3. Reflections on Several Contrasts Among the Six Studies

The tensions between the first four studies on one hand, and the final two studies on the other, are stark – and deserve consideration. It seems clear that the primary reason for this fault-line is that the survey data that underlies the studies of Stella, Mangelsdorf, Vandenbussche, and Littman are based on responses from people who actually identify as detransitioners,[444] while the surveys supporting Turban, et al. and MacKinnon, et al. are not. Again, Turban, et al. was based on the 2015 USTS, an "eligibility requirement" for which was that respondents currently "identified as TGD [transgender and gender diverse]."[445] This means that any people who currently identified as a detransitioner, rather than as transgender, were excluded from the USTS survey. Similarly, MacKinnon, et al.'s study included no direct input from any people who actually detransitioned. *It is difficult to over-emphasize the significance of this difference between the first four studies on one hand, and the final two studies on the other*. To note just two of the crucial points at which this difference manifests itself:

a. Contrasting Conclusions on Why People Detransition

[442] Ibid.
[443] Ibid.
[444] The survey conducted by Hailey [Mangelsdorf] did so as well, but because the results are no longer publicly available, there is little we can say about it.
[445] Turban, et al., "Factors Leading to 'Detransition,'" 276.

The three main surveys of detransitioners to which we currently have access (Stella, Vandenbussche, and Littman) reflect a broad agreement that *internal factors* were the primary motivators for the decision to detransition. For example, among the leading reasons given for detransition in these three surveys of self-identified detransitioners – each reason representing more than 40% of the respondents – were:

- Stella – "Political/ideological concerns" (63%); "Found alternative ways to cope with dysphoria" (59%).
- Vandenbussche – "Realized that my gender dysphoria was related to other issues" (70%); "Transition did not help my dysphoria" (50%), "Found alternatives to deal with my dysphoria" (45%); and "Change in political views" (43%).
- Littman – "My personal definition of female or male changed and I became more comfortable identifying as my natal sex" (natal females 65%; natal males 48.4%); "I was concerned about potential medical complications from transitioning" (natal females 58%); "My mental health did not improve while transitioning (natal females 44.9%); "I was dissatisfied by the physical results of the transition/felt the change was too much" (natal females 50.7%); "I discovered that my gender dysphoria was caused by something specific (ex, trauma, abuse, mental health condition)" (natal females 40.6%).

These three studies also broadly agree that *external factors* were among the *least common reasons* detransitioners give for why they chose to detransition:

- Stella – "The three most commonly cited reasons for detransition among trans activists – financial concerns, lack of social support, and institutional discrimination were among the lowest [in this survey], at 18%, 17%, and 7% – in fact, institutional discrimination was the lowest scoring category."
- Vandenbussche – The least common responses were "lack of support from social surroundings" (13%), "financial concerns" (12%) and "discrimination" (10%).
- Littman – "External pressures to detransition such as experiencing discrimination (23.2%) or worrying about paying for treatments (17.0%) were less common."

In contrast to this, Turban, et al. concluded that *external factors* were the most common reason given by people surveyed in the USTS for why they detransitioned (82.5%), whereas only 15.9%

of respondents cited one or more *internal factors*. This stark contrast between the findings of Turban, et at. on one hand, vs. Stella, Vandenbussche, and Littman on the other, is easily understood once it is recognized that the former study is reporting on reasons for past detransition experiences of people who *currently identify as transgender/gender diverse (i.e., retransitioners)*, while the three latter studies are reporting on reasons for detransition given by people who *currently identify as detransitioners*.

This significant difference in the surveys' sample populations presumably explains a related contrast. While Turban, et al. – along with the USTS upon which it is based – reported on a range of different types of external "pressure" to detransition experienced by respondents, no mention at all is made of any contrasting "pressure" related either to their original transition or to their (post-detransition) retransition. In contrast to this, more than a third (37.4%) of the self-identified detransitioners in Littman's study reported that they had experienced "pressure" to transition in the first place. Littman explains:

> Twenty-eight participants provided open-text responses of which 24 described sources of pressure [to transition] (17 described social pressures and 7 described sources that were not associated with other people). Clinicians, partners, friends, and society were named as sources that applied pressure to transition.[446]

In the months following the release of Turban, et al.'s study, a number of news outlets reported on its findings as crucial data on key factors that motivate people to detransition. Some outlets mentioned that the survey participants were "transgender" people.[447] Others were less clear about this fact. For example, a report on Turban, et al. by GenderGP begins with the statement: "*Detransition facts and statistics that are unbiased are hard to come by in 2021*." It continues:

> Well, why do people detransition? The main reason cited for detransition is social pressure. Recent research by Dr Jack Turban has found that around 90 percent of people who return to their birth gender in the US don't do so because of regret or dissatisfaction, but because of pressure from family, school, work, or society in general. The National Center for Transgender Equality found that the most common reasons for

[446] Littman, "Survey of 100 Detransitioners," 3360.
[447] E.g., "New Study Shows Discrimination, Stigma, And Family Pressure Drive "Detransition" Among Transgender People," *Fenway Health* (April 7, 2021), https://fenwayhealth.org/new-study-shows-discrimination-stigma-and-family-pressure-drive-detransition-among-transgender-people/.

> detransitioning were lack of support at home, problems in the workplace, and harassment and discrimination.[448]

It is never made clear that this study is based solely on ex-detransitioners/retransitioners, rather than on the reports of currently-identified detransitioners themselves. Unfortunately, in not making this fact abundantly clear – along with entirely neglecting to mention studies involving actual detransitioners that came to the opposite conclusion – this report by GenderGP itself only serves to contribute to the difficulty of finding unbiased facts and statistics about detransition in 2021.

b. Contrasting Conclusions on the Nature of the Detransition Experience Itself

In comparing MacKinnon, et al.'s findings with those of the Stella, Vandenbussche, and Littman studies, additional contrasts are readily apparent. The first to be considered here involves the nature of the detransition experience itself. As noted above, based upon their interviews with 22 people – 11 clinicians, 2 administrators, 9 trans patients; and their reviewed of 14 healthcare documents relating to gender-affirming care in Canada – MacKinnon, et al. concluded that transition regret and detransitioning are "exceedingly rare" phenomena, and that they "even more rarely [appear] in a 'life-ending' form."[449] They clarify their latter claim by stating that there is "scant evidence that detransitioning is a negative phenomenon."[450]

This conclusion contrasts with the statements of actual detransitioners – found both in anecdotal reports and in the conclusions drawn by academics based upon formal surveys. For example, informed by the reported experiences of detransitioners themselves, Pablo Expósito-Campos expresses a very different awareness of the potentially negative outcomes associated with detransition:

> 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 . . .

[448] "Detransition Facts and Statistics 2021: Exploding the Myths Around Detransitioning," *Gender GP* (June 21, 2021), https://www.gendergp.com/detransition-facts/ (emphasis in original).
[449] MacKinnon, et al., "Preventing Transition 'Regret,'" 7.
[450] Ibid., 3.

> . 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.[451]

Contrasting with MacKinnon, et al.'s conclusions, a remarkable number of the detransitioners within Littman's study reported significant transition regret:

> At least some amount of transition regret was common (79.8%) and nearly half (49.5%) reported strong or very strong regret. Most respondents (64.6%) indicated that if they knew then what they know now, they would not have chosen to transition.[452]

Another area of contrast between MacKinnon, et al. vs. the studies of Vandenbussche and Littman involves the controversial "lost to follow-up" problem. This involves the question of how many people who detransition return to their transition-related health professionals to notify them of their detransition. This question is important, in that *health professionals who assist people with medical transition are often queried as to just how common detransition is based on the number of transitioned clients who return to them seeking further help with their detransition.*[453] A clinician's primary means of answering this question is, of course, the after-the-fact feedback they receive from people they assisted in the transition process. As a clinician, one might be inclined to think that the people you help transition, and eventually do not hear from any longer, are probably leading a life of successful transition.

On the other hand, it has been argued that it is just as likely that people who detransition may simply decide not to return to their previous health provider. In such cases, people who clinicians assume are living a life of successful transition are actually living a life of detransition. As discussed above, MacKinnon, et al. reject this suggestion, noting that their own "analysis contradicts this claim, given that a detransitioning person returned to the same clinician for an assessment/referral to obtain breast augmentation surgery . . . .[454]

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[451] Expósito-Campos, "Typology of Gender Detransition," 275, 276.
[452] Littman, "Survey of 100 Detransitioners," 3363-64.
[453] E.g., Danker, et al., "Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries."
[454] MacKinnon, et al., "Preventing Transition 'Regret,'" 7.

However, detransitioner reports, drawn from the surveys of both Vandenbussche and Littman, reveal that, in fact, a significant number of detransitioners never do contact their former health provider to notify them of – let alone seek help with – their detransition. Vandenbussche found that a

> total of 29% reported having received support for their detransition from the medical professionals that helped them during their transition. In contrast, 38% sought support from a new therapist/doctor. A part of the sample reported not receiving help from anybody for . . . detransitioning (11%).[455]

The detransitioners in Littman's study reported similarly: "Only a small percentage of detransitioners (24.0%) informed the clinicians and clinics that facilitated their transitions that they had detransitioned." Littman highlights the important conclusion:

> Therefore, clinic rates of detransition are likely to be underestimated and gender transition specialists may be unaware of how many of their own patients have detransitioned, particularly for patients who are no longer under their care . . . . There are several obstacles to obtaining accurate rates of detransition and desistance, including stigma and the low numbers of detransitioners who inform their clinicians that they detransitioned. One approach to bypass some of these barriers would be to incorporate non-judgmental questions about detransition and desistance into nationally representative surveys that collect health data.[456]

This observation coincides with the insights of a well-known detransitioner who previously wrote under the pseudonym of CrashChaosCats. In reference to a piece she wrote in 2017 titled "Lost to Follow-up/How Far Can You Follow Me?," she remarks:

> [A]nxiety, fear and other intense feelings [can] get in the way of a detransitioned person contacting their old medical providers and informing them of their detransition. People often overlook how many detransitioned people don't trust their old providers, feel shame about transitioning or otherwise experience strong emotions that could prevent them from coming forth and how this could lead providers into thinking that detransition is much less common than it is. How can you accurately gauge how many people detransition if many of us don't want to talk about it for one reason or another?[457]

Based on a single, second-hand report by a clinician of having one person who detransitioned return to them for help with breast augmentation surgery, it appears that MacKinnon, et al. are

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[455] Vandenbussche, "Detransition-Related Needs and Support," 1609.
[456] Littman, "Survey of 100 Detransitioners," 3364, 3366.
[457] Crashchaoscats. "Follow-up to 'Lost to Follow-up,'" (February 8, 2018), https://crashchaoscats.wordpress.com/2018/02/08/follow-up-to-lost-to-follow-up/. The original piece, "Lost to Follow-up/How Far Can You Follow Me?," is no longer available online. The author, Ky Schevers, has more recently (re-)identified as transmasculine.

willing to dismiss both the clear survey data and the self-reports of other detransitioners about a common reluctance among detransitioners to return to the clinicians who assisted them with their transition. The rationale behind this broad-brush dismissal is puzzling to say the least. One is left with the impression that, in their understandable zeal to preserve the rights of trans people to access transition-related health care, *MacKinnon, et al. have chosen to ignore the voices of detransitioners*.

One is left with this same impression when assessing MacKinnon, et al.'s conclusions on the current psychological evaluation requirements for people seeking to medically transition. As we have seen, according to MacKinnon, et al., the current requirements as articulated in the WPATH's SOC-7 are overly stringent, and function as a needlessly restrictive obstacle to transition care. Behind this "gate-keeping" tactic, they see a medical establishment that is beholden to "cisnormativity," "transnormativity," and an unreasonable fear of lawsuits, which, in turn, has created – and ongoingly sustains – "unethical, paternalistic, and dehumanizing practice conditions."[458]

However, the survey data from detransitioners tells a different story of their own experience with the medical establishment and its pre-transition information and assessment protocols. For example, Vandenbussche found that

> Forty-five percent of the whole sample reported not feeling properly informed about the health implications of the accessed treatments and interventions before undergoing them. A third (33%) answered that they felt partly informed, 18% reported feeling properly informed and 5% were not sure.[459]

As noted above, Vandenbussche also found that of the four areas of need – medical, psychological, legal, and social – detransitioners reported the greatest area of need was *psychological*: "Psychological needs appeared to be the most prevalent of all, with only 4% of the respondents reporting not having any."[460] Several of the more highly ranked responses regarding their psychological needs reveal that many detransitioners do not feel that their psychological needs were properly assessed prior to transition. And the experience of

[458] MacKinnon, et al., "Preventing Transition 'Regret,'" 3.
[459] Vandenbussche, "Detransition-Related Needs and Support," 1606.
[460] Ibid., 1608.

detransition only added to their list of psychological needs – including "the need for therapists to validate the feelings of being harmed by transition that some detransitioners experience, rather than dismissing or opposing them."[461]

Similarly, Littman's survey found that the

> majority (56.7%) of participants felt that the evaluation they received by a doctor or mental health professional prior to transition was not adequate and 65.3% reported that their clinicians did not evaluate whether their desire to transition was secondary to trauma or a mental health condition.[462]

It appears that, once again, MacKinnon, et al. have neglected the voices of the detransitioned themselves.

c. Final Thoughts

To conclude these reflections on the six studies under consideration: three final thoughts about detransition research moving forward:

1) One thing that all of these studies can agree on is the lack of robust studies of detransition and the need for future research in this area.

2) In light of the stark contrast between the findings of Stella, Vandenbussche, and Littman on one hand, and those of Turban, et al., and MacKinnon, et al. on the other, we can see the importance of basing future detransition studies primarily upon the experiences of detransitioners themselves.

3) All of the surveys focusing on detransitioners were populated primarily by natal/assigned females. In addition, many of them were adolescents when they originally transitioned and were in their 20s when they detransitioned. This parallels the reports of many gender clinics regarding the shift in the sex ratio among transgender adolescents over the last decade-plus that favors natal/assigned females over males.[463] Some of these younger adult female detransitioners have,

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[461] Ibid., 1609.
[462] Littman, "Survey of 100 Detransitioners," 3360; see also 3366.
[463] E.g., M. Aitken, T. D. Steensma, R. Blanchard, D. P. VanderLaan, H. Wood, A. Fuentes, et al., "Evidence for an Altered Sex Ratio in Clinic-referred Adolescents with Gender Dysphoria," *Journal of Sexual Medicine* 12/3 (2015), 756– 763; L. N. Chiniara, H. J. Bonifacio, and M. R. Palmert, "Characteristics of Adolescents Referred to a Gender

in hindsight, understood their experience through the lens of rapid-onset gender dysphoria (ROGD).[464] Hopefully, future studies will be able to provide more data on the experiences of detransition among natal/assigned males and/or among those who detransition later in life.

C. A Review of Transition Outcome and NTE/Detransition-Related Research

One of the most highly charged issues related to detransition is the question of its prevalence rate. The charged nature of this question is directly related to the way in which detransition rates have figured into the polarizing narratives of the culture war surrounding transgender identity. Just as it serves the political interests of trans activists and allies – along with gender affirmative advocates in general – to emphasize a relatively low detransition rate, so it equally serves the political interests of detransitioners and their allies – along with gender critical constituencies within both left-leaning radical feminism and right-leaning conservative groups – to emphasize a relatively high detransition rate.

The issue of detransition is related to – but, as mentioned above, is also distinct from – the issue of transition regret or other forms of negative transition experience (NTE). The articulation of this distinction by Expósito-Campos is worth repeating:

> [C]linicians 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 . . . .

Clinic: Are Youth Seen Now Different than Those in Initial Reports?," *Hormone Research in Pediatrics* 89 (2018), 434-41; Kaltiala-Heino, et al., "Time Trends in Referrals"; R. Kaltiala-Heino, M. Sumia, M. Työläjärvi, and N. Lindberg, "Two Years of Gender Identity Services for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development," *Child and Adolescent Psychiatry and Mental Health* 9 (2015), 1-9. https://doi.org/10.1186/s13034-015-0042-y; H. Wood, S. Sasaki, S. J. Bradley, D. Singh, S. Fantus, A. Owen-Anderson, A. Di Giacomo, J. Bain, and K. J. Zucker, "Patterns of Referral to a Gender Identity Service for Children and Adolescents (1976-2011): Age, Sex Ratio, and Sexual Orientation," *Journal of Sex and Marital Therapy* 39 (2013), 1-6.

[464] E.g., Helena Kerschner, "Helena Part 1: Social Justice, Fandoms & FtM Gay Boys," Gender: A Wider Lens Podcast – Episode 45 (October 15, 2021), https://gender-a-wider-lens.captivate.fm/episode/45-helena-part-1-social-justice-fandoms-ftm-gay-boys. On ROGD, see Lisa Littman, "Correction: Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," *PLoS One* 14/3 (2019), e0214157. https://doi.org/ 10.1371/journal.pone.0214157; Anna Hutchinson, Melissa Midgen, and Anastassis Spiliadiss, "In Support of Research into Rapid-Onset Gender Dysphoria," *Archives of Sexual Behavior* 49/1 (2020), 79-80; Lee Jussim, "Rapid Onset Gender Dysphoria: A Saga of Outrage and Science Reform," *psychologytoday.com* (March 20, 2019), https://www.psychologytoday.com/us/blog/rabble-rouser/201903/rapid-onset-gender-dysphoria.

> Detransition processes are as multiple and diverse as transition processes, so clinicians must avoid applying a homogeneous prism of interpretation.[465]

Simply put: Although the experience of transition regret and the decision to detransition are linked for many people, for others they are not. On one hand, a sector of the people who choose to detransition report that they do not regret having made the decision to transition in the first place.[466] Often this is explained by saying that transitioning was a necessary – or at least helpful – part of their journey of gender exploration. On the other hand, there are people who report experiencing transition regret (or some other form of NTE) – or who simply stop identifying as transgender – and yet, for one reason or another, choose to not pursue detransition.[467] It is also important to remember that NTEs can be associated with any number of different aspects of transition: i.e., negative physical/medical outcomes, negative – or at least less-than-positive – psychological outcomes, negative impact upon social relationships, negative economic repercussions, etc.

1. Typologies of NTEs, Transition-related Regret and Related Phenomena

In 1998, Abraham Kuiper and Peggy Cohen-Kettenis proposed a four-fold typology of transition regret:[468]

> 1. [I]ndividuals openly express regret about their decision to undergo SRS, and they have returned to living in their former gender role and/or apply for a second SRS.
> 2. [I]ndividuals who have undergone SRS may express the feeling that they would never consider SRS again, when in the same position as before treatment, or even express regret on their decision, but may not make any attempt for gender role reversal.
> 3. [I]ndividuals do not live any longer in the previously desired sex, but do not express any regret. Some may even state that they are happy about their decision, and still consider themselves transsexuals, but choose to live in the original gender role again for social reasons.
> 4. [I]ndividuals may not openly express any feelings of regret with respect to their SR

[465] Expósito-Campos, "Typology of Gender Detransition," 275.
[466] This was recognized in the 1990s by A. J. Kuiper and P. T. Cohen- Kettenis, "Gender Role Reversal among Postoperative Transsexuals," *International Journal of Transgenderism* 2/3 (1998), http://www.symposion.com/ijt/ijtc0502.htm. More recently, see Aron Janssen, Ann Lurie and Robert H. Lurie, "Understanding Gender 'Detransition' With and Without Regret," *Journal of the American Academy of Child & Adolescent Psychiatry* 60/10 Supp. (2021), S4.
[467] E.g., Rene Jax, *Don't Get on the Plane: Why a Sex Change Will Ruin Your Life* (n.p.: Rene Jax, 2016); Jillian St. Jacques, "Retrotranslations of Post-Transsexuality, Notions of Regret," *Journal of Visual Culture* (April 1, 2007), https://doi.org/10.1177/1470412907075070.
[468] A. J. Kuiper and P. T. Cohen- Kettenis, "Gender Role Reversal among Postoperative Transsexuals," *International Journal of Transgenderism* 2/3 (1998), http://www.symposion.com/ijt/ijtc0502.htm.

> process, nor make any attempt to reverse their current situation, but clinicians, relatives, or others may attribute unfavorable social and/or psychological circumstances (e.g. feelings of loneliness, suicide attempts or psychiatric problems) to feelings of regret.

In contemporary terms, we can summarize their typology as follows: (1) Regret leading to detransition; (2) Regret without detransition; (3) Detransition without expressed regret (i.e., either regret left unexpressed or no regret at all); and (4) No expressed regret or detransition, but regret (potentially) detected by others via indirect signals. It is important to not here that this typology of regret is entirely focused on *people who have undergone surgical transition*. As will be clear from the evidence discussed below, the vast majority of studies on NTEs, including transition regret and detransition, have focused entirely on those who have experienced surgical transition – *to the general neglect of people who have only undergone hormonal transition*. *This represents a significant lacuna in NTE research, given that a good number of contemporary detransitioners report having undergone hormonal transition and/or social transition without surgical transition*. We will return to this issue below.

More recent work has brought new typologies. Drawing from Hildebrand-Chupp's concept of NTEs – along with insights from a recent study by Sasha Narayan and colleagues on different types of transition-related regret[469] – a typology of NTEs can be constructed that will provide help in analyzing data related to NTE and detransition. To begin, the umbrella category of NTEs can be sub-divided into four distinct post-transition outcomes: (1) difficulty, (2) dissatisfaction, (3) regret, and (4) detransition. Definitions are as follows:

(1) *Post-transition difficulty* involves any dimension of transition – e.g., subjective experience, physical challenge, external repercussion, etc. – that is experienced as negative in one sense or another. Post-transition difficulty may be either temporary or permanent, and it may or may not be accompanied by an expression of dissatisfaction, a sense of regret, and/or the decision to detransition.

(2) *Post-transition dissatisfaction* involves the explicit expression of dissatisfaction with one or more aspects associated with transition. It may be either temporary or permanent, certainly

[469] Narayan, et al., "Guiding the Conversation – Types of Regret."

involves some form of difficulty, and may or may not be accompanied by a sense of regret and/or the decision to detransition.[470]

(3) *Post-transition regret* involves the sense or conviction that the decision to transition "now feels incorrect."[471] Like difficulty and dissatisfaction, it can be temporary or permanent. It is typically associated with some experience(s) of post-transition difficulty and/or dissatisfaction, and may or may not lead the person to detransition.

(4) Finally, there is *detransition* itself, which certainly involves some type of post-transition difficulty and/or dissatisfaction. It may be temporary (i.e., followed by a subsequent retransition) or permanent, and may or may not be associated with a sense of transition regret.

Narayan, et al. have proposed a more finely grained four-fold typology of the sub-type of *transition regret* itself:

(1) *True Regret* (or, better, *Gender-related Regret*, on which see below) – "true regret" is identified as when a person undergoes some form of gender transition, "who then desires to return to their assigned sex at birth or a different gender identity."[472]

(2) *Social Regret* – social regret is defined as "one's desire to return to their sex assigned at birth to alleviate the repercussions of transitioning on their social life."[473]

[470] As an example of someone who expresses significant dissatisfaction regarding their medical transition, but without expressed regret, see Scott Newgent, "Forget What Gender Activists Tell You: Here's What Medical Transition Looks Like," *Quillette* (October 6, 2020), https://quillette.com/2020/10/06/forget-what-gender-activists-tell-you-heres-what-medical-transition-looks-like/. For an even more nuanced "autoethnographic account" of the layered complexities involved with surgical transition, see Saoirse Caitlin O'Shea, "If I Knew Then What I Know Now," *Gender, Work & Organization* 29/2 (2022), 626-38. See also: Anonymous, "A Person Beyond Gender: A First-hand Account," in *Sexuality and Gender Now: Moving Beyond Heteronormativity*, eds. L. Hertzmann and J. Newbigen (New York: Routledge, 2020), 256-87; Chu, "My New Vagina Won't Make Me Happy, And It Shouldn't Have To."
[471] Narayan, et al., "Guiding the Conversation – Types of Regret," 7.
[472] Ibid., 7.
[473] Ibid.

(3) *Medical Regret* – medical regret involves "regret originating from a direct outcome of a surgery or an irreversible consequence thereof."[474] One would want to add that medical regret can also involve negative outcomes associated with HRT and even puberty blockers. Narayan, et al. go on to propose three sub-types of medical regret:

(a) *Medical complication-induced regret* – involves any regret associated with medical complications associated with the medical transition process itself (e.g., temporary or ongoing pain, etc.)

(b) *Long-term functional outcome-related regret* – involves any regret associated with dissatisfaction with anticipated functional outcomes of medical transition (e.g., poor post-operative sexual functioning).

(c) *Preoperative decision-making-related regret* – involves any regret associated with "a medical intervention, but it is not due to a change in gender identity, medical complication, functional outcome, or social stigma."[475] Examples include:

> choosing a simple-release metoidioplasty rather than a phalloplasty or regretting gonadal sterilization later in life . . . . In these situations, individual may not have appreciated the long-term implications at the time they underwent the procedure, may have received incomplete or accurate counseling, may have had a change in life goals, or may have not had access to technologies that are currently available.[476]

Although Narayan, et al. do not explicitly make this extrapolation themselves, it is worth noting that, logically speaking, each of these three sub-types of medical regret can be transposed to the other three forms of regret. I.e., [1] medical complication-related difficulty/dissatisfaction/ detransition; [2] long-term functional outcome-related difficulty/dissatisfaction/detransition; and [3] preoperative decision-making-related difficulty/dissatisfaction/detransition.

(4) *Nonbinary Regret* – finally, Narayan, et al. note that post-transition recognition that one's gender identity is actually nonbinary/genderfluid "can be one etiology for true gender-related regret."[477]

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[474] Ibid.
[475] Ibid., 8.
[476] Ibid.
[477] Ibid., 9.

This typology of regret proposed by Narayan, et al. is generally helpful. However, certain features could be strengthened or corrected. First, their use of the label "true regret" seems strange on several counts. Indexing "true" regret to that which stems only from a desire to "return to their assigned sex at birth or a different gender identity" is odd, to say the least. Does this mean, say, that transition regret stemming from social repercussions – which they identify as "social" regret in distinction from "true" regret – is somehow less impacting, less genuine or authentic, less "true?" One is left with the distinct impression that in choosing to designate regret associated with an internal shift in one's gender identity as "true," Narayan, et al. are not merely identifying one of the etiological types of transition-related regret. They are, instead, going beyond a merely descriptive typology to assign a *value judgment to one type of regret over another*. The categories of "social" and "medical" regret are clearly indexed to the etiological cause of the regret. "True" regret, however, is not explicitly descriptive of any particular etiology. An appropriately descriptive parallel to "social" regret and "medical" regret for this first category would be something along the lines of "internal," "gender-based," or "identity-based" regret – not "true" (as opposed to what – false?) regret. In fact, in the abstract to their article, Narayan, et al. refer to this category as "true gender-related regret." Their typology would be best served by dropping the term "true" regret and replacing it with simply "gender-related" regret or some similarly descriptive, value-neutral modifier. In this study, Narayan, et al.'s "true regret" will henceforth be designated as *gender-related regret*.

Second, as noted above, Narayan, et al.'s definition of "true regret" involves someone who transitions and then "desires to return to their assigned sex at birth or a different gender identity."[478] But this definition comes dangerously close to collapsing and conflating their category of *true regret* with their category of *detransition*, which they define as "a change in gender role and/or the cessation of medical transition."[479] Practically speaking, the only sliver of daylight between these two definitions is that "true regret" involves the "desire" to detransition, while "detransition" involves the act of detransition. One problem here is that, throughout their study, Narayan, et al. make it clear that, on one hand, the various forms of "regret" do not necessarily include the desire and/or choice to detransition; and, on the other hand, that the desire

[478] Ibid., 7.
[479] Ibid., 9.

and/or choice to detransition does not necessarily include regret toward the initial transition itself. So, it seems quite strange that "true regret" is then defined as the desire "to return to their assigned sex at birth or a different gender identity" – i.e., a desire for "the cessation of [their current form of] medical transition," which is at the core of their definition of detransition itself. A bit of conceptual clarification and tidying up would aid this otherwise helpful typology of transition regret. It is worth nothing that future reflections on transition regret could benefit from further engagement with interdisciplinary studies on the wider phenomenon of human regret.[480]

Beyond their typology of transition regret, Narayan, et al. also identify and define several related phenomena. Beyond offering definitions of *detransition* and *retransition*, they also discuss: (1) *Continued Transition* – i.e., the post-transition pursuit of additional medical transition procedures related to a desire to "express an evolving gender identity" or a desire for "further surgical consolidation of their identity."[481] Continued transition may or may not involve regret over initial transition.

(2) *Fleeting Ambivalence* – i.e., short-term regret regarding transition. Narayan, et al. state that fleeting ambivalence "is common, especially if the patient experiences initial surgical complications or loss of their support communities." They encourage people in the midst of fleeting ambivalence to "trust in their long-standing gender identification."[482]

Finally, another typological set appears in light of an important distinction highlighted by Hildebrand-Chupp, who points out that, over the years, most transition regret and/or detransition research has focused on people who have undergone *transition-related surgery*. However, as Hildebrand-Chupp observes, to date, "there is almost no research on the rate of detransition or NTEs among those who are taking hormones and have not undergone surgery."[483] Thus, in future research, it will be important to "distinguish the detrans rates of different forms/levels of transition: i.e., social transition without medical transition; hormonal transition but without

[480] E.g., Carla Bagnoli, "Value in the Guise of Regret," *Philosophical Explorations* 3/2 (2000), 169-87; T. Gilovich and V. H. Medvec, "The Experience of Regret: What, When, and Why," *Psychological Review* 102/2 (1995), 379-95; Janet Landman, *Regret: The Persistence of the Possible* (New York: Oxford University Press, 1993).
[481] Narayan, et al., "Guiding the Conversation – Types of Regret," 9.
[482] Ibid.
[483] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 805.

surgical transition; surgical transition [including types of surgeries]."[484] This leads to a separate tripartite sub-typology of what we can call *surgical transition regret*, *HRT transition regret* and *social transition regret* emerges.

With these distinctions and typologies in mind, we are now able to venture into the contested issue of transition outcomes and NTE/desistance prevalence rates. As we do so, it is worth recalling Hildebrand-Chupp's observation: "negative transition experiences are not synonymous with the act of detransition or with identifying as a detransitioner."[485]

2. Surveying Six-plus Decades of Transition Outcome Studies and NTE/Detransition Prevalence Rates

This section will provide a survey of studies published over the last six-plus decades that report on transition outcomes, including NTEs (i.e., post-transition difficulty, dissatisfaction and/or regret) and detransition, along with their prevalence rates. A note on terminology and language use in this section of the study: In reporting on the various studies over the past 60-plus years, the terminology used within the studies themselves will often be reproduced in order to more accurately represent them and their historical context. However, at times, more contemporary terminology and language will be employed to represent their findings, even though this reflects some degree of linguistic anachronism.

a. Key Studies Published in the 1960s

In the first half of the 20th-century, medical transition outcome reports were commonly published in the form of individual case studies.[486] By the late 1950s and 1960s, longitudinal outcome

[484] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 805.
[485] Ibid., 803.
[486] E.g., Abraham, "Genitalumwandlung an zwei maenlichen Transvestiten" (1931); Hans Binder, "Das Verlangen nach Geschlechtsumwandlung," *Zeitschrift für die Gesamte Neurologie und Psychiatrie* 143 (1933), 84-174; M. Boss, "Umwandlungsoperation," *Psyche* 4 (1950), 230-33; B. Dukor, "Probleme um den Transvestitismus," *Schweizerische Medizinische Wochenschrift* 81 (1951), 516-19; C. Hamburger, G. K. Stürup, and E. Dahl-Iversen, "Transvestism: Hormonal, Psychiatric, and Surgical Treatment," *Journal of the American Medical Association* 12 (1953), 391–96; Fogh-Andersen, "Transvestism and Trans-sexualism" (1956). See also Schaefer and Wheeler, "Harry Benjamin's First Ten Cases (1938-1953)."

studies, and meta-analyses of such, involving increasing numbers of people, began to appear more frequently.[487] The following are a representative set of such studies from this decade.

Hertz, et al. (1961)

This 1961 publication – recognized as one of the early longitudinal outcome studies – reported on five cases of surgical transition: two MtF patients and three FtM patients. The authors conclude:

> Postoperative follow-ups for 3 ½ to 16 years revealed that the final outcome in three of the cases could be characterized as satisfactory and in one case as definitely good. In the fifth case the outcome was satisfactory until an unsuccessful attempt to form an artificial vagina induced rather deep depression [which led to a social detransition].[488]

Pauly (1965)

In a 1965 meta-analysis, Ira Pauly summarized the post-operative outcomes of 48 cases of MtF surgical transition:

> In this series of 48 operated cases, 20 were thought to be definitely improved by the reporting author, whereas six were thought to be definitely not improved. Eleven cases were equivocal, still requesting further surgery or not substantially different, and no follow-up information was given for the remaining 11 cases. Despite the apparent success indicated by these figures, I suggest caution in interpreting these results. The criteria for success are difficult to determine, and this leaves the reporting author vulnerable to his own bias. Also, it is probable that positive outcomes are more likely to be reported, because of the controversial nature of these demasculinizing procedures.[489]

Wålinder (1967)

In 1967, Swedish researcher Jan Wålinder provided a provisional follow-up report on 43 cases of surgical transition. The average length of time between surgery and assessment was 20.7 months. He states that all of the patients reported satisfactory post-operative adjustment, and that none of them expressed transition regret.[490]

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[487] E.g., J. B. Randell, "Transvestism and Transsexualism: A Study of 50 Cases," *British Medical Journal* 2 (1959), 1448-52; Ira B. Pauly, "Male Psychosexual Inversion: Transsexualism: A Review of 100 Cases," *Archives of General Psychiatry* 13/2 (1965), 172–81.
[488] Hertz, et al, "Transvestism," 293 (on the social detransition, see p. 286).
[489] Pauly, "Male Psychosexual Inversion: Transsexualism," 177.
[490] Jan Wålinder, *Transsexualism: A Study of Forty-three Cases*, trans. H. Frey (Göteborg: Scandinavian University Books, 1967).

Benjamin (1969)

In the 1964, Harry Benjamin reported on post-surgical outcomes. Of 40 people who were followed, he observed that 34 reported post-operative satisfaction, while the remaining six cases reported otherwise.[491] By 1967, Benjamin's database had risen to 73 people.[492] In 1969 – at the end of the decade – Benjamin reported outcomes on 95 MtF and (roughly) 30 FtM post-operative cases.[493] He summarizes his findings and conclusions on post-surgical outcomes in these words:

> Ninety-five of my male transsexual patients have undergone sex reassignment surgery. I have seen most of them before and after. The results of the operation are not easily evaluated. We have to depend mostly on what the patient tells us and that can vary according to his mood from month to month, if not from day to day. A happy love affair with a satisfactory sex experience including orgasm and the seventh heaven is open. The operation is a magnificent success. A fight with husband or lover, an unsuccessful attempt at intercourse, perhaps due to a contracted vagina, the loss of a job, and despondency, pessimism and regret may prevail . . . . At least three months had to elapse before I applied a classification of good, satisfactory, doubtful or unsatisfactory . . . . My impression is that the percentages have remained approximately the same. *In about one third of the patients, the result could be called "good", (if not better), and in one half of the remaining ones, satisfactory. Since this last report of two years ago, unsatisfactory outcomes seem to have increased from 2% to about 8%, due perhaps to as yet unresolved surgical or psychiatric complications or my own more critical assessment . . . . The results of the operation are favorable, to a greater or lesser degree, in more than 75% of the patients that I have observed*.[494]

It is worth noting that Benjamin's post-transition outcome reports include data on people who had transitioned as recently as just three months prior to assessment. While all data can be helpful, data drawn from the context of an extremely brief time-period between surgery and outcome assessment poses an obvious limitation to one's findings.

Pauly (1968)

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[491] Harry Benjamin, "Nature and Management of Transsexualism with a Report of Thirty-one Operated Cases," *Western Journal of Surgery, Obstetrics, and Gynecology* 72 (1964), 105-11; idem, "Clinical Aspects of Transsexualism in the Male and Female." See also Benjamin, *Transsexual Phenomenon*. Here I draw on Pauly's ("Male Psychosexual Inversion: Transsexualism," 177) summary of Benjamin's studies.
[492] Benjamin, "Transvestism and Transsexualism in the Male and Female."
[493] Harry Benjamin, "Newer Aspects of the Transsexual Phenomenon," *Journal of Sex Research* 5/2 (1969), 135-41.
[494] Ibid., 139, 141 (emphasis added). For another end-of-the-decade report, see J. B. Randell, "Preoperative and Postoperative Status of Male and Female Transsexuals," in *Transsexualism and Sex Reassignment*, eds. R. Green and J. Money (Baltimore: Johns Hopkins University Press, 1969), 355-82.

In another end-of the decade study, Ira Pauly reports on surgical outcomes of 121 MtF cases – 48 cases drawn from his own work and 73 from Benjamin's (up to 1967).[495] The follow-up period ranged from three months to 13 years, with an average of five years. Pauly categorized outcome under three types:

(1) Satisfactory – i.e., "good emotional and social adjustment has occurred, together with the patient's indication that he is pleased with the results"[496]

(2) Unsatisfactory – i.e., "either the postoperative adjustment was considered worse than before surgery, or the patient was dissatisfied and wished he had not undergone surgery"[497]

(3) Uncertain – i.e., "insufficient or contradictory evidence exists."[498]

The results: "The combination of these two series [i.e., his and Benjamin's] indicates a satisfactory result from sex reassignment surgery in 67.8 percent of cases, compared to an unsatisfactory result in only 6.6 percent."[499] This leaves 25.6% of the cases in the "uncertain" category. Pauly concludes:

> However cautiously one interprets the results, it would appear that a satisfactory outcome to sex reassignment surgery in terms of improved social and emotional adjustment, is at least 10 times more likely than an unsatisfactory outcome.[500]

Already in the early decades, there was a growing consensus that transition-related outcomes were affected by a number of factors including: (1) the absence/presence of pre-transition psychosis or other serious mental illness; (2) time spent in social transition prior to medical transition; (3) sexual orientation – i.e., those with a homosexual orientation (vis-à-vis their assigned/natal sex) reportedly had better chances of a successful outcome than heterosexuals; (4) medical/surgical complications; (5) post-surgical physical/sexual functionality; (6) effects of transition upon social relationships, especially the response of one's family, (7) whether one was able to "pass" socially as a member of the desired sex/gender; and (8) post-transition

[495] Ira B. Pauly, "The Current Status of the Change of Sex Operation," *Journal of Nervous and Mental Disease* 147/5 (1968), 460-71. For another end-of-the-decade report, see Randell, "Preoperative and Postoperative Status of Male and Female Transsexuals" (1969).
[496] Pauly, "Current Status of the Change of Sex Operation," 464.
[497] Ibid.
[498] Ibid.
[499] Ibid., 464-65.
[500] Ibid., 465.

experience(s) of depression, continuing gender dysphoria, and/or fluctuations in gender identity.[501]

b. Key Studies Published in the 1970s

At the beginning of the decade, J. Hoenig, et al. reported that "there are more than 700 cases [of surgical transition] reported in the world literature."[502] As studies continued to appear on into the 1970s, they tended to report predominately favorable outcomes for medical transition.

Hoenig, et al. (1971)

For example, in their 1971 report on nine cases of surgical transition – six MtF and three FtM – J. Hoenig, et al. state:

> The 7 patients who could be followed up and who had other forms of surgical treatment have done reasonably well with the exception of 2 patients, one man and one woman. Even they did not regret the steps taken but were unhappy that surgery did not completely succeed. The empirical evidence here is in line with that given by other authors and shows that the treatment helps the majority of patients both subjectively and objectively . . . . Nevertheless success was not complete. Perhaps, in view of the surgical difficulties which seem greater than Benjamin's report would lead one to expect, one should try to assess the patients as to their ability to tolerate failure.[503]

Stürup (1971)

In the same year, Georg Stürup had a paper published in which he considered trans people's experience within the correctional setting.[504] Among the cases he describes, he gives significant attention to one person who – after years of HRT and seeking governmental allowance for surgical transition – underwent what Stürup describes as a surprising detransition. The note of concern is apparent when he writes:

> I have mentioned this case in such detail, because I certainly was convinced that the proper treatment would be castration and change of sex, but I am still unable to explain why I was mistaken and thus I risk making similar mistakes again.[505]

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[501] E.g., Benjamin, *Transsexual Phenomenon*; Hertz, et al, "Transvestism"; N. Knorr, S. R. Wolf, and E. Meyer, "The Transsexual's Request for Surgery," *Journal of Nervous and Mental Disease* 147 (1968), 517-24.
[502] J. Hoenig, J. C. Kenna, and Ann Youd, "Surgical Treatment for Transsexualism," *Acta Psychiatrica Scandinavica* 47 (1971), 106–33 (here p. 106).
[503] Ibid., 119.
[504] Georg K. Stürup, "Transsexual Problems in a Correctional Setting," *Australian Journal of Forensic Sciences* 4/2 (1971), 47-55.
[505] Ibid., 50.

Stürup does note that a romantic relationship with an emotionally supportive woman played a significant role in this man's detransition.[506]

Pauly and Lindgren (1976)

Two studies at mid-decade continue to reveal a pattern of generally positive reported outcomes for surgical transition. In a study on gender identity and body image published in 1976, Ira Pauly and Thomas Lindgren conclude:

> Results show a trend toward increased body satisfaction moving from the untreated transsexual, to the treated transsexual, and finally, to the nontranssexual. Transsexuals of both sexes revealed more body dissatisfaction than the nontranssexuals. Nontreated male-to-female transsexuals were more dissatisfied with their bodies than nontreated female-to-male transsexuals. This difference decreased after hormone treatment. Other data indicate that physical alteration of the body through hormones or surgery did improve overall body attitudes in most cases.[507]

Stürup (1976)

In another 1976 study, Georg Stürup reported longitudinal follow-up data on ten MtF surgical transitions spanning up to 19 years post-surgery.[508] Nine of the ten people reported post-operative satisfaction and/or happiness.[509] The final person, who underwent surgical transition 19 years earlier, had since socially detransitioned (i.e., returned to living "as a male"). However, Stürup reported that the man nonetheless believes that "the operation saved his life," and "he claims to be satisfied."[510]

Wålinder, et al. (1978)

[506] Ibid.
[507] Ira B. Pauly and Thomas W. Lindgren, "Body Image and Gender Identity," *Journal of Homosexuality* 2 (1976), 133-42 (here p. 133).
[508] Georg K. Stürup, "Male Transsexuals: A Long-term Follow-up after Sex Reassignment Operations," *Acta Psychiatrica Scandinavica* 53/1 (1976), 51-63.
[509] A sign of the times, Stürup (Ibid., 51) records his concern about three of the cases due to a "promiscuous massive sexual activity exhibited by these patients" that "made it difficult to endorse a surgical solution to their wish to obtain sex reassignment."
[510] Ibid, 51.

In 1978, Jan Wålinder, Bengt Lundstrom, and Inga Thuwe reported on factors associated with transition regret within the Swedish population by comparing nine cases of favorable outcomes with five cases of regret.[511] The authors note that the

> number of factors suspected to be prognostically unfavourable was to a statistically significant degree more common among five 'repentant' cases than among nine cases with favourable outcome.[512]

This research team assessed for 12 potential factors. Those that were found "significantly more often in those transsexuals who regretted the measures taken" included "unstable personality, criminality, inadequate support from the family, inadequacy in self-support, inappropriate physical build and heterosexual experience." They also reported that "the patients with unfavourable outcome were considerably older when they first sought help with the aim of obtaining sex reassignment."[513]

Meyer and Reter (1979)

At decade's end, a transition follow-up study was published that would dramatically affect the future of transition-related medicine in the U.S. This 1979 study involved 50 applicants for medical/surgical transition and compared quality of life outcomes of those who underwent surgical transition vs. those who had not undergone surgery. The study's outcome measures included "job, education, marital, and domiciliary stability."[514] The study concluded that, while surgical transition is usually "subjectively satisfying" for the person, it nonetheless "confers no objective advantage in terms of social rehabilitation" (i.e., in terms of stability in the areas of employment, education, marital relations, etc.).[515]

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[511] Jan Wålinder, Bengt Lundstrom, and Inga Thuwe, "Prognostic Factors in the Assessment of Male Transsexuals for Sex Reassignment," *British Journal of Psychiatry* 132/1 (1978), 16-20. For prior work from this Swedish team, see Jan Wålinder, *Transsexualism: A Study of Forty-three Cases*, trans. H. Frey (Göteborg: Scandinavian University Books, 1967); Wålinder and Thuwe, *Social-Psychiatric Follow-up Study of 24 Sex-Reassigned Transsexuals*.
[512] Wålinder, Lundstrom, and Thuwe, "Prognostic Factors in the Assessment of Male Transsexuals," 19.
[513] Ibid., 16.
[514] Jon K. Meyer and Donna J. Reter, "Sex Reassignment. Follow-up," *Archives of General Psychiatry* 36/9 (1979), 1010-15 (p. 1010).
[515] Ibid.

The lead author of this study was Jon Meyer, a psychiatrist at Johns Hopkins University. Meyer, along with Paul McHugh – the Chair of the Department of Psychiatry at Johns Hopkins – were critical of SRS and were seeking to close the University's gender clinic. Meyer's study provided the evidence base that allowed them to move in that direction. Meyer publicly announced the study's findings at a press conference in October 1979, and the clinic was closed shortly after. This study also served to persuade a number of psychologists and psychoanalysis that medical transition was not an appropriate treatment path for people experiencing gender dysphoria.

Meyer's study and the closing of the Johns Hopkins clinic fueled a public conflict between Meyer and clinic co-founder and advocate John Money, reported in the pages of the *Washington Post* and the *New York Times*.[516] Over the years, this study has drawn intense criticism. Chief foci of critique include the use of questionable statistical procedures and researcher bias motivated by a political agenda.[517] Nonetheless, along with other coalescing factors, this study played a role in the string of U.S. gender clinic closings throughout the 1980s.[518]

c. Key Studies Published in the 1980s

Lothstein (1980)

The decade opened with the publication of a study by L. M. Lothstein titled "The Postsurgical Transsexual: Empirical and Theoretical Considerations."[519] Lothstein's study led to the conclusion that "surgery provided in the context of a comprehensive Gender Identity Clinic program may lead to moderate social-sexual gains." At the same time however, he noted a number of methodological problems with current post-transition follow-up studies, including "the need for a more systematic approach to follow-up, including the use of standardized interviews and clinical assessment tools and adequate control groups."[520]

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[516] Siotos, et al., "Origins of Gender Affirmation Surgery," 133-34.
[517] See e.g., S. I. Abramowitz, "Psychosocial Outcomes of Sex Reassignment Surgery," *Journal of Consulting and Clinical Psychology* 54/2 (1986), 183-89; Richard Green and Davis T. Fleming, "Transsexual Surgery Follow-Up: Status in the 1990s," *Annual Review of Sex Research* 1/1 (1990), 163-74; Richard Carroll, "Outcomes of Treatment for Gender Dysphoria," *Journal of Sex Education and Therapy* 24/3 (1999), 128-36 (esp. p. 132).
[518] Siotos, et al., "Origins of Gender Affirmation Surgery," 133-34.
[519] L. M. Lothstein, "The Postsurgical Transsexual: Empirical and Theoretical Considerations," *Archives of Sexual Behavior* 9 (1980), 547-64.
[520] Ibid., 547.

Hunt and Hampson (1980)

1980 also brought the publication of a study of 17 assigned/natal males who underwent SRS, with an average assessment period of 8.2 years post-surgery. The researchers found

> [n]o changes in levels of psychopathology and only modest gains overall in economic functioning and interpersonal relationships . . . . Larger gains were made in sexual satisfaction and being accepted by family members. None of the 17 transsexuals had doubts about having had the surgery.[521]

They conclude that "for a select group surgery is still the best means of coping with transsexualism."[522]

Pauly (1981)

In a 1981 study, Ira Pauly – citing the need to re-investigate the question of SRS outcomes in light of the fall-out of the 1979 Meyer and Reter study – offered his assessment of data on 283 MtF and 83 FtM cases of surgical transition. Similar to his 1968 study, he concludes that

> [a] satisfactory outcome, as indicated by improved social and emotional adjustment is ten times more likely than an unsatisfactory result . . . . Unfortunately, there are some 17% of patients for whom the result is still uncertain, usually involving those who have not been followed for a long enough period of time to make a determination.[523]

Pauly goes on to note that "the present data indicates that the outcome is better for F-M than for M-F transsexuals."[524] "One sees that 71.4% of the M-F transsexuals were thought to have a satisfactory result; 8.1% unsatisfactory; 17.0% uncertain – and 2.1% of these sex reassigned M-F committed suicide."[525]

Four themes, each of them highlighted in one or more of these three studies, would go on to characterize many of the studies that followed throughout the 1980s and beyond.

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[521] D. D. Hunt and J. L. Hampson, "Follow-up of 17 Biologic Male Transsexuals after Sex-Reassignment Surgery," *American Journal of Psychiatry* 137 (1980), 432-38 (here p. 432).
[522] Ibid.
[523] Ira B. Pauly, "Outcome of Sex Reassignment Surgery for Transsexuals," *Australian New-Zealand Journal of Psychiatry* 15 (1981), 45–51 (here p. 47).
[524] Ibid., 48.
[525] Ibid., 47.

(1) First, as reflected in Pauly's findings, studies consistently found that a significant majority of people who experienced medical transition reported generally positive outcomes. For example, a Danish study by T. **Sörensen (1981)** of post-operative trans women found that "66% were satisfied with the surgical outcome" and "[p]sychically, 83% felt better after than before sex-reassignment."[526] Another study published in a Scandinavian journal (**Lundström, et al. [1984]**) noted that 85-90% of post-operative people reported generally successful outcomes.[527] Relatedly, a study of psycho-social outcomes of SRS by Stephen **Abramowitz (1986)** reported that "[a]pproximately two-thirds of those undergoing sex-change procedures were improved at follow-up. Females-to-males enjoyed somewhat greater success than males-to-females."[528] And a study by F. G. **Bouman (1988)** of MtF genital surgery outcomes reported that

> [i]n the follow-up, special attention was paid to the patients' reactions to the surgery and to the anatomical and functional results. There was only 1 patient who regretted having had the operation. All the others were well pleased and content that their external sexual organs at last fitted their body image.[529]

The conclusion of **Kuiper and Cohen-Kettenis (1988)** involving a study of 141 post-operative Dutch people (105 MtF and 36 FtM) reflects the broad 1980s consensus regarding the majority of those who pursue medical transition: "there is no reason to doubt the therapeutic effect of sex reassignment surgery."[530]

(2) Second, despite the generally positive outcome reports for most people who medically transition, studies in the 1980s also found that a significant number of people – even a majority of the subjects in some studies – reported some form or another of negative transition experience (NTE) – sometimes to the point of expressing overall transition regret and/or choosing to detransition. For example, in the study by Sörensen (1981) mentioned above, 23 post-operative

[526] T. Sörensen, "A Follow-up Study of Operated Transsexual Males," *Acta Psychiatrica Scandinavica* 63/5 (1981), 486-503 (here p. 486).
[527] B. Lundström, I. Pauly, and J. Wålinder, "Outcome of Sex Reassignment Surgery," *Acta Psychiatrica Scandinavica* 70/4 (1984), 289-94.
[528] Stephen I. Abramowitz, "Psychosocial Outcome of Sex Reassignment Surgery," *Journal of Consulting and Clinical Psychology* 54/2 (1986), 183-89 (here p. 183).
[529] F. G. Bouman, "Sex Reassignment Surgery in Male to Female Transsexuals," *Annals of Plastic Surgery* 21/6 (1988), 526-31 (here p. 526).
[530] Bram Kuiper and Peggy Cohen-Kettenis, "Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals," *Archives of Sexual Behavior* 17/5 (1988), 439–57 (here p. 439).

(MtF) people were assessed at an average follow-up period of six years. Sörensen concluded that

> [t]he operations turned out not to be resocializing, rather the contrary. The majority had no occupation at follow-up . . . . About 66% lived alone and the majority of those with sexual relationships had had problems. Both before and after operation the majority felt socially isolated.[531]

While 66% were satisfied with their surgeries, this left 34% who were less than satisfied, with 50% of the total group wanting additional surgery. And while 83% reported feeling better psychologically, 17% reporting otherwise. Sörensen goes on to note that

> [t]he majority have had complications and subjective trouble in connection with plastic surgery leading to reoperations of the vagina in most of them. Almost 75% have had sexual relationships postoperatively but not without difficulties.[532]

In 1981, Sörensen also published a companion study on post-operative outcomes for eight FtM Danish people. He reports that "75% found that sex reassignment involved severe practical and social problems."[533]

Abramowitz (1986) notes that while 66% of the people in his study who underwent SRS expressed improved psycho-social outcomes at follow-up, this still leaves 33% who expressed otherwise – with 10% of the MtF subjects reporting "a serious complication."[534]

Finally, a 1986 study by a Swedish research team **(Lindemalm, et al.1986)** based on intensive interviews with 13 MtF people with a relatively long follow-up period of an average of 12 years reported – with a generally pessimistic tone – that

> [s]urgical outcome was disappointing, and only one-third of the patients where a vaginal construction was carried out had a functioning vagina . . . . [O]nly one-third were judged as having a fair or good sexual adjustment after sex reassignment. The possibility of unsuccessful surgical results must continue to be an important part of presurgery reality orientation both in doctors and patients. One striking finding is that overall sexual adjustment is often unchanged by genital surgery. Psychosocial adjustment showed a slight improvement after surgery. However, the majority of patients (eight) were judged

[531] Sörensen, "Follow-up Study of Operated Transsexual Males," 486.
[532] Ibid.
[533] T. Sörensen, "A Follow-up Study of Operated Transsexual Females," *Acta Psychiatrica Scandinavica* 64/1 (1981), 50-64 (here p. 50).
[534] Abramowitz, "Psychosocial Outcome of Sex Reassignment Surgery," 183.

> to be unchanged . . . . One patient had officially requested reversal of sex change and another three were judged as repenting surgery in more indirect ways. Thus for a total of four individuals (30%), sex reassignment was considered retrospectively to be a mistake.[535]

While some found that "[f]emales-to-males enjoyed somewhat greater success than males-to-females," others report that "[t]here are as many failures in the female to male group as in the male to female group."[536] An outcome factor reported by several studies involved the age of a person at transition: "Relatively high age when first requesting sex reassignment may be regarded as a risk factor for poor outcome."[537]

(3) Third, throughout the 1980s, it was common for post-surgical outcome studies to claim that, among the broader group of those who experience gender dysphoria, one distinct subset of people tends to benefit significantly from SRS, while a second group tends to benefit much less so. One ramification of this conclusion was that a set of characteristics of people seeking medical transition could potentially be ascertained that could serve to predict positive vs. negative transition outcomes.

The conviction that there were distinct types of transsexualism had become progressively ensconced within the field over the previous two decades. As mentioned earlier, Harry Benjamin had proposed a six-point Sex Orientation Scale in his ground-breaking 1966 book, *The Transsexual Phenomenon*. This scale categorized people according to the intensity of their desire to identify with the opposite biological sex. The scale offered six distinct types that span the spectrum of gender-variant experiences from an occasional desire to cross-dress to the highest level of desire to medically transition to the opposite sex. Benjamin gave the following labels to the six catrgories: (1) pseudo-transvestism; (2) fetishistic transvestism; (3) true transvestism; (4)

[535] G. Lindemalm, D. Körlin, and N. Uddenberg, "Long-term Follow-up of 'Sex Change' in 13 Male-to-Female Transsexuals," *Archives of Sexual Behavior* 15/3 (1986), 187-210 (here p. 187).
[536] See respectively, Abramowitz, "Psychosocial Outcome of Sex Reassignment Surgery," 183; Lundström, Pauly, and Wålinder, "Outcome of Sex Reassignment Surgery," 289. On this issue, Kuiper and Cohen- Kettenis ("Sex Reassignment Surgery," 439) conclude their study with: "The findings obtained in the female-to-male transsexuals compare favorably with those obtained in male-to-female transsexuals."
[537] Lundström, Pauly, and Wålinder, "Outcome of Sex Reassignment Surgery," 289.

nonsurgical transsexualism; (5) true transsexualism (moderate intensity); and (6) true transsexualism (high intensity).[538]

Among other things, Benjamin correlated each category with the expressed level of desire for surgical transition, concluding that only those identified as one of the two sub-types of "true transsexual" are suitable for SRS. Benjamin's six categories naturally left linguistic room for further development of sub-types of transsexualism. One distinction that emerged was "primary" vs. "secondary" transsexualism. In a pair of 1974 articles, Ethel Person and Lionel Ovesey explain this distinction:

> Transsexuals are described as falling into 2 groups: primary and secondary. The former are transsexuals throughout the course of their development; the latter are effeminate homosexuals and transvestites who become transsexuals under stress.[539]

They elaborate on secondary transsexualism:

> Secondary transsexualism is defined as transsexualism developing in homosexuals and transvestites regressively under conditions of stress. Secondary transsexuals, homosexual and transvestitic, are differentiated, each from the other, and both from primary transsexuals, who are essentially asexual.[540]

The categories of primary vs. secondary transsexualism play a significant role in a study by Richard **Docter (1988)**, titled *Transvestites and Transsexuals: Towards a Theory of Cross-Gender Behavior*.[541] Docter provides this description of primary transsexualism:

> This category describes individuals who have presented a lifelong history of gender dysphoria, a history of cross-gender identity, and an absence of fetishism associated with cross-dressing. It is imperative that early childhood roots of major gender discontentment are revealed. Sexual preference is usually homosexual from an early age. There usually will have been a history of cross-dressing. The critical component that sets this category part from all others is the necessary history of lifelong gender dysphoric feelings.[542]

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[538] Benjamin, *Transsexual Phenomenon*, 21-24.
[539] Ethel Person and Lionel Ovesey, "The Transsexual Syndrome in Males: I. Primary Transsexualism," *American Journal of Psychotherapy* 28/1 (1974), 4-20 (here p. 4)
[540] Ethel Person and Lionel Ovesey, "The Transsexual Syndrome in Males: II. Secondary Transsexualism," *American Journal of Psychotherapy* 28/2 (1974), 174-93 (here p. 174).
[541] Richard F. Docter, *Transvestites and Transsexuals: Towards a Theory of Cross-Gender Behavior* (New York: Springer, 1988).
[542] Ibid., 24-25.

Docter goes on to describe secondary transsexualism and its two sub-types: transvestite and homosexual:

> Two patterns of secondary transsexualism have been identified . . . . One is based on a career as a transvestite and the other is based on a prior career as a homosexual. It is because of these preceding career life styles which may be considered primary that the subsequent change to transsexualism is called secondary. It is essential that one of these preceding patterns of behavior be identified and that there be an absence of long-standing gender dysphoria.[543]

Among the key characteristics of the transvestite type of secondary transsexualism, Docter lists: (1) an absence of life-long gender dysphoria (i.e., late-onset); (2) a history of sexual arousal to cross-dressing; and (3) a progressive growth of gender dysphoria (which can be stress-related).[544] Key characteristics of the homosexual type of secondary transsexualism include: (1) an absence of life-long gender dysphoria (i.e., late-onset); (2) No history of erotically-motivated cross-dressing; (3) history of predominately homosexual erotic preference.[545]

The categories of primary and secondary transsexualism – or similar ones – play a role in a number of studies in the 1980s as they offer guidance on which gender dysphoric people are best suited for surgical transition. For example, Lundström, Pauly, and Wålinder write:

> Genuine transsexuals as a group seem to have a better prognosis for successful outcome of sex reassignment than a group of secondary transsexuals (i.e. transvestites and effeminate homosexuals). On the other hand, secondary transsexuals do better than genuine transsexuals when sex reassignment is refused. It is stressed that great importance should be given to the differential diagnosis when evaluating gender dysphoric patients for sex reassignment.[546]

Lothstein concludes:

> There is evidence suggesting that some gender dysphoric patients benefit primarily from sex reassignment surgery. Most such patients, however, are secondary transsexuals who can benefit from various modes of psychotherapy. Sex reassignment surgery should only be considered as the last resort for a highly select group of diagnosed gender dysphoric patients.[547]

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[543] Ibid., 29.
[544] Ibid.
[545] Ibid., 32.
[546] Lundström, Pauly, and Wålinder, "Outcome of Sex Reassignment Surgery," 289.
[547] L. M. Lothstein, "Sex Reassignment Surgery: Historical, Bioethical, and Theoretical Issues," *American Journal of Psychiatry* 139/4 (1982), 417-26 (here p. 417).

Sörensen makes use of the categories of *core* and *non-core* transsexuals to articulate a similar distinction:

> A special core group of transsexual males has been described as characterized by a stable defence in the form of a pseudofeminine narcissism, a stable ego strength, an intact reality testing and a poor genital interest. These patients are expected to have a relatively stable life postoperatively . . . . It is the general impression at follow-up that the advantages of sex-reassignment outweigh the disadvantages where the core group is concerned. But among the persons who do not belong to the core group subjective and objective problems seem so pronounced that operation must be advised against in spite of the often extremely, subjectively unsatisfactory condition of these patients preoperatively.[548]

Another set of categories emerged in the 1980s that has incited controversy on up to today. In a 1982 article, a Toronto-based team of researchers **(Freund, et al. 1982)** proposed that "apart from rare exceptions, some modes of cross-gender identity occur only in heterosexuals, others only in homosexuals."[549] By the end of the decade, Ray **Blanchard (1985; 1989)** had developed this idea – that sexual orientation plays a crucial role in the type of transsexualism that one experiences – into the typology of androcentric vs. autogynephilic transsexualism.[550] According to Blanchard's theory, *androphilic* (or homosexual) transsexuals are gay men (vis-à-vis their assigned/natal sex) who typically come out as transsexual early in life, and whose motivation for transitioning is grounded in their desire for heterosexual men to be attracted to them *as a woman*. Blanchard's second type, *autogynephilic* transsexuals, are heterosexual men who typically present as transexual later in life (late-onset), and whose desire for transition is fed by their own sexual arousal associated with experiencing themselves as a woman.

Blanchard's theory ties into our survey of negative transition experiences and transition regret in that he and his colleagues (**Blanchard, et al. [1989]**) eventually proposed that autogynephilic transsexuals tend to have higher rates of postoperative regret than androphilic transsexuals.[551]

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[548] Sörensen, "Follow-up Study of Operated Transsexual Males," 486.
[549] Kurt Freund, Betty W. Steiner, and Samuel Chan, "Two Types of Cross-Gender Identity," *Archives of Sexual Behavior* 11/1 (1982), 49–63 (here p. 59).
[550] Ray Blanchard, "Typology of Male-to-Female Transsexualism," *Archives of Sexual Behavior* 14/3 (1985), 247-61; idem, "The Concept of Autogynephilia and the Typology of Male Gender Dysphoria," *Journal of Nervous and Mental Disease* 177 (1989), 616-23.
[551] Ray Blanchard, Betty W. Steiner, Leonard H. Clemmensen, and Robert Dickey, "Prediction of Regrets in Postoperative Transsexuals," *Canadian Journal of Psychiatry* 34 (1989), 43-45.

Specifically, their study is based on responses to a self-administered questionnaire by 111 post-operative trans people who had undergone SRS at least one year prior. Their response rate to this follow-up study was 84.1%. The results showed that none of the 61 homosexual females or 36 homosexual males expressed surgical regret, However, "[i]n contrast, 4 of the 14 heterosexual males (28.6%) consciously regretted the decision to undergo reassignment surgery."[552]

This trend to distinguish between different types of transsexualism – and especially the different transition outcomes for different types – strengthened the conviction that proper clinical assessment and diagnosis was an essential step in the transition process. This conviction was, for example, strongly voiced by Milton Edgerton – a pioneering plastic surgeon and one of the original team members at the Johns Hopkins clinic – and colleagues in a 1982 article: "The selection of transsexuals for surgery must be based on the correct diagnosis."[553] In recent years, this conviction has been strongly challenged by trans activists and allies who argue that making medical transition dependent upon psychological diagnosis only contributes to the stigmatizing pathologization of trans experience and the oppressive "gate-keeping" power of the psychiatric establishment.

(4) Fourth and finally, a number of the studies published in the 1980s register concerns that significant methodological problems plagued then-current studies of transsexualism. Methodological concerns include: (1) the lack of control groups (i.e., randomized controlled trials);[554] (2) the lack of standardized diagnoses and diagnostic criteria related to gender dysphoria;[555] (3) the lack of uniformity in follow-up methods;[556] (4) the inherent weaknesses of "ex post facto" studies based solely on subjects' self-reports;[557] and (5) the lack of longitudinal follow-up studies of sufficient length.[558] These methodological problems – along with additional

[552] Ibid., 44.
[553] Milton T. Edgerton, Jr., Margateha W. Langman, Joyce S. Schmidt, and William Scheppe, Jr., "Psychological Considerations of Gender Reassignment Surgery," *Clinics in Plastic Surgery* 9/3 (1982), 355-66 (here p. 355). Similarly, Lundström, Pauly, and Wålinder, "Outcome of Sex Reassignment Surgery," 289.
[554] Abramowitz, "Psychosocial Outcome of Sex Reassignment Surgery," 183.
[555] Lundström, Pauly, and Wålinder, "Outcome of Sex Reassignment Surgery," 289.
[556] Ibid., 289-90.
[557] Kuiper and Cohen-Kettenis, "Sex Reassignment Surgery," 439.
[558] Lothstein, "Sex Reassignment Surgery," 417.

methodological concerns that emerged later – have become a perennial concern for many researchers on up to today.

d. Key Studies Published in the 1990s

Green and Fleming (1990)

The decade opened with a robust 1990 review by Richard Green and Davis Fleming of surgical transition outcome studies conducted between 1979 – 1989.[559] They summarize their findings:

> Of the 130 F-Ms reported, about 97% of the outcomes can be considered "satisfactory," and about 3% "unsatisfactory." Of the 220 M-Fs, about 87% of the outcomes can be considered "satisfactory," about 13% "unsatisfactory," and 1% "uncertain."[560]

They go on to clarify their use of the categories of "satisfactory" vs. "unsatisfactory": "Generally, unless the patient is reported to regret surgery, the outcome is considered 'satisfactory.'"[561] In light of this definition of "satisfactory" and using the four-fold typology proposed above, it seems that people registering something short of explicit post-transition "regret" – i.e., post-transition difficulty and/or dissatisfaction – would still be counted as "satisfactory" outcomes. Apparently, this means that in reporting an "unsatisfactory" surgical transition outcome rate of 13% for trans women, they are actually reporting *a 13% regret rate*.

Regarding the challenge of identifying appropriate – let alone standardized – criteria for the assessment of "satisfactory" vs. "unsatisfactory" outcomes, they write:

> We recognize the inherent limitation of judging such results "satisfactory." We are mindful of the propensity to report major life decisions as having been wisely taken. However, these gross categories are offered to provide a general impression of reported follow-up status, which must be elaborated upon further . . . . The lack of reported standardized selection criteria for surgery, and the infrequent use of standardized outcome instruments and rating criteria make follow-up conclusions difficult. This difficulty remains after 25 years of sex-reassignment surgery.[562]

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[559] Richard Green and Davis T. Fleming, "Transsexual Surgery Follow-Up: Status in the 1990s," *Annual Review of Sex Research* 1/1 (1990), 163-74.
[560] Ibid., 164.
[561] Ibid.
[562] Ibid., 164, 171.

Despite these methodological challenges, they conclude that four "pre-operative factors" appear to predict favorable outcomes: (1) a "reasonable degree of mental and emotional stability"; (2) "successful adaptation in the desired role [i.e., social transition] for at least 1 year"; (3) "sufficient understanding of the limitations and consequences of surgery"; and (4) "pre-operative application of psychotherapy preferably in the context of a gender identity program."[563] They also note:

> There is some evidence that outcome is less favorable for secondary transsexuals [i.e., "transvestites and feminine homosexuals"[564]], and some reports suggest that secondary transsexuals function reasonably well when denied surgery.[565]

Stein, et al. (1990)

1990 also saw the publication of a study by Stein, Tiefer, and Melman. The purpose of this study was to assess post-surgical psychosocial and functional outcomes through in-depth interviews with ten (out of a total cohort of 22) MtF trans people who underwent vaginoplasty between May 1985 and December 1988.[566] The follow-up period ranged from 5 months to four years post-surgery. Their findings were generally positive:

> Most patients were able to develop strong support systems and showed a marked decrease in suicidal tendencies postoperatively. Functionally, the majority of the patients were able to lubricate the neovagina and have painless intercourse with a potential for orgasm. The cosmetic result was judged to be good, with no patient reporting being discovered of having had a prior operation by the sexual partner.[567]

However, as others have pointed out, this study serves to highlight an ongoing methodological problem for post-transition studies: namely the high "lost to follow-up" (or "attrition") rates – i.e., the fact that a significant number of people in any post-transition study cohort are, for one reason or another, unable or unwilling to participate in the follow-up assessment.[568] In obtaining

[563] Ibid., 172.
[564] Ibid., 163.
[565] Ibid., 172.
[566] M. Stein, L. Tiefer, and A. Melman, "Follow-up Observations of Operated Male-to-Female Transsexuals," *Journal of Urology* 143 (1990), 1188-92.
[567] Ibid., 1188.
[568] E.g., Aude Michel, Christian Mormont, and Jean-Jacques Legros, "A Psycho-endocrinological Overview of Transsexualism," *European Journal of Endocrinology* 145/4 (2001), 365–76.

in-depth interviews from only 10 of the 22 cohort members, it appears that this study experienced a 54.5% lost to follow-up rate.[569]

Pfäfflin and Junge (1992/1998); Pfäfflin (1993)

In 1992, Friedemann Pfäfflin and Astrid Junge produced the most thorough review of post-surgical outcome studies to that point in time.[570] In 1993, Pfäfflin produced a related study focusing on transition regret.[571] The 1992 review surveyed over seventy individual studies and eight previously published meta-analyses from a range of countries spanning four different continents. By gleaning from this range of studies, Pfäfflin and Junge were able to report on the post-surgical outcomes of roughly 2,000 individuals from 1961 to 1991. They conclude that – with proper presurgical diagnosis and surgical execution – SRS is an effective means of treating transgender people seeking to transition. They found that roughly 70% of MtF people – and 90% of FtM people – reported satisfaction with their transition outcomes. They note, however, that this is not a pathway to be used in isolation. Other important components that are vital to positive outcomes include: preparatory "real life" experience (i.e., a period of pre-surgical social transition), hormone therapy, counseling/psychotherapy, legal name and sex change, etc.

With regard to transition regret, Pfäfflin and Junge report an overall regret rate of 1% among FtM subjects and 1-1.5% among MtF subjects. Once again, these percentages may well reflect an underreporting of regret due to low response-rates in the follow-up studies. In a related article, Pfäfflin notes three major sources of regret: (1) inadequate pre-surgical diagnosis; (2) failure to socially transition for a period of time as a "real life" test; and (3) disappointing surgical results (i.e., in terms of aesthetics or functionality).[572]

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[569] I say "appears" here, because at another point in the article the authors state: "Followup from 5 to 48 months was available for 14 patients." If this means that 14 patients were involved in the extensive outcome interviews – rather than the statement cited here that "10 of the 22" were involved – then the lost to follow-up rate would be 36.4%. In either case, the attrition rate is significant.

[570] Friedemann Pfäfflin and Astrid Junge, *Nachuntersuchungen nach Geschlechusumwandlung: eine Kemmentierte Literatureubersicht 1961-1991* (Stuttgart: Scahttauer, 1992). It was eventually translated into English and published as: Friedemann Pfäfflin and Astrid Junge, "Sex Reassignment: Thirty Years of International Follow-up Studies After Sex Reassignment Surgery: A Comprehensive Review, 1961–199," *International Journal of Transgenderism* – Book Section. Translated by Roberta. B. Jacobson and Alf B. Meier. Dusseldorf, Germany: Symposion, 1998 [1992].

[571] Friedemann Pfäfflin, "Regrets After Sex Reassignment Surgery," *Journal of Psychology & Human Sexuality* 5/4 (1993), 69–85.

[572] Ibid.

Tsoi (1993)

In 1993, Wing Foo Tsoi published a post-surgical follow-up study of psychosocial outcomes for 45 MtF and 36 FtM Singaporean Chinese subjects who underwent SRS between 1972 and 1988 – the first such study of Chinese trans people.[573] The reported mean age-of-onset of gender dysphoria was 8.71 years for assigned/natal males and 8.64 years for assigned/natal females.[574] The follow-up period was between one and eight years post-surgery, with the majority being assessed between two and five years. Using the Post-operative Adjustment Scale, Tsoi found that "overall results were 56% very good and 44% good."[575] Tsoi goes on to conclude that "successful sex -reassignment surgery improves the social and emotional functions of carefully selected transsexuals."[576]

Regarding the set of selection criteria used to approve transition surgery in this Singaporean study, Tsoi lists the following:

> well -established transsexuals, good physical health, mentally healthy, not mentally retarded, absence of heterosexual tendencies, feeling comfortable with cross-dressing, willing to take opposite sex hormones and living the life of the opposite sex for at least six months.[577]

In comparing the assigned/natal male vs. female cohorts for potential predictive factors associated with transition outcomes, Tsoi concluded that there are "no pre-operative variables that can predict good adjustments for female transsexuals." However, [f]or male transsexuals, earlier age of transsexual manifestation was related to good post-operative adjustments."[578] Tsoi reports that with regard to genital surgeries specifically:

> Compared with the females, the male transsexuals (91%) were more satisfied with the results of surgery than female transsexuals (39%). This resulted in the female transsexuals having less satisfaction with their new sex organ (Table II). This is understandable because it was not possible to construct a fully functioning male neophallus.[579]

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[573] W. F. Tsoi, "Follow-up Study of Transsexuals After Sex-Reassignment Surgery," *Singapore Medical Journal* 34/6 (1993), 515-17.
[574] Ibid., 516.
[575] Ibid., 515.
[576] Ibid., 517.
[577] Ibid., 515.
[578] Ibid.
[579] Ibid., 516.

Bodlund and Kullgren (1996)

In 1996, two Swedish researchers published a study based on a five-year follow-up of 19 people who were approved for surgical transition. Their outcome evaluation focused on measurements of "social, psychological, and psychiatric functioning."[580] At the time of follow-up, 18 of the people were accessing hormone therapy, 12 had completed SRS, and 3 FtM subjects were awaiting phalloplasty. Among the study results:

> Overall, 68% (n=13) had improved in at least two areas of functioning. In 3 cases (16%) outcome were judged as unsatisfactory and one of those regarded sex change as a failure [i.e., one of the MtF subjects "regretted the decision to change sex and had quit the process" = detransition]. Another 3 patients were mainly unchanged after 5 years. Female transsexuals had a slightly better outcome . . . . Baseline factors associated with negative outcome (unchanged or worsened) were presence of a personality disorder and high number of fulfilled axis II criteria.[581]

van Kesteren, et al. (1996)

In the same year, a research team in the Netherlands produced a study involving 1,285 trans identified Dutch people (including both males and females), over 95% of which were seen at their Amsterdam clinic between 1975 and 1992. Among their findings:

> The majority of female-to-male transsexuals apply for reassignment between the ages of 20–25, seldom in middle ages. The majority of male-to-female transsexuals do so between the ages of 25–30 and middle-aged subjects are not rare. Between 77–80% of both categories receive surgical and/or hormonal treatment. Five male-to-female transsexuals regretted sex reassignment.[582]

Cohen-Kettenis and van Goozen (1997)

The next year (1997), Peggy Cohen-Kettenis and Stephanie van Goozen – also based in the Netherlands – conducted the first post-transition outcome study of people who were adolescents at the commencement of transition.[583] Practically speaking, this meant that the 19 subjects who were interviewed at the time of follow-up (which included "14 FMs and 5 MFs") began the early

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[580] Owe Bodlund and Gunnar Kullgren, "Transsexualism—General Outcome and Prognostic Factors: A Five-Year Follow-up Study of Nineteen Transsexuals in the Process of Changing Sex," *Archives of Sexual Behavior* 25 (1996), 303-16 (here p. 303).
[581] Ibid.
[582] P. J. M. van Kesteren, L. J. Gooren, and J. A. Megens, "An Epidemiological and Demographic Study of Transsexuals in the Netherlands," *Archives of Sexual Behavior* 25/6 (1996), 589–600 (here p. 589).
[583] Peggy T. Cohen-Kettenis and Stephanie H. M. van Goozen, "Sex Reassignment of Adolescent Transsexuals: A Follow-up Study," *Journal of the American Academy of Child and Adolescent Psychiatry* 36 (1997), 263-71.

phase(s) of the transition process (i.e., social transition; or social transition along with partial or full hormone treatment) while still below the legal age of adulthood. At follow-up, each of the subjects were legal adults and had undergone surgery at least one-year prior.[584] Regarding their findings, Cohen-Kettenis and van Goozen state:

> Postoperatively the group was no longer gender-dysphoric; they scored in the normal range with respect to a number of different psychological measures and they were socially functioning quite well. Not a single subject expressed feelings of regret concerning the decision to undergo sex reassignment . . . . Starting the sex reassignment procedure before adulthood results in favorable postoperative functioning, provided that careful diagnosis takes place in a specialized gender team and that the criteria for starting the procedure early are stringent.[585]

They do note a factor of their study that limits the universalizing of its overall positive outcomes to all trans adolescents: "[M]ost of the transsexuals in our study were FMs. From other studies we know that FMs in many respects fare better than MFs postoperatively."[586]

Barrett (1998)

In 1998, James Barrett published a study in the recently launched *International Journal of Transgenderism* that investigated post-surgical outcomes for trans men who had undergone phalloplasty.[587] More specifically, this study compared "23 transsexuals accepted for phalloplasty" with "40 who had undergone such surgery between six and one hundred and sixty months previously."[588] Barrett reports that this comparison reveal "significant differences" between the two groups. A number of the outcomes were quite positive:

> There was improved satisfaction with genital appearance post-operatively . . . . Most other changes were in the expected direction but did not achieve significance. Transsexuals accepted for phalloplasty have very good psychological health. Tendency to further improvement is the case after phalloplasty.[589]

[584] Ibid., 266.
[585] Ibid., 263.
[586] Ibid., 270.
[587] James Barrett, "Psychological and Social Function Before and After Phalloplasty," *International Journal of Transgenderism* 2/1 (1998), 1-8.
[588] Ibid., 1.
[589] Ibid.

However, Barrett also found some less encouraging results: "The post operative group showed higher depression ratings on the depression subscale of the GHQ [i.e., General Health Questionnaire] . . . . and quality of relationships declines somewhat, perhaps in consequence."[590]

Kuiper and Cohen-Kettenis (1998)

1998 also brought two studies explicitly focused on the issue of post-transition regret. We have already mentioned one of them: the study by Abraham Kuiper and Peggy Cohen-Kettenis, in which they propose a four-fold typology of transition regret.[591] For this study, Kuiper and Cohen-Kettenis conducted an extensive interview with ten people who explicitly expressed regret about their transition and/or who detransitioned (nine assigned/natal males and one assigned/natal female). The mean age of the participants at interview was 46 years. On average, they had applied for SRS 11 years prior to the interview.

Kuiper and Cohen-Kettenis describe the current status of the ten people as follows:

> Seven subjects, including the FM, reported to have, at some point in their lives, changed their gender identity towards their former biological status (table 3). One person (MF) felt stable and confident in the new gender, one person felt in-between, and one person reported to have a fluctuating gender identity.
>
> Seven subjects, including the FM, had decided to live again permanently in their former gender role. Two MFs showed fluctuating gender role behavior. Sometimes they lived as a woman, sometimes as a man. The only MF with a stable female gender identity leads a double life. On request of his wife and his six children this elderly person lived at home as a woman, but publicly as a man . . . . With the exception of one MF not one person would ever decide again to start with the sex reassignment procedure (table 4). They now think that it did not solve their real problems.[592]

Reasons given for the causes of their transition regret include: "wrong diagnosis, . . . social isolation, disappointing surgical results, and a sudden vanishing of the urge to live as a woman."[593] Kuiper and Cohen-Kettenis go on to note that:

> Seven subjects already had doubts before or during the SR procedure (table 6), but five of them only expressed them postoperatively. They didn't dare to share their feelings with their psychologist or psychiatrist, as they were afraid that it would put the SRS at risk.

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[590] Ibid.
[591] A. J. Kuiper and P. T. Cohen- Kettenis, "Gender Role Reversal among Postoperative Transsexuals," *International Journal of Transgenderism* 2/3 (1998), http://www.symposion.com/ijt/ijtc0502.htm.
[592] Ibid.
[593] Ibid.

> Two MFs reported, even before the start of the SR procedure, to their clinician to have significant doubts about the correctness of the decision to undergo the sex reassignment. One felt driven by his former partner to become a woman and claimed never to have had a female gender identity. He never expressed his doubts. The other MF feared the future, because of his very poor social conditions. He said to have showed his hesitations to his psychologist, but had been reassured by him.[594]

Kuiper and Cohen-Kettenis also draw attention to an interesting dynamic within this group of people regarding their gender development:

> Five subjects had their first cross-gender feelings in childhood (table 7). The other five persons had this experience on a much later age. Furthermore, 7 MFs and the one FM started cross-dressing only after the beginning of puberty; the other 2 MFs incidentally cross-dressed before puberty. For one person the cross-dressing had always been associated with sexual arousal. It is very notable that with exception of 1 MF and the FM no person showed distinct atypical gender role behavior during their childhood.[595]

They go on to reflect on the fact that "almost no one reported extreme atypical gender role behavior during childhood":

> This places our cases among the late to very late manifestations [i.e., late-onset] of gender dysphoria. It is assumed that late onset gender dysphoria itself may be a risk factor, . . . certainly if there are plausible psychological explanations for the arisal of the gender dysphoria. In our opinion, for five subjects there were such explanations (subjects 1, 2, 3, 7 and 9). In these cases, psychotherapeutic or other non-medical treatment exploring the request for SRS as a solution for their problems should probably have been the treatment of choice.[596]

In conclusion, they propose several risk factors for transition regret/detransition, including "stress-related late onset of the gender conflict, fetishistic cross-dressing, psychological instability and/or social isolation."[597] "In spite of strict prior selection and counseling during the treatment, an estimated 1 to 2 percent of those treated express regret about the SRS, be it for different reasons."[598]

Landén, et al. (1998); Landén (1999)

[594] Ibid.
[595] Ibid.
[596] Ibid.
[597] Ibid.
[598] Ibid.

The second 1998 study focusing on transition regret was produced by a team of Swedish researchers (Landén, Wålinder, Hambert, and Lundström).[599] This article is, itself, informed by Mikael Landén's 1999 doctoral thesis.[600] Drawing from a database of all people approved for medical transition in Sweden between 1972 and 1992 – a total cohort of 218 – they compared the smaller sub-group of those who eventually chose to detransition with the majority who did not. The follow-up period between application for transition to evaluation ranged from 4 to 24 years.

Landén, et al. report that "3.8% of the patients who were sex reassigned during 1972-1992 regretted the measures taken."[601] They also found that two of the primary factors predicting transition regret were "lack of support from the patient's family, and the patient belonging to the non-core [i.e., "secondary"] group of transsexuals."

Rehman, et al. (1999)

The decade closed with a study based on data from a New York-based medical center involving people who had medically transitioned (MtF) between 1980 and 1994.[602] The minimum follow-up period was three years. Of the 47 people in this cohort, 28 responded to the follow-up invitation. This represents a 40.5% lost to follow-up rate. Among the findings of this study:

> Physical and functional results of surgery were judged to be good, with few patients requiring additional corrective surgery. General satisfaction was expressed over the quality of cosmetic (normal appearing genitalia) and functional (ability to perceive orgasm) results. None of the patients regretted having had surgery. However, some were, to a degree, disappointed because of difficulties experienced postoperatively in adjusting satisfactorily as women both in their relationships with men and in living their lives generally as women.[603]

One "significant outcome" of this study is

> the importance of proper preparation of patients for surgery and especially the need for additional postoperative psychotherapy . . . . Findings of this study make a strong case for

[599] M. J. Landén, J. Wålinder, G. Hambert, and B. Lundström, "Factors Predictive of Regret in Sex Reassignment," *Acta Psychiatrica Scandinavica* 97 (1998), 284–89.
[600] Mikael Landén, "Transsexualism. Epidemiology, Phenomenology, Regret after Surgery, Aetiology, and Public Attitudes," Doctoral thesis (University of Gothenburg, 1999).
[601] Landén, et al., "Factors Predictive of Regret in Sex Reassignment," 284.
[602] Jamil Rehman, Simcha Lazer, Alexandru E. Benet, Leah C. Schaefer, and Arnold Melman, "The Reported Sex and Surgery Satisfactions of 28 Postoperative Male-to-Female Transsexual Patients," *Archives of Sexual Behavior* 28/1 (1999), 71–89.
[603] Ibid., 71.

> making a change in the Harry Benjamin Standards of Care to include a period of postoperative psychotherapy.[604]

The four themes drawn from and used to summarize the key findings of the 1980 studies above are, once again, clearly visible in the studies published during the 1990s. We will use them once again to summarize this decades-worth of research findings.

(1) The majority of people undergoing medical transition reported generally positive post-transition outcomes on most areas of measurement

This conclusion is highlighted in virtually every study. Green and Fleming (1990) report that out of 130 FtM people, 97% were considered satisfactory outcomes. And out of 220 MtF people, 87% were considered satisfactory outcomes. Stein, et al (1990) report overall very positive psycho-social and functional outcomes for MtF people who underwent vaginoplasty.

Significantly, Pfäfflin and Junge (1992/1998) produced the most thorough review of post-surgical outcome studies to that point in time. They found that roughly 70% of MtF people – and 90% of FtM people – reported satisfactory transition outcomes. Even more remarkably, using the Post-operative Adjustment Scale, Tsoi found that none of his 81 Singaporean Chinese study participants (45 MtF and 36 FtM) showed evidence of a "poor adjustment," with overall post-surgical adjustment scores ranking as 56% "very good" and 44% "good."[605] In his follow-up study of post-operative outcomes for MtF people undergoing phalloplasty, Barrett (1998) reported positive outcomes on most measures. Finally, Rehman, et al.'s (1999) follow-up study of post-operative outcomes for 28 MtF people reported that, generally speaking, "[p]hysical and functional results of surgery were judged to be good."[606]

Of significant note is Cohen-Kettenis and van Goozen (1997), which represents the first post-transition outcome study of adolescents. Although their outcome report was very positive, they warn against universalizing its results since most of their participants were FtM subjects who tend to report better outcomes that MtF people.

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[604] Ibid.
[605] Tsoi, "Follow-up Study of Transsexuals After Sex-Reassignment Surgery," 516, 515.
[606] Rehman, et al., "Reported Sex and Surgery Satisfactions," 71.

(2) A not-insignificant sub-set of people who undergo medical transition reported various types of NTEs, including negative psycho-social and surgical outcomes, as well as transition regret and/or detransition

Green & Fleming report that 3% of the 130 FtM people in their study – and roughly 13% of the 220 MtF people – considered their transition outcome "unsatisfactory." Importantly, given their specifically regret-oriented definition of "unsatisfactory," this appears to amount to *a 13% regret rate*.[607] In contrast to this, in their comprehensive review of transition outcome studies up to 1991, Pfäfflin and Junge report an overall regret rate of roughly 1% among FtM people and 1-1.5% among MtF people. In their study of 19 Swedish people approved for SRS, Bodlund and Kullgren (1996) report that three of the total cohort (16%) were judged as unsatisfactory outcomes, with one of the three "regretting the decision to change sex and [quitting] the process" – amounting to a 5.3% regret – and, apparently, detransition – rate. Barrett's (1998) study of *outcomes for ph*alloplasty found some less encouraging post-operative results for certain measurements: "The post operative group showed higher depression ratings" and a decline in relationship quality.[608] In their study with a specific focus on transition regret, Kuiper and Cohen-Kettenis (1998) estimate that 1% - 2% of people who undergo SRS end up reporting regret. Finally, based on the 218-person cohort of people who were approved for medical transition in Sweden between 1972 and 1992, Landén, et al. (1998) report that "3.8% of the patients who were sex reassigned during 1972-1992 regretted the measures taken."[609]

(3) Most studies report a set of pre-transition factors that can serve to predict positive vs. negative transition outcomes

Green and Fleming (1990) note five such factors: (1) mental and emotional stability; (2) a successful one-year period of social transition; (3) a clear understanding of the surgical limitations and risks; (4) pre-operative psychotherapy; and (5) outcomes appear more favorable for "primary" than for "secondary" transsexuals.

[607] Green and Fleming, "Transsexual Surgery Follow-Up," 164.
[608] Barrett, "Psychological and Social Function Before and After Phalloplasty," 1.
[609] Landén, et al., "Factors Predictive of Regret in Sex Reassignment," 284.

Pfäfflin and Junge (1992/1998) make note of three sources of regret: (1) inadequate pre-surgical diagnosis; (2) failure to socially transition for a period of time; and (3) disappointing surgical results (aesthetically and/or functionally). They add that (1) counseling/psychotherapy and (2) legal name and sex change add to the likelihood of positive outcomes.

Tsoi (1993) is the outlier in these studies when he reports that he did not find much in the way of "pre-operative variables that could predict good post-operative outcome."[610] He concludes: "In this study, early onset of petting activity was the only variable that was related to good outcome for male transsexuals," while there were "no pre-operative variables that can predict good adjustments for female transsexuals."[611]

Bodlund and Kullgren (1996) mention that personality disorder and a "high number of fulfilled axis II criteria" are correlated with more negative outcomes.[612] They also note that assigned/natal females have slightly better outcomes than assigned/natal males.

Kuiper and Cohen-Kettenis (1998) report that the primary reasons given by people for their transition regret are: (1) wrong diagnosis; (2) social isolation; (3) disappointing surgical results; and (4) "a sudden vanishing of the urge to live as [the other sex]."[613] They go on to add several more pre-operative risk factors: (5) (stress-related) late onset gender dysphoria; (6) fetishistic cross-dressing, and (7) psychological instability.

Landén, et al. (1998) found that two primary factors predicting transition regret were: (1) lack of family support; and (2) belonging to the non-core [i.e., "secondary"] group of transsexuals.

Finally, Rehman, et al. (1999) note that one "significant outcome" of their study is "the importance of proper preparation of patients for surgery and especially the need for additional postoperative psychotherapy."[614]

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[610] Tsoi, "Follow-up Study of Transsexuals After Sex-Reassignment Surgery," 517.
[611] Ibid., 517, 515.
[612] Bodlund and Kullgren, "Transsexualism—General Outcome and Prognostic Factors," 303.
[613] Kuiper and Cohen- Kettenis, "Gender Role Reversal among Postoperative Transsexuals."
[614] Rehman, et al., "Reported Sex and Surgery Satisfactions," 71.

(4) A number of these studies reveal troubling methodological problems that continue to plague post-transition outcome research

a) Standardization problems

Green and Fleming comment on standardization problems in the field, including the "lack of reported standardized selection criteria for surgery, and the infrequent use of standardized outcome instruments and rating criteria make follow-up conclusions difficult."[615]

b) Small sample sizes

Several of these 1990s studies exemplify robust sample sizes, including: 2,000 people in Pfäfflin and Junge (1992/1998); 1,285 people in van Kesteren, et al. (1996); and 218 people in Landén, et al. (1998). Others, however, are based on noticeably small samples, including: ten people (out of an original cohort of 22) in Stein, et al. (1990); and 12 people (the sub-group who actually completed SRS) in Bodlund and Kullgren (1996).

c) A wide variation in follow-up time-spans, with many representing relatively short follow-up duration periods.

Several of these studies involve follow-up periods of significant length, including: a range of four to 24 years in Landén, et al. (1998); and an average of 11 years (from application for SRS to assessment) in Kuiper and Cohen-Kettenis (1998). However, follow-up period durations were distinctly less robust in most of the other studies: Bodlund and Kullgren (1996) had a five-year follow-up. The follow-up period for Tsoi (1993) was between one- and eight-years post-surgery, with most falling in the two-to-five-years range. Rehman, et al. (1999) set a minimum follow-up period of only three years, whereas Cohen-Kettenis and van Goozen (1997) set their minimum post-surgery follow-up period at one year. At the low end of things, Barrett's (1998) minimum duration for follow-up was six months, while Stein, et al.'s (1990) was 5 months.

d) High participant attrition (lost to follow-up) rates

Once again, a number of these studies are plagued by significant lost to follow-up rates. For example, Stein, et al. (1990) report that they conducted follow-up interviews with only 10

[615] Green and Fleming, "Transsexual Surgery Follow-Up," 163.

members of an original 22-member cohort, which suggests a 54.5% lost to follow-up rate. Rehman, et al. (1999) state that 28 people of a 47-person cohort responded to the follow-up invitation: a 40.5% lost to follow-up rate. In light of more recent findings (documented and discussed above) regarding the tendency for people who detransition to not inform their transition providers about their subsequent detransition, there is a legitimate reason to wonder if the reportedly low rates of regret and/or detransition in many of these studies may well reflect an underreporting of regret/detransition due to low response-rates in the follow-up studies.

e. Key Studies Published in the 2000s

Compared to prior decades, an increase in the number of transition-related outcome studies is evident in the first ten years of the 21st century. The four themes used to structure findings from the last decade will now provide a framework for our survey of studies published in this decade and the next.

(1) Most people continue to report generally positive post-transition outcomes

Three studies – each published in 2001 – serve to bridge this 20th-century trend on into the new millennium. First, in an overview of transsexualism from a psycho-endocrinological perspective, a Belgian research team (**Michel, et al., [2001]**) concludes that in "the great majority of cases, transsexuals seem satisfied with their transformation, with only about 10% of subjects being unsatisfied. This percentage is lower in FM . . . compared with MF subjects."[616]

Next, in a follow-up report on a cohort of 46 MtF patients who underwent a new neovaginoplasty technique (i.e., a combination of penile skin flaps and non-genital skin grafts) between April 1995 and June 1999, a German team (**Krege, et al. [2001**]) assessed (by

[616] Aude Michel, Christian Mormont, and Jean-Jacques Legros, "A Psycho-Endocrinological Overview of Transsexualism," *European Journal of Endocrinology* 145/4 (2001), 365–76 (here pp. 372-73). See also a related article by this team: A. Michel, M. Ansseau, J. J. Legros, W. Pitchot, and C. Mormont, "The Transsexual: What About the Future?," *European Psychiatry* 17 (2002), 353–362.

questionnaire) for post-surgical psycho-social, aesthetic and functional outcomes.[617] They were able to obtain data on 31 members of the cohort – a lost to follow-up rate of 32.6%.[618] They report that "[m]ore than 90% of the patients were satisfied with the cosmetic result and capacity for orgasm . . . . None of the present patients claimed to regret their decision to undergo gender-transforming surgery."[619]

Finally, a Dutch team (**Smith, et al. [2001]**) did both pre- and post-surgical assessments of 20 people who originally began medical transition while adolescents (i.e., HRT) in order to "evaluate early sex reassignment."[620] Comparisons were made to a control group of "21 nontreated and 6 delayed-treatment adolescents."[621] Follow-up periods were one to four years post-SRS for treated subjects, and one to seven years post-application for nontreated patients. They report that

> [a]ll treated (T) patients responded positively . . . . Postoperatively the treated group was no longer gender-dysphoric and was psychologically and socially functioning quite well. Nobody expressed regrets concerning the decision to undergo sex reassignment. Without sex reassignment, the nontreated group showed some improvement, but they also showed a more dysfunctional psychological profile.[622]

They conclude: "The results of our studies point to the desirability of early rather than late medical interventions."[623]

In 2003, a study by Anne **Lawrence (2003)** explored factors related to post-SRS satisfaction and regret in a group of 232 MtF people who underwent surgical transition between 1994 and 2000 at the clinic of Dr. Toby Meltzer in Portland, OR.[624] The follow-up assessment was by written

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[617] S. Krege, A. Bex, G. Lümmen, and H. Rübben, "Male-to-Female Transsexualism: A Technique, Results and Long-term Follow-up in 66 Patients," *British Journal of Urology* 88/4 (2001), 396–402.
[618] Ibid., 399.
[619] Ibid., 396.
[620] Yolanda L. Smith, Stephanie H. S. van Goozen, and Peggy T. Cohen-Kettenis, "Adolescents with Gender Identity Disorder Who were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-up Study," *Journal of the American Academy of Child and Adolescent Psychiatry* 40/4 (2001), 472- 81 (here p. 472).
[621] Ibid.
[622] Ibid.
[623] Ibid., 480.
[624] Anne A. Lawrence, "Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery," *Archives of Sexual Behavior* 32/4 (2003), 299-315. See also Anne A. Lawrence, "Patient-reported Complications and Functional Outcomes of Male-to-Female Sex Reassignment Surgery," *Archives of Sexual Behavior* 35/6 (2006), 717–27.

questionnaire completed at least one-year post-surgery. Interestingly, Meltzer performed Lawrence's own surgical transition in the 1990s. Lawrence reports that

> [p]articipants reported overwhelmingly that they were happy with their SRS results and that SRS had greatly improved the quality of their lives. None reported outright regret and only a few expressed even occasional regret.[625]

Lawrence's 2003 study represents one of the most positive post-surgical outcomes reports ever published.

The Dutch team responsible for the 2001 study mentioned above published another study in 2005. This prospective study (**Smith, et al. [2005]**) of post-operative outcomes is based on data from 166 adults.[626] The conclusion:

> After treatment the group was no longer gender dysphoric. The vast majority functioned quite well psychologically, socially and sexually . . . . The results substantiate previous conclusions that sex reassignment is effective.[627]

In 2006, a Brazilian team reported on outcomes for 19 people who underwent SRS between 2000 and 2004 (18 MtF; 1 FtM), based upon responses to a written questionnaire administered at a two-year post-surgical follow-up (**Lobato, et al. [2006]**).[628] The authors summarize their findings:

> None of the patients reported regret for having undergone the surgery. Sexual experience was considered to have improved by 83.3% of the patients, and became more frequent for 64.7% of the patients. For 83.3% of the patients, sex was considered to be pleasurable with the neovagina/neopenis. In addition, 64.7% reported that initiating and maintaining a relationship had become easier. The number of patients with a partner increased from 52.6% to 73.7%. Family relationships improved in 26.3% of the cases, whereas 73.7% of the patients did not report a difference. None of the patients reported worse relationships with family members after sex reassignment. In conclusion, the overall impact of sex reassignment surgery on this cohort of patients was positive.[629]

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[625] Lawrence, "Factors Associated with Satisfaction or Regret," 299.
[626] Yolanda L. Smith, Stephanie H. S. van Goozen, A. J. Kuiper, and Peggy T. Cohen-Kettenis, "Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals," *Psychological Medicine* 35/1 (2005), 89–99.
[627] Ibid., 89.
[628] Maria I. Lobato, Walter J. Koff, Carlo Manenti, Débora da Fonseca Seger, Jaqueline Salvador, Maria da Graca Borges Fortes, et al., "Follow-Up of Sex Reassignment Surgery in Transsexuals: A Brazilian Cohort," *Archives of Sexual Behavior* 35 (2006), 711-15.
[629] Ibid., 711.

A multi-disciplinary Belgian team based in Ghent produced a 2006 study (**De Cuypere, et al. [2006]**) of 62 Dutch-speaking people who underwent SRS between 1986 and 2001 (35 MtF; 27 FtM).[630] They report that "[t]he subjects proclaimed an overall positive change in their family and social life. None of them showed any regrets about the SRS."[631]

Two researchers based at the VU University Medical Center in Amsterdam conducted a review of SRS outcome studies to date, focusing on "effects of SRS on gender dysphoria, sexuality, and regret" (**Gijs and Brewaeys [2007**]).[632] They conclude that, "[d]espite methodological shortcomings of many of the studies, we conclude that SRS is an effective treatment for transsexualism and the only treatment that has been evaluated empirically with large clinical case series."[633]

2009 was a noteworthy year for transition-related studies. One 2009 study, conducted by a UK team, looked at outcomes for reduction mammaplasty in FtM subjects (**Nelson, et al. [2009]**).[634] The mean follow-up period post-surgery was 10 months (range = two to 23 months). 17 people were invited to complete mail-in surveys, 12 of which completed them – a response rate of 70%. Summarizing their results, they write:

> All respondents expressed satisfaction with their result and no regret. Seven patients had nipple sensation and nine patients were satisfied with nipple position. All patients thought their scars were reasonable and felt that surgery had improved their self-confidence and social interactions. Conclusion: Reduction mammaplasty for female-to-male gender reassignment is associated with high patient satisfaction and a positive impact on the lives of these patients.[635]

[630] G. De Cuypere, E. Elaut, G. Heylens, G. Van Maele, G. Selvaggi, G. T'Sjoen, R. Rubens, P. Hoebeke, and S. Monstrey, "Long-term Follow-up: Psychosocial Outcome of Belgian Transsexuals after Sex Reassignment Surgery," *Sexologies* 15/2 (2006), 126-33.
[631] Ibid., 126.
[632] Luk Gijs and Anne Brewaeys, "Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges," *Annual Review of Sex Research* 18 (2007), 178–224.
[633] Ibid., 178.
[634] L. Nelson, E. J. Whallett, and J. C. McGregor, "Transgender Patient Satisfaction Following Reduction Mammaplasty," *Journal of Plastic, Reconstructive & Aesthetic Surgery* 62/3 (2009), 331-34.
[635] Ibid., 331.

A second 2009 study, published by a Serbian research team, considers factors associated with medical transition in the Serbian context (**Vujovic, et al [2009]**).[636] Among their findings:

> Applicants for sex reassignment in Serbia are relatively young. The sex ratio is close to 1:1. They often come from single-child families. More than 10% do not wish to undergo surgical sex reassignment . . . . *Of those who had undergone sex reassignment, none expressed regret for their decision*.[637]

A third study published in 2009 – conducted by another UK team – is an evaluative review of prior studies on SRS outcomes of specific surgical procedures; five related to MtF transition and eight related to FtM transition (**Sutcliffe, et al. [2009]**).[638] Findings point to a number of satisfactory outcomes, especially for FtM subjects.

A fourth 2009 study, conducted by an Italian team, analyzed post-SRS satisfaction levels of 139 people who underwent MtF SRS between January 1992 and September 2006 (**Imbimbo, et al. [2009]**).[639] The original clinical cohort consisted of 163 people. The researchers note that out of "the 163 patients initially contacted, 24 (15%) refused to participate in the survey for various reasons" – i.e., a 15% lost to follow-up rate.[640] Regarding the follow-up period:

> Patients were contacted by telephone 12–18 months after surgery and were requested to attend our clinic for a follow-up visit. At that time, they were requested to complete a Patient's Satisfaction Questionnaire devised by our gender physician team.

Those unable to return to the clinic were interviewed over the phone.

Imbimbo, et al. report that the post-surgical satisfaction rate was 78%, while 22% reported they were dissatisfied. They also investigated overall satisfaction and eventual regrets. 131 patients (94%) reported they were satisfied with their new sexual status and did not experience transition

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[636] S. Vujovic, S. Popovic, G. Sbutega-Milosevic, M. Djordjevic, and L. Gooren, "Transsexualism in Serbia: A Twenty-year Follow-up Study," *Journal of Sexual Medicine* 6/4 (2009), 1018-23.
[637] Ibid., 1018 (emphasis added).
[638] Paul A. Sutcliffe, Simon Dixon, Ron L. Akehurst, Alan Wilkinson, Andrea Shippam, Sinclair White, Richard Richards, and Christopher Michael Caddy, "Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review," *Journal of Plastic, Reconstructive and Aesthetic Surgery* 62/3 (2009), 294–308.
[639] C. Imbimbo, P. Verze, A. Palmieri, N. Longo, F. Fusco, D. Arcaniolo, and V. Mirone. "A Report from a Single Institute's 14-year Experience in Treatment of Male-to-Female Transsexuals," *Journal of Sexual Medicine* 6/10 (2009), 2736-45.
[640] Ibid., 2738.

surgical regret, "while 8 patients (6%) were dissatisfied with results and regretted the surgery."[641]

Regarding factors associated with post-operative satisfaction, the authors conclude that

> the relatively high satisfaction level with the functional and aesthetic qualities of the newly acquired genitalia reported by the patients is the result of a combination of competent surgical skills, a well-conducted preoperative preparation program, and adequate postoperative counseling, which, based upon our experience, are indispensable for a successful SRS outcome. When these factors are present within the context of a supportive and accepting family and social environment, the transsexual patient can be considered sufficiently equipped to successfully cross the gender divide.[642]

Finally, a fifth 2009 study, produced by the Belgian team based at Ghent University Hospital, focused on the mental and physical/sexual health outcomes of 50 MtF subjects who, at the time of self-report assessment, had undergone SRS at least six months prior (**Weyers, et al. [2009]**).[643] Outcomes were assessed using the Dutch versions of the Short-Form-36 (SF-36) Health Survey and the Female Sexual Function Index (FSFI). The outcomes report from this study is generally positive:

> Compared with reference populations, transsexual women scored good on physical and mental level (SF-36). Gender-related bodily features were shown to be of high value. Appreciation of their appearance as perceived by others, as well as their own satisfaction with their self-image as women obtained a good score (8 and 9, respectively). However, sexual functioning as assessed through FSFI was suboptimal when compared with biological women, especially the sublevels concerning arousal, lubrication, and pain.[644]

(2) A significant sub-set of people report various types of NTEs (e.g., negative psycho-social and/or surgical outcomes; transition regret and/or detransition; etc.)

Transition outcome studies published in this first decade of the 21st century also documented that a sub-set of people continue to report various NTEs – including regret and detransition.

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[641] Ibid., 2740.
[642] Ibid., 2743.
[643] Steven Weyers, Els Elaut, Petra De Sutter, Jan Gerris, Guy T'Sjoen, Gunter Heylens, Griet De Cuypere, and Hans Verstraelen, "Long-Term Assessment of the Physical, Mental, and Sexual Health among Transsexual Women," *Journal of Sexual Medicine* 6/3 (2009), 752-60.
[644] Ibid., 752.

Regarding NTEs and less-than-satisfactory outcomes

(a) In their review of the field, Michel, et al. (2001) found that 10% of people initially reported some level of dissatisfaction with their transition. They note that a

> temporary dissatisfaction can be observed immediately after the sex change. Certain transsexuals find themselves confronted with various difficulties (postoperation pain, surgical complications, dissatisfaction with surgical results, departure of the partner, loss of job, familial conflicts, etc.) and experience a phase of dissatisfaction that can lead to regret in some cases. However, most often this dissatisfaction disappears during the year following the surgical transformation where no other intervention was deemed necessary (142). More deep regrets are rare. Studies report only less than 1% of FM subjects regretting the intervention, and 1.5% of MF subjects.[645]

(b) In their study based on data from 31 MtF surgical outcomes, Krege, et al. (2001) found that 14% reported major complications, while 36% reported minor complications – i.e., post-transition difficulties.

(c) In 2009, a Swiss team produced a study of post-SRS quality of life for 55 people (52 MtF; 3 FtM) in comparison to a control group using the King's Health Questionnaire (**Kuhn, et al. [2009]**).[646] The follow-up period was quite lengthy at 15 years post-surgery. Results revealed that "[o]verall satisfaction was statistically significant lower in TS [transsexuals] compared with controls . . . . Fifteen years after sex reassignment operation quality of life is lower in the domains general health, role limitation, physical limitation, and personal limitation."[647]

Regarding psycho-social outcomes, several studies reported less-than-encouraging results.

(a) In 2008, a team based at the Leicester Gender Identity Clinic in the UK published a study that failed to substantiate the positive post-surgical psychological outcomes they had hypothesized (**Udeze, et al. [2008]**).[648] For both pre- and post-surgical assessments, the study made use of the self-administered Symptom Check List-90R (SCL-90R). The SCL-90R is a widely used

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[645] Michel, et al., "Psycho-endocrinological Overview of Transsexualism," 372-73.
[646] A. Kuhn, C. Bodmer, W. Stadlmayr, P. Kuhn, M. D. Mueller, and M. Birkhäuser, "Quality of Life 15 Years after Sex Reassignment Surgery for Transsexualism," *Fertility and Sterility* 92/5 (2009), 1685-89.
[647] Ibid., 1685.
[648] B. Udeze, N. Abdelmawla, N., D. Khoosal, and T. Terry, "Psychological Functions in Male-to-Female Transsexual People Before and After Surgery," *Sexual & Relationship Therapy* 23/2 (2008), 141-45.

assessment tool that evaluates a broad range of psychological problems and is commonly used to measure the progress and outcomes of various treatment protocols. Forty people who underwent SRS completed the SCL-90R both prior to and within six-months after SRS. The administration of pre- and post-surgical assessments to the same cohort provided a methodological advantage for this study, compared to many others, in that it minimized "inter-individual variability."[649] Despite hypothesizing that there would be psychological improvement following SRS, the researchers found that

> [t]here was no significant change in the different sub-scales of the SCL-90R scores in patients with male-to-female GID pre- and within six months post-surgery. The results of the study showed that GRS had no significant effect on functioning as measured by SCL-90R within six months of surgery . . . . [T]here was no evidence of significant change in any of the items of the SCL-90R – somatisation, obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, anger/ hostility, phobic anxiety, paranoid ideation, psychoticism, sexual problems and marital problems – within six months of achieving GRS.[650]

Unexpectedly, they do report that

> [t]here was, however, a reported trend of an increase in anger/hostility post-surgery . . . . We are uncertain about the reasons for the reported trend of an increase in postsurgery anger/hostility. As patients in our sample had achieved GRS, this trend was surprising.[651]

(b) A 2009 study, Stephen Levine – the chair of the WPATH's SOC-5 (1998) and a member of the DSM-IV's Subcommittee on Gender Identity Disorders – and Anna Solomon conducted a review of the last 10 patients seen at their Gender Identity Clinic, the final one dating to August 2007 (**Levine and Solomon [2009]**).[652] Their report has a distinct tone of pessimism:

> We found 90% of these diverse patients had at least one other significant form of psychopathology. This finding seems to be in marked contrast to the public, forensic, and professional rhetoric of many who care for transgendered adults. Much of this rhetoric sounds remarkably certain about the long-term value of gender transition, hormones, and sex reassignment surgery in improving the lives of those with Gender Identity Disorder (GID). Such clinical certainty would have to be based on carefully established sophisticated follow-up findings. These are lacking. The psychopathologies in this series

[649] Ibid., 143.
[650] Ibid., 141, 144.
[651] Ibid., 143, 144.
[652] Stephen B. Levine and Anna Solomon, "Meanings and Political Implications of 'Psychopathology' in a Gender Identity Clinic: A Report of 10 Cases," *Journal of Sex and Marital Therapy* 35 (2009), 40 – 57.

included problems of mood and anxiety regulation and adapting in the world. Two of the 10 have had persistent significant regrets about their previous transitions.[653]

Regarding regret rates

The 2001 study by Michel, et al. (2001) served to bolster what has become a widely-cited overall transition regret rate of roughly 1% (similarly, Smith, et al. [2005]). It is worth noting that Michel, et al. appear to draw this regret rate directly from the prior study of Pfäfflin and Junge (1992/1998). Among their conclusions is that "deep regrets are rare. Studies report only less than 1% of FM subjects regretting the intervention, and 1.5% of MF subjects."[654]

However, other studies reported regret rates above the 1-1.5% range. For example: In their 2009 study involving post-transition outcomes for 50 trans women, Weyers, et al. report a regret rate of 4%.[655] In a post-transition follow-up study of 139 Brazilian trans women, Imbimbo, et al. (2009) report that "8 patients (6%) were dissatisfied with results and regretted the surgery."[656] And, finally, in their review of 22 years of research on post-SRS outcomes, an Austrian-based team (**Baranyi, et al. [2009]**) found that "[r]egret and feelings of doubt can occur in up to 8% of the cases."[657]

A 2006 study by two Swedish researchers offers a unique window into one example of transition regret – and the importance of taking co-occurring psychological issues seriously – by providing a four-decade follow-up of an assigned/natal male who underwent SRS and later expressed regret (**Olsson and Möller [2006]**).[658] The follow-up data was drawn from two sources: (1) medical records spanning from the early 1960s to the early 1990s, and (2) case notes taken from one of the author's weekly therapy sessions conducted over a two-year period, which took place

[653] Ibid., 40.
[654] Michel, et al., "Psycho-endocrinological Overview of Transsexualism," 372-73.
[655] Weyers, et al., "Long-Term Assessment."
[656] Imbimbo, et al., "Report from a Single Institute's 14-year Experience in Treatment of Male-to-Female Transsexuals," 2740.
[657] Andreas Baranyi, Dominique Piber, and Hans-Bernd Rothenhäusler, "Mann-zu-Frau-Transsexualismus. Ergebnisse geschlechtsangleichender Operationen in einer biopsychosozialen Perspektive" [Male-to-Female Transsexualism. Sex Reassignment Surgery from a Biopsychosocial Perspective], *Wiener Medizinische Wochenschrift* 159/21-22 (2009), 548-57 (here p. 548).
[658] Stig-Eric Olsson and Anders Möller, "Regret After Sex Reassignment Surgery in a Male-to-Female Transsexual: A Long-term Follow-up," *Archives of Sexual Behavior* 35/4 (2006), 501–06.

roughly 15 years after SRS. The purpose of the study was "to shed light on aspects of regret, its manifestation in a male-to-female transsexual with psychiatric co-morbidity, and to show the complexity of the process of adjustment when regret is involved."[659] Along with diagnoses of transsexualism in adolescence and adulthood, the subject was also diagnosed with "overanxious reaction of childhood, [and] fetishism and transvestism during adolescence."[660] (This subject would, of course, fit the "secondary transsexualism" category that was so central to studies published in the 20th century.)

During therapy, many years after surgical transition, the subject expressed regret, stating that "the failed SRS contributed to feeling of being a 'freak.'"[661] In the subject's own words:

> I want to become two persons instead of being one body with two personalities fighting to come out. If I'd had a better life, maybe I would never have changed sex. But not feeling at peace with yourself, feeling that you are not one person but two young persons—one boy and one girl—in an old woman's body in terms of appearance and an old man's body genetically, that is a disaster.[662]

Olsson and Möller conclude: "The present case is an argument for a strict interpretation of the Standards of Care provided by the Harry Benjamin International Gender Dysphoria Association in terms of evaluating patients' mental health."[663]

The next year, a Swiss team based out of the University of Geneva published a case study of an assigned/natal male who underwent SRS at age 36, and, within a few months, expressed regret and the "desire to become a man again" (**Borras, et al. [2007]**).[664] The subject had a 22-year history of schizophrenia, which included "intrusive gender identity preoccupations over the years."[665] Borras, et al. note that

> [t]wenty percent of all schizophrenic patients experience sexual delusions at some point during the evolution of their illness. Among them, some patients develop the conviction

[659] Ibid., 501.
[660] Ibid.
[661] Ibid., 505.
[662] Ibid., 504.
[663] Ibid., 501.
[664] L. Borras, P. Huguelet, and A. Eytan, "Delusional 'Pseudotranssexualism' in Schizophrenia," *Psychiatry* 70/2 (2007), 175-79 (here p. 177).
[665] Ibid., 175.

> of belonging to the other sex. Although true coexistence of schizophrenia and gender identity disorder is rare, it can be difficult to disentangle the two conditions.[666]

They conclude: "Considering the irreversible consequences of surgery and its medico-legal implications, these patients should be properly detected."[667] This concern of mistaking schizophrenia-related gender confusion with true gender dysphoria through misdiagnosis is the focus of a number of studies from various countries in this decade.[668]

(3) A number of studies continue to report a set of pre-transition factors predicting positive vs. negative transition outcomes

Mirroring Pfäfflin and Junge's (1992/1998) prior findings, Michel, et al. (2001) report three major sources of regret: (1) mistaken diagnoses that fail sufficiently to consider co-occurring psychological problems; (2) failure to conduct a pre-surgical social transition trial period; and (3) dissatisfaction with surgical procedures and aesthetic and functional outcomes. They also note that assigned/natal females report lower regret rates than assigned/natal males.

Smith, et al. (2001) reiterate the importance of "[c]areful diagnosis and strict criteria" when considering adolescents for HRT.[669] They point out that "[a]lthough psychopathology may be the result rather than the underlying problem of [gender dysphoria], SR [sex reassignment] may also be sought as a solution to nongender problems."[670] The case study of Olsson and Möller (2006) also strongly emphasizes the importance of

> a strict interpretation of the Standards of Care provided by the Harry Benjamin International Gender Dysphoria Association [now the WPATH] in terms of evaluating patients' mental health, apart from the evaluation of the gender identity disorder, and the patients' subsequent need for treatment interventions.[671]

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[666] Ibid.
[667] Ibid.
[668] E.g., C. Caldwell and M. S. Keshavan, "Schizophrenia with Secondary Transsexualism," *Canadian Journal of Psychiatry* 36/4 (1991), 300-01; M. Urban, "Transseksualizm czy urojenia zmiany płci? Uniknać błednej diagnozy [Transsexualism or Delusions of Sex Change? Avoiding Misdiagnosis]," *Psychiatria Polska* 43/6 (2009), 719-28; M. Brüne, "Wahnhafter 'Pseudotranssexualismus' bei schizophrener Psychose [Delusional 'Pseudotranssexualism' in Schizophrenic Psychosis]," *Psychiatrische Praxis* 23/5 (1996), 246-47.
[669] Smith, et al., "Adolescents with Gender Identity Disorder," 472.
[670] Ibid., 480.
[671] Olsson and Möller, "Regret After Sex Reassignment Surgery," 501.

It is worth noting that, during this decade, Lynn Conway – a widely recognized trans woman and activist – published a "Warning for Those Considering MtF SRS," in which she discusses some pre-transition factors that can signal higher levels of post-transition regret:

> Regrets and adjustment difficulties seem to occur especially frequently in the cases of older intense crossdressers and sexual fetishists whose drive to transition is based primarily on male sexual feelings and habits. These individuals will gradually lose their male libidinous responses to their new female body as time passes after the removal of their testicles during SRS. This loss of libidinous rewards, combined with accumulating practical, social and emotional difficulties in postoperative life, can lead to serious long-term adjustment difficulties for those who've "made a mistake" . . . .[672]

In an important study at the end of the decade, Belgian researchers Griet De Cuypere and Herman Vercruysse, Jr. published a wide-ranging literature review of transition follow-up studies (**De Cuypere and Vercruysse, Jr. [2009]**).[673] Their purpose was to provide recommendations concerning eligibility and readiness criteria for SRS in order to inform the 7th revision of the WPATH's Standards of Care, which was eventually released as the SOC-7 in 2011. Like Michel, et al. (2001) at the beginning of the decade, they concur with Pfäfflin and Junge's (1992/1998)'s three primary pre-transition factors that predict regret: (1) "inadequate diagnosis; that is, major co-morbidity such as psychosis or alcohol dependency"; (2) "an absence of or a disappointing real-life experience" (i.e., social transition); and (3) "disappointing surgical results (aesthetic and functional)."[674] They expand upon the first concern:

> The case studies of persons who regret SRS lead us to conclude that inadequate diagnosis and major psychiatric co-morbidity are the major indicators for regret. But the fact remains that data on the numbers and characteristics of persons who regret their SRS will be lacking until all operated patients are systematically studied over a well-defined time and with clearly defined method.[675]

One of the primary concerns voiced by De Cuypere and Vercruysse, Jr. about the then-current SOC-6 has to do with its relative neglect of co-occurring psychological problems:

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[672] Lynn Conway, "A Warning for Those Considering MtF SRS." (updated March 16, 2007), http://ai.eecs.umich.edu/people/conway/TS/Warning.html.
[673] Griet De Cuypere and Herman Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery: Recommendations for Revision of the WPATH *Standards of Care*," *International Journal of Transgenderism* 11/3 (2009), 194-205.
[674] Ibid., 196.
[675] Ibid., 197.

> Although psychiatric co-morbidity is consistently mentioned in the literature as a negative predictive factor, it is barely addressed in the eligibility and readiness criteria for SRS [in the SOC-6]. Therefore this paper suggests some changes and a shift in emphasis in the eligibility and readiness criteria of the *Standards of Care* . . . . The case studies of persons who regret SRS lead us to conclude that inadequate diagnosis and major psychiatric co-morbidity are the major indicators for regret. [676]

This issue of potential co-occurring psychological problems and the importance of proper pre-transition psychological diagnosis is reiterated by De Cuypere and Vercruysse, Jr. when they offer two recommendations for the SOC-7 revision: (1) the need for a clinical diagnosis of Gender Identity Disorder according to the DSM-IV [which, today, would correlate with the DSM-5's diagnosis of Gender Dysphoria]; and (2) if a co-occurring psychiatric problem arises in the pre-SRS assessment, the transition process should be halted until the problem is resolved through pharmacotherapy and/or psychotherapy.[677]

This significant end-of-the decade study by De Cuypere and Vercruysse, Jr. also provided a comprehensive analysis of factors – each of which is supported by multiple studies – that predict both negative and positive surgical transition outcomes. They list eight factors that predict negative outcomes: (1) "Choice of a heterosexual sex partner before SRS, which results in a homosexual couple after SRS"; (2) "GID [Gender Identity Disorder] with transvestism or autogynephilic transsexualism"; (3) "An age over 30 years at first request for SRS"; (4) "Psychiatric co-morbidity and personal instability"; (5) "Inadequate social functioning, indicated by periodical or full dependence on social assistance"; (6) "Poor support from the patient's family"; (7) "Dissatisfaction with secondary sex characteristics at initial assessment"; and (8) "Unsatisfactory surgical results."[678]

They go on to list six factors that predict positive outcomes: (1) "Sexual attraction to same-sex partner before SRS, that is, GID with homosexual orientation"; (2) "Early onset of transsexualism"; (3) "Age under 30 years at first request for SRS"; (4) "Absence of coexisting

[676] Ibid., 194, 197.
[677] Ibid., 203.
[678] Ibid., 197.

mental illness (psychosis) and emotional stability in life history"; (5) "Good familial and social support after SRS"; and (6) "Satisfactory surgical results."[679]

One noticeable outlier from this decade in regard to identifying pre-operative predictive outcome factors is the 2003 study by Anne Lawrence, who argues against the consensus of the field at several points. First, Lawrence concludes that "[m]ost indicators of transsexual typology, such as age at surgery, previous marriage or parenthood, and sexual orientation, were not significantly associated with subjective outcomes."[680] Lawrence also went on to call into question the need to strictly follow the "minimum eligibility requirements for SRS specified by the Harry Benjamin International Gender Dysphoria Association [now WPATH]," stating that compliance with these Standards of Care – including the psychological evaluation requirements – were "not associated with more favorable subjective outcomes."[681] Finally, Lawrence also argues that there is no empirical evidence that pre-operative social transition predicts better post-surgical results.[682]

In their assessment of Lawrence's study, De Cuypere and Vercruysse, Jr., register their concern about its "shortcomings," including "its low rate of response and a possible lack of objectivity because of the author's personal involvement with the surgeon whose patients were studied."[683]

(4) Ongoing methodological problems associated with post-transition outcome research

In this first decade of the 21st century, researchers continued to register concerns about various methodological problems associated with post-transition outcome studies. In fact – if anything – it appears that this concern intensified over past decades. Several studies raise the warning that – taken as a field – the findings of post-transition outcome research are lacking a robust evidence base.

[679] Ibid., 198.
[680] Lawrence, "Factors Associated with Satisfaction or Regret," 299.
[681] Ibid.
[682] Ibid., 311, 313. Lawrence argued this claim two years prior in a conference paper: "Sex Reassignment Surgery Without a One-Year Real-Life Experience: Still No Regrets," Paper presented at the XVII Harry Benjamin International Symposium on Gender Dysphoria, Galveston, TX, November 2001.
[683] De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery," 198.

2004 marked a particularly controversial expression of the questionable evidence-base for SRS outcomes. In that year, the British newspaper *The Guardian* asked the Aggressive Research Intelligence Facility (ARIF) to conduct a medical review of the evidence base for medical transition procedures and their effectiveness. The ARIF was a specialty research unit based at the University of Birmingham. Among other things, it functioned as a "request service providing responsive evidence synthesis reports on topics of interest."[684] ARIF had already done an evidence synthesis report on SRS in 1997. At *The Guardian*'s request, they created an updated report in July 2004.[685] *The Guardian* reported on ARIF's findings in a story written by David Batty.[686] ARIF's review – based on over 100 international medical studies of post-transition outcomes – concludes that there is "no robust scientific evidence that gender reassignment surgery is clinically effective."[687] In Batty's words: "There is no conclusive evidence that sex change operations improve the lives of transsexuals, with many people remaining severely distressed and even suicidal after the operation."[688] Championing high-quality evidence-based medicine, ARIF would have naturally combed the transition-related literature for studies employing the method of *randomized controlled trail* (RCT) – the gold standard of evidence-based medicine. For various reasons – not least of which is the inherent ethical problems involved – researchers have never performed RCT-based studies of SRS. Inevitably, this fact has contributed to transition-related research being left open to the criticism of a weak evidence base. Naturally, the ARIF review has received criticism from trans activists and allies over the years.[689]

At the end of the decade, another study of the quality of the broad evidence-base of post-surgical outcome studies was published. While this study – written by members of the Belgian team at Ghent University (**Monstrey, et al. [2009]**) – sparked much less controversy than the ARIF

[684] Aggressive Research Intelligence Facility (ARIF), https://www.birmingham.ac.uk/research/activity/mds/projects/haps/pheb/arif/index.aspx
[685] The essence of the ARIF review can be seen at https://genderchallenge.no/onewebmedia/ARIF%20summary%20gender%20reassignment.docx.
[686] David Batty, "Sex Changes are Not Effective, Say Researchers," *The Guardian* (July 30, 2004), https://www.theguardian.com/society/2004/jul/30/health.mentalhealth.
[687] Ibid.
[688] Ibid.
[689] E.g., Cake Kidd, "2014-08-02 A commentary on the 2004 ARIF study and the Guardian article 'Sex changes are not effective, say researchers,'" (August 2, 2014), http://www.cakeworld.info/news/2014-08-02acommentaryonthe2004arifstudyandtheguardianarticlesexchangesarenoteffectivesayresearchers

report, its conclusions were tinged with pessimism nonetheless.[690] The authors begin by explaining the four level-types of evidence based on the system used by the Oxford Centre for Evidence-Based Medicine (CEBM), which runs from Level A (the best evidence-type) to Level D (the lowest evidence-type). The four levels are defined as follows:

Level A: "Consistent Randomized Controlled Clinical Trial, Cohort Study, All or None, Clinical Decision Rule validated in different populations."

Level B: "Consistent Retrospective Cohort, Exploratory Cohort, Ecological Study, Outcomes Research, Case-Control Study; or extrapolations from Level A studies."

Level C: "Case-series Study or extrapolations from Level B studies."

Level D: "Expert opinion without explicit critical appraisal, or based on physiology, bench research or first principles."

In their evaluation of the field of post-surgical outcome studies, Monstrey, et al. set the stage by noting:

> Due to the lack of randomized studies with a control population, the level of evidence of the beneficial effect of gender reassignment surgery in relation to psychotherapy can at most be a Level B.[691]

In light of the available evidence, they conclude:

> Because the literature shows a lack of randomized clinical trials or high-quality follow-up studies on large numbers of operated transsexuals, it offers no evidence based-research above level B or C . . . . Overall it seemed, and this has not changed since the publication of the [SOC-6], that the quality of evidence was poor due to the lack of concealment of allocation, completeness of follow-up, and blinding . . . . In the majority of studies a large number of transsexual individuals experience a successful outcome in terms of subjective well-being and cosmetic and sexual function. However, taking into consideration the difficulties in interpretation of review evidence, the magnitude of benefit and harm cannot be estimated accurately using the current available evidence.[692]

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[690] Stan Monstrey, Herman Vercruysse, Jr., and Griet De Cuypere, "Is Gender Reassignment Surgery Evidence Based? Recommendation for the Seventh Version of the WPATH *Standards of Care*," *International Journal of Transgenderism* 11/3 (2009), 206-14.

[691] Ibid., 209.

[692] Ibid., 206, 212, 213.

In a separate 2009 publication produced by two of the three authors of this current study, they note that "it becomes clear that the research is sometimes Level of Evidence B, but mostly Level of Evidence C."[693]

A number of specific methodological problems are mentioned in studies published throughout the decade, including:

(a) The lack of randomized controlled trials

As mentioned above, a number of studies have pointed out that transition-related outcome research is completely devoid of the gold standard in evidence-based medicine: the randomized controlled trial method.[694] At the same time, virtually everyone agrees that – by the very nature of the case – such studies cannot be done in this area of research for both practical and ethical reasons.

(b) The lack of standardized validated assessment measures

As Green and Fleming pointed out in their 1990 review of post-SRS outcomes, the "lack of reported standardized selection criteria for surgery, and the infrequent use of standardized outcome instruments and rating criteria make follow-up conclusions difficult."[695] Two decades later, this methodological problem still plagued the field. As Sutcliffe, et al. note in 2009, the "lack of validated assessment measures" remain a significant challenge.[696]

(c) A high number of studies using a retrospective – as opposed to a prospective – method

A retrospective study design is one in which subjects are asked to recall and report on their past experience. A prospective study, on the other hand, collects data from subjects multiple times over the course of an extended study period. Compared to prospective studies, retrospective studies are generally considered to be of lower quality evidence due to the inherent weaknesses

[693] De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery," 203.
[694] E.g., the ARIF review; Monstrey, et al., "Is Gender Reassignment Surgery Evidence Based?," 209; De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery," 203; Sutcliffe, et al., "Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review," 294.
[695] Green and Fleming, "Transsexual Surgery Follow-Up," 163.
[696] Sutcliffe, et al., "Evaluation of Surgical Procedures for Sex Reassignment," 294.

that naturally occur when people are asked to report on their own pasts – i.e., memory distortion, confounding errors, bias, etc.

Most transition outcomes studies reported on in this decade are retrospective in nature, with a few exceptions – e.g., Smith, et al. (2001); Smith, et al. (2005). The ARIF review mentioned this as a common weakness of outcome studies. Similarly, at their end-of-the-decade review, Griet De Cuypere and Vercruysse, Jr. note this prevalent problem:

> All the studies mentioned here are retrospective studies, some are cohort studies, and all of them suffer from methodological draw backs: (a) a lack of preoperative data, which makes comparison between pre- and post-SRS impossible and (b) a likely bias of the selection of the study population.[697]

(d) Small sample sizes

The transition outcome studies of this decade commonly reflect significantly small sample sizes. While, once again, some studies included cohorts of significant size, most are relatively small. The issue here is that smaller sample size brings with it the risk of sample size bias.[698] Examples of smaller sample sizes from the studies during this decade include: Smith, et al. (2001) = 20 subjects; Lobato, et al. (2006) = 19 subjects; Nelson, et al. (2009) = 17 subjects.

(e) A wide variation in follow-up time-spans, with many representing relatively short follow-up duration periods

Many of the studies published in this decade involved a relatively short follow-up period. For example: Smith, et al. (2001) = one to four years; Lobato, et al. (2006) = a two-year evaluation; Lawrence (2003) = a minimum of one-year post-op; Nelson, et al. (2009) = a mean follow-up period of 10 months; Weyers, et al. (2009) = a minimum of 6 months post-op; Krege, et al. (2001) = a minimum of 6 months; Udeze, et al. (2008) = six months. In explaining their extremely short follow-up period, Udeze, et al. write: "A period of six months was chosen because we have found that transsexual patients tend to drop out of treatment follow-up fairly

[697] De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery," 198.
[698] E. A. Spencer, J. Brassey, K. Mahtani, and C. Heneghan, "Wrong Sample Size Bias," *Catalogue of Bias* (2017), https://catalogofbias.org/biases/wrong-sample-size-bias/

soon after completing GRS [gender reassignment surgery]."[699] This observation leads to our final methodological problem.

(f) High participant attrition rates (lost to follow-up)

As discussed above the lost to follow-up problem has posed a perennial methodological challenge for transition outcome research for decades. The decade under consideration here is no different. At its beginning, the review by Michel, et al. (2001) observes:

> [A] major obstacle in conducting follow-up studies is that it is very difficult to find transsexuals who have been operated on, and even more difficult to find those who accept reassessment . . . . Therefore, those few who do agree to participate in follow-up studies do not constitute a representative sample of the population of transsexuals who have been operated on.[700]

This concern is reflected in the remarkably high lost to follow-up rates of most of the studies published in this decade. For example:

- Imbimbo, et al. (2009) – Of the 163 patients initially contacted, 139 participated in the survey – a 15% lost to attrition rate.
- Nelson, et al. (2009) Of the 17 people targeted for the study, 12 responded – a 30% lost to follow-up rate.
- Krege, et al. (2001) – Of the 46 people invited to participate in the survey, 15 were lost to follow-up; a 32.6% lost to follow-up rate.
- De Cuypere, et al. (2006) – Of the 107 Dutch people who had undergone SRS between 1986 and 2001, 62 completed questionnaires or interviews – a 42% lost to follow-up rate.
- Lawrence (2003) – Of the 727 people who were invited to participate in the survey, only 232 responded: a stunning 68% lost to follow-up rate.

To wrap up our analysis of this decade: Monstrey, et al. (2009) helpfully summarize some of the "significant limitations" of this decade's transition outcome studies as reflected in these sorts of methodological problems:

[699] Udeze, et al., "Psychological Functions in Male-to-Female Transsexual People," 143.
[700] Michel, et al., "Psycho-endocrinological Overview of Transsexualism," 372.

> Many studies suffer from methodological problems related to small sample sizes . . . , participant heterogeneity, recruitment biases, variations in surgical techniques, and a high rate of "dropout"-participants [i.e., lost to follow-up].[701]

f. Key Studies Published from 2010 - 2022

Once again, the increase in transition outcome-related studies from the first to the second decade of this current century is noticeable. Here, we will consider a number of representative studies published from 2010 until early 2022 (the time writing). Once again, our four-fold structure of analysis serves the data well.

(1) Most people continue to report generally positive post-transition outcomes

A Swedish study published in the first year of this new decade followed up with "42 (25 male-to-female [MF] and 17 female-to-male [FM]) transsexuals . . . 5 or more years in the [medical transition] process or 2 or more years after completed sex reassignment surgery (**Johansson, et al. [2010**])."[702] The 42 people who completed the survey were part of a wider 60-person cohort that had been approved for SRS – a response rate of 70%. The research team reports that "almost all patients were satisfied with the sex reassignment; 86% were assessed by clinicians at follow-up as stable or improved in global functioning."[703] Although "5–15% were dissatisfied with the hormonal treatment, results of surgery, total sex reassignment procedure, or their present general health," none of the cohort reported transition regret.[704] In this study, favorable outcome reports were substantially the same for trans men and trans women.

[701] Monstrey, et al., "Is Gender Reassignment Surgery Evidence Based?," 208. Similarly, see De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery," 202.
[702] A. Johansson, E. Sundbom, T. Höjerback, and O. Bodlund, "A Five-year Follow-up Study of Swedish Adults with Gender Identity Disorder," *Archives of Sexual Behavior* 39/6 (2010), 1429–37 (here p. 1429).
[703] Ibid.
[704] Ibid.

A meta-analysis published in the same year focuses on transition outcomes for people accessing HRT (**Murad, et al. [2010]**).[705] This analysis surveyed the results of 28 studies involving 1,833 people (1093 trans women and 801 trans men). Findings included:

> 80% of individuals with GID reported significant improvement in gender dysphoria (95% CI = 68-89%; 8 studies; I^2 = 82%); 78% reported significant improvement in psychological symptoms (95% CI = 56-94%; 7 studies; I^2 = 86%); 80% reported significant improvement in quality of life (95% CI = 72-88%; 16 studies; I^2 = 78%); and 72% reported significant improvement in sexual function (95% CI = 60-81%; 15 studies; I^2 = 78%).[706]

A 2011 study by a Belgian team reports on transition outcomes of "49 transsexual men (mean age 37 years) after long-term testosterone therapy and on average 8 years after SRS," 94% of which underwent phalloplasty (**Wierckx, et al. [2011]**).[707] This study concludes:

> Compared with a Dutch reference population of community-dwelling men, transsexual men scored well on self-perceived physical and mental health . . . . Surgical satisfaction was high, despite a relatively high complication rate . . . . Results of the current study indicate transsexual men generally have a good quality of life and experience satisfactory sexual function after SRS.[708]

Another 2011 publication, this time by the well-known Dutch team based primarily out of the VU University Medical Center in Amsterdam, offered a case study involving an unusually lengthy (i.e., 22 year) follow-up of a trans man (**Cohen-Kettenis, et al. [2011**]).[709] The subject was originally treated with puberty suppression drugs at age 13, began HRT at 17, and underwent surgical transition between the ages of 20-22. Cohen-Kettenis and colleagues report that

> [a]t follow-up, he indicated no regrets about his treatment. He was functioning well psychologically, intellectually, and socially; however, he experienced some feelings of sadness about choices he had made in a long-lasting intimate relationship. There were no clinical signs of a negative impact on brain development. He was physically in good

[705] Mohammad Hassan Murad, Mohamed B. Elamin, Magaly Zumaeta Garcia, Rebecca J. Mullan, Ayman Murad, Patricia J. Erwin, and Victor M. Montori, "Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes," *Clinical Endocrinology* 72 (2010), 214-31.
[706] Ibid., 214.
[707] K. Wierckx, E. Van Caenegem, E. Elaut, D. Dedecker, et al., "Quality of Life and Sexual Health after Sex Reassignment Surgery in Transsexual Men," *Journal of Sexual Medicine* 8/12 (2011), 3379-88 (here p. 3379).
[708] Ibid.
[709] P. T. Cohen-Kettenis, S. E. E. Schagen, T. D. Steensma, A. L. C. de Vries, and H. A. Delemarre-van de Waal, "Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-up," *Archives of Sexual Behavior* 40/4 (2011), 843–47.

> health, and metabolic and endocrine parameters were within reference ranges. Bone mineral density was within the normal range for both sexes.[710]

They go on to extrapolate from this case:

> This first report on long-term effects of puberty suppression suggests that negative side effects are limited and that it can be a useful additional tool in the diagnosis and treatment of gender dysphoric adolescents.[711]

A 2012 study conducted by Colin Close – a trans advocate who co-founded FTM Sonoma County in 2004 – "examines the impacts of medically-assisted transition [both hormonal and surgical] . . . on the lives of 448 transgender people" (**Close, [2012]**).[712] Among the reported findings:

> Most participants reported that medically-assisted transition resulted in less gender dysphoria, better quality of life, and more emotional well-being. Time on hormones and genital surgery appeared to have positive impacts on participants.[713]

Overall, 96% reported satisfaction with transition. More specifically: 97% reported satisfaction with hormone therapy; 96% with chest surgery; and 90% with genital surgery.[714] In the "limitations" section of this published report, the author notes:

> As the survey did not undergo a university-based Institutional Review Board process, the results are not eligible for publication in peer-reviewed academic or research journals . . . . This project was not sponsored by a national organization or university, and this probably limited participation. Potential respondents may have felt unwilling to complete the survey or redistribute it due to their uncertainty about who was conducting the study and how the data would be used."[715]

2012 also brought the landmark publication of the **WPATH's SOC-7**.[716] In the course of reviewing the development of a standard treatment pathway, the authors write:

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[710] Ibid., 843.
[711] Ibid.
[712] Colin Close, *Affirming Gender, Affirming Lives: A Report of the 2011 Transition Survey* (Santa Rosa: GATE, 2012). On the methodological problems associated with this study, see the methodological section below.
[713] Ibid., 1.
[714] Ibid., 2.
[715] Ibid., 7.
[716] Originally published as E. Coleman, W. Bockting, M. Botzer, P. Cohen-Kettenis, G. DeCuypere, et al., "Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People, Version 7," *International Journal of Transgenderism* 13/4 (2012), 165-232. Available at https://www.wpath.org/publications/soc

> This approach [i.e., medical transition] was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1–1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993).[717]

A 2014 study was conducted by a Swedish team of researchers primarily based at Karolinska University Hospital in Stockholm. This impressive longitudinal study was based on applications within the Swedish population for legal and surgical transition over a 50-year period – from 1960 to 2010 (**Dhejne, et al. [2014]**).[718] During this period, a total of "681 persons (FM: 252/289, 87 %; MF: 429/478, 90 %) were granted a new legal gender and had undergone sex confirmation surgery."[719] Among other things, this study reports on the transition regret rate of this cohort:

> A total of 15 individuals (5 FM and 10 MF) out of 681 who received a new legal gender between 1960 and 2010 applied for reversal to the original sex (regret applications). This corresponds to a regret rate of 2.2 % for both sexes (2.0 % FM and 2.3 % MF). As showed in Table 4, the regret rate decreased significantly over the whole study period.[720]

With regard to the regret rate reported in this study, two points are worth noting. First, since "regret" is defined not merely as expressing subjective regret, but rather as officially applying "for [surgical] reversal to the original sex," this means that "regret" is equated with *seeking medical detransition*. Thus, the 2.2% "regret" rate is actually *a 2.2% detransition rate*. Second, this research team found that the "median (range) time elapsed from attaining a new legal gender to the regret application was 7.5 years (90 months, range 75–137) for FM, and 8.5 years (102 months, range 22–177) for MF."[721] In other words, *the average median length of time from new legal status to regret application was 8 years*. This data point is highly relevant in that it suggests that *the majority of regret studies* – studies with follow-up periods of less, often much less, than eight years – *are drawing conclusions about people's transition regret rates prior to the point in*

[717] Ibid., 8. It is worth noting that – almost 20 years after its publication – Pfäfflin (1993) is still being used to anchor the claim of a 1 – 1.5% regret rate.
[718] Cecelia Dhejne, Katarina Öberg, Stefan Arver, and Mikael Landén, "An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010: Prevalence, Incidence, and Regrets," *Archives of Sexual Behavior* 43/8 (2014), 1535–45.
[719] Ibid., 1539.
[720] Ibid., 1540.
[721] Ibid., 1540-41.

time at which regret tends to manifest. We will return to this observation below in the final methodological section.

A third 2014 study was produced by a German research team. 254 trans women who had undergone bottom surgery at Essen University Hospital between 2004 and 2010 were sent a questionnaire inquiring about their postoperative satisfaction (**Hess, et al. [2014]**).[722] 119 completed questionaries were returned, resulting in a lost to follow-up rate of 53.1%. The mean follow-up period from completed surgery to survey response was 5.05 years. Reported results include:

> 90.2% said their expectations for life as a woman were fulfilled postoperatively. 85.4% saw themselves as women. 61.2% were satisfied, and 26.2% very satisfied, with their outward appearance as a woman; 37.6% were satisfied, and 34.4% very satisfied, with the functional outcome. 65.7% said they were satisfied with their life as it is now.[723]

A final 2014 study, produced by a team of Irish researchers, reviewed the medical records of 218 people (159 transwomen; 59 trans men) with a "suspected or confirmed" diagnosis of GD and referred to their endocrine service for consideration of HRT between 2005 and 2014 (**Judge, et al. [2014]**).[724] At the time of follow-up, 74.3% of the cohort were on HTR and 9.17% had already undergone SRS. The authors comment on the significant referral rate increase during this time period: "The rate of referral has increased year-on-year, with 55 patients referred in 2013 versus 6 in 2005." Regarding transition regret, the authors report: "Regret following hormonal or surgical treatment was in line with other Western European countries (1.83%)."[725]

In 2015, a French team produced a study that sought to follow up on 266 people who had undergone SRS ("one third of MtF and two thirds of FtM") between 1991 and 2009 (**Karpel, et**

[722] Jochen Hess, Roberto Rossi Neto, Leo Panic, Herbert Rübben, and Wolfgang Senf, "Satisfaction with Male-to-Female Gender Reassignment Surgery," *Deutsches Ärzteblatt International* 111 (2014), 795–801.
[723] Ibid., 795.
[724] C. Judge, C. O'Donovan, G. Callaghan, G. Gaoatswe, and D. O'Shea, "Gender Dysphoria – Prevalence, and Co-morbidities in an Irish Adult Population," *Frontiers in Endocrinology* 5 (2014), 87, doi: 10.3389/fendo.2014.00087.
[725] Ibid.

al. [2015]).[726] Of the 266 people contacted, 207 (78%) responded to the survey – a lost to follow-up rate of 22%. Karpel, et al. report that

> [s]ixty percent of the patients are satisfied with the surgery, 25% are dissatisfied and 15% have an ambivalent opinion. Seventy-one percent of the patients attribute their dissatisfaction to an insufficient result from an aesthetic point of view and 46% from a functional point of view . . . . Two patients (MtF) have never asked for a change of their civil status because of their deep regret of the SRS. One of them has also asked to return to his sex of birth. Ninety-five percent of patients do not express any regret. About 4.5% felt some regret given the results of the surgery . . . . [The] majority of patients express a sexual and psychological well-being after surgery. However, a greater number of FtM are satisfied with their social and family life, whereas a greater number of MtF is satisfied with the result of the surgery and their sexual life.[727]

In 2015, Ulrike Ruppin and Friedmann Pfäfflin published a study that is noteworthy for its remarkably lengthy follow-up period. The primary inclusion criterion was "the legal recognition of participants' gender change via a legal name change had to date back at least 10 years" (**Ruppin and Pfäfflin [2015]**).[728] They note that

> [a]ltogether, a total of 140 persons received letters of which 101 (72.1 %) made contact with the authors and, thereupon, were informed about the study and asked for their participation . . . . Finally, 71 persons decided to take part in the study which corresponds to 50.7 % of all contacted persons and 70.3 % of the persons who got back to the authors.[729]

This amounts to a lost to follow-up rate (vis-à-vis the original 140 people contacted) of 49.3%. Of the 71 participants (35 trans women and 36 trans men), the time period between legal name change and follow-up was between 10 and 24 years, with a mean of 13.8 years.[730] The authors report that

> [p]ositive and desired changes were determined by all of the instruments: Participants reported high degrees of well-being and a good social integration. Very few participants were unemployed, most of them had a steady relationship, and they were also satisfied with their relationships with family and friends. Their overall evaluation of the treatment process for sex reassignment and its effectiveness in reducing gender dysphoria was

[726] Lea Karpel, Berenice Gardel, Marc Revol, Catherine Bremont-Weil, Jean-Marc Ayoubi, and Bernard Cordier, "Psychological and Sexual Well Being of 207 Transsexuals after Sex Reassignment in France" [French], *Annales Medico Psychologiques* 173 (2015), 511-19 (here p. 511).
[727] Ibid. (from the English abstract).
[728] Ulrike Ruppin and Friedmann Pfäfflin, "Long-Term Follow-Up of Adults with Gender Identity Disorder," *Archives of Sexual Behavior* 44 (2015), 1321-29 (here p. 1321).
[729] Ibid., 1322.
[730] Ibid.

> positive. Regarding the results of the standardized questionnaires, participants showed significantly fewer psychological problems and interpersonal difficulties as well as a strongly increased life satisfaction at follow-up than at the time of the initial consultation.[731]

Also in 2015, an Italian study was published in which quality of life (QoL) indicators for 60 post-operative trans people and 60 "healthy matched controls" from the wider Italian population were compared (**Castellano, et al. [2015]**).[732] They conclude:

> The QoL and the quality of body image scores in transpeople were not statistically different from the matched control groups' ones. In the sexual life subscale, transwomen's scores were similar to biological women's ones, whereas transmen's scores were statistically lower than biological men's ones (P = 0.003). The quality of sexual life scored statistically lower in transmen than in transwomen (P = 0.048). A significant inverse relationship between LH and body image and between LH and quality of sexual life was found . . . . This study highlights general satisfaction after SRS. In particular, transpeople's QoL turns out to be similar to Italian matched controls.[733]

A German team, based at the University Hospital Rechts der Isar in Munich, published a retrospective study in 2017 in which they surveyed quality of life outcomes for trans women who underwent SRS at their center from 2007 to 2013 (**Papadopulos, et al. [2017]**).[734] 121 patients were eligible for the study. 47 (38.8%) of them completed the survey – a lost to follow-up rate of 61.2%.[735] The follow-up period was an average of 19 months post-surgery. Among their reported findings:

> The self-developed indication-specific questionnaire showed that 91% experienced an improvement of QOL. All patients stated they would undergo SRS again and did not regret it at all. Patients stated their femininity significantly increased . . . . Our self-developed combined surgical technique seemed to have a positive influence on QOL after SRS. Satisfaction with breasts, genitals, and femininity increased significantly and show the importance of surgical treatment as a key therapeutic option for MTF transsexuals.[736]

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[731] Ibid., 1321.
[732] E. Castellano, C. Crespi, C. Dell'Aquila, R. Rosato, C. Catalano, V. Mineccia, G. Motta, E. Botto, and C. Manier, "Quality of Life and Hormones After Sex Reassignment Surgery," *Journal of Endocrinological Investigation* 38 (2015), 1373-81.
[733] Ibid., 1373.
[734] Nikolaos A. Papadopulos, Jean-Daniel Lellé, Dmitry Zavlin, Pater Herschbach, Gerhard Henrich, Laszlo Kovacs, et al., "Quality of Life and Patient Satisfaction Following Male-to-Female Sex Reassignment Surgery," *Journal of Sexual Medicine* 14/5 (2017), 721-30.
[735] Ibid., 722.
[736] Ibid., 721.

In 2018, the What We Know Project – based out of Cornell University – produced a meta-analysis involving a literature review of 72 (English language) article abstracts published between 1991 and June 2017 that report on outcomes for medical transition (**What We Know Project [2018]**).[737] In their summary of the study's "bottom line," they write:

> This search found a robust international consensus in the peer-reviewed literature that gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals. The literature also indicates that greater availability of medical and social support for gender transition contributes to better quality of life for those who identify as transgender.[738]

A Swiss study also published in 2018 investigated quality of life outcomes for people who had undergone medical transition (**Jellestad, et al. [2018]**).[739] Their target sample consisted of 373 trans people "who had formerly presented to the outpatient clinic of the collaborating hospitals."[740] Of this target cohort, 66 people (18%) completed and returned their questionnaires – a lost to follow-up rate of 82.3%. To increase their sample size, the research team then recruited more trans participants by reaching out to "the larger Swiss trans community via advocacy groups," and inviting participation in a web-based survey.[741] Of this additional online cohort of 201 people who reported an initial interest in participating, only 77 completed the survey – "an inclusion rate of 38%" and thus a non-response rate of 62%.[742] Thus, "[i]n total, 143 individuals completed the questionnaire and were included."[743] A general finding from their study: "Medical GAI [gender-affirming interventions] are associated with better mental wellbeing."[744]

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[737] What We Know Project, *What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-being?* (New York: Cornell University, 2018), https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/#top.
[738] Ibid., 1.
[739] Lena Jellestad, Tiziana Jäggi, Salvatore Corbisiero, Dirk J. Schaefer, Josef Jenewein, Andres Schneeberger, Annette Kuhn, and David Garcia Nuñez, "Quality of Life in Transitioned Trans Persons: A Retrospective Cross-Sectional Cohort Study," *Hindawi - BioMed Research International* (2018), 8684625, 10 pp., https://doi.org/10.1155/2018/8684625
[740] Ibid., 2.
[741] Ibid.
[742] Ibid., 3.
[743] Ibid.
[744] Ibid., 1.

2018 also brought a study by an international team involved with the European Network on the Investigation of Gender Incongruence (ENIGI), and based at gender centers in Amsterdam (the Netherlands), Ghent (Belgium), Hamburg (Germany), and Oslo (Norway). Their target population involved "persons diagnosed with gender dysphoria (DSM-IV-TR) who applied for medical interventions from 2007 until 2009" at several of the gender clinics represented by the research team, and their research focus was post-SRS outcomes "4 to 6 years after first clinical contact, and the associations between postoperative (dis)satisfaction and quality of life (QoL)" (**van de Grift, et al. [2018]**).[745] A total of 546 potential participants were identified and invited to participate in the survey. By the "end of the recruitment period, 201 (37%) people filled out the survey" – a lost to follow-up rate of 63%.[746] However, of these 201 responders, "[t]wenty-nine did not receive medical interventions and 36 received [only] hormonal therapy." This means that only "136 (67% [of the 201 responders]), who had received both hormonal therapy and GAS (genital, chest, facial, vocal cord, and/or thyroid cartilage surgery), were included for analysis."[747] Among the reported findings:

> The satisfaction with feminizing surgeries was 96% to 100%, except for a single person receiving vocal cord surgery who was not satisfied. For trans men, . . . [s]atisfaction with the surgeries ranged from 94% (mastectomy) to 100% (penis construction), although some procedures were provided to only a few participants . . . . None of the respondents reported major regret.[748]

In 2018, a presentation abstract from an annual convention of plastic surgeons was posted in *Plastic and Reconstructive Surgery – Global Open*.[749] The abstract summarized findings from "an anonymous survey [that] was sent to all surgeons who registered for the WPATH conference in 2016 and USPATH conference in 2017" regarding patients who have reported post-surgical regret and/or detransition (**Danker, et al. [2018]**).[750] A total of 46 surgeons (30%) responded to the survey – a non-response rate of 70%. Based on participant responses, this group of gender

[745] Tim C. van de Grift, Els Elaut, Susanne C. Cerwenka, Peggy T. Cohen-Kettenis, and Baudewijntje P. C. Kreukels, "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study," *Journal of Sex & Marital Therapy* 44/2 (2018), 138-48 (here p. 138).
[746] Ibid., 140.
[747] Ibid.
[748] Ibid., 143, 144.
[749] I.e., this was not a study that went through the peer-reviewed article process.
[750] Sara Danker, Sasha K. Narayan, Rachel Bluebond-Langner, Loren S. Schechter, and Jens U. Berli, "Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries," *Plastic and Reconstructive Surgery – Global Open* 6/95 (September 2018), 189, doi: 10.1097/01.GOX.0000547077.23299.00.

surgeons estimated that they had surgically treated 22,725 trans people. Reported findings include:

> 49% [i.e., 23] of respondents had never encountered a patient who regretted their gender transition or were seeking detransition care. 12 providers encountered 1 patient with regret and the rest [i.e., 11] encountered more than one patient. This amounted to a total of 62 patients. There were 13 patients who regretted chest surgery and 45 patients who regretted genital surgery. The composition of the patients who sought detransition is as follows: 16 trans-men, 37 trans-women, and 6 non-binary patients. The most common reason cited for detransition was change in gender identity (22 patients) followed by rejection or alienation from family or social support (8 patients) and difficulty in romantic relationships (7 patients). Chronic post-operative pain was also cited as a reason for detransition.[751]

Interestingly, 88% of surgeons responding stated that the WPATH's SOC-8 should add a chapter on detransition. Danker, et al. also note that "[t]here is a paucity of literature examining the incidence and/or etiology of surgical de- and re-transition."[752]

Also in 2018, a research team based in Germany published a prospective study involving 40 eligible "MTF transgender patients who underwent two-stage SRS . . . between September 2012 and January 2014" (**Zavlin, ert al. [2018]**).[753] 49 people were eligible for the study, with 40 of them completing both pre- and post-surveys – a lost to follow-up rate of 22.5%. The two surveys were administered "1 day before the first stage (T0) and 6 months after the second stage of SRS (T1)."[754] Reported findings include:

> Patients rated their surgical satisfaction of most items with mean scores above 7 on a 0-10-point scale. Many items evaluating everyday life activities improved significantly after SRS compared to T0 ($p < 0.01$). All but one patient (97.5%) reported no regrets about having undergone surgery, and the majority recommended it to other patients with gender dysphoria. Femininity and sexual activity increased significantly postoperatively ($p < 0.01$). Satisfaction with intercourse and orgasm was high: 6.70 and 8.21, respectively, on a 0-10 scale. Conclusion: Satisfaction with the cosmetic outcome, as well as the functional and sexual outcomes, reveal positive effects of SRS.[755]

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[751] Ibid.
[752] Ibid.
[753] Dmitry Zavlin, Jürgen Schaff, Jean-Daniel Lellé, Kevin T. Jubbal, Peter Hherschbach, Gerhard Henrich, et al., "Male-to-Female Sex Reassignment Surgery Using the Combined Vaginoplasty Technique: Satisfaction of Transgender Patients with Aesthetic, Functional and Sexual Outcomes," *Aesthetic Plastic Surgery* 42/1 (2018), 178-87.
[754] Ibid., 178.
[755] Ibid.

An international research team (Italy and Thailand) published a 2018 meta-analysis of retrospective studies produced between 1985 and 2017 on the outcomes of vaginoplasty for trans women with the goal of ascertaining data on "surgical complications and [improvement of] patient outcomes for transgender patients" (**Manrique, et al. [2018]**).[756] The authors note that 471 potential studies were identified, 46 of which met their inclusion criteria. Together, this pool of studies involved 3,716 cases of vaginoplasty. Reported findings include:

> Overall incidence of complications included the following: 2% (1%-6%) fistula, 14% (10%-18%) stenosis and strictures, and 1% (0%-6%) tissue necrosis, and 4% (2%-10%) prolapse (upper and lower limits of the 95% confidence interval). Patient-reported outcomes included a satisfaction rate of 93% (79%-100%) with overall results, 87% (75%-96%) with functional outcomes, and 90% (79%-98%) with esthetic outcomes. Ability to have orgasm was reported in 70% (54%-84%) of patients. The regret rate was 1% (0%-3%) . . . . Multiple surgical techniques have demonstrated safe and reliable means of MtF vaginoplasty with low overall complication rates and with a significant improvement in the patient's quality of life.[757]

Another 2018 study – produced by the respected multi-disciplinary team at the VU University Medical Center in Amsterdam – has been heralded as particularly important due to its large sample size and unusually lengthy follow-up period (**Wiepjes, et al. [2018]**).[758] The stated aim of this retrospective study is to investigate "the current prevalence of gender dysphoria, how frequently gender-affirming treatments are performed, and the number of people experiencing regret of this treatment."[759] The study population was determined by performing a retrospective medical record review in order identify all of the people seen at their gender clinic from 1972 to 2015. The authors note that

> 6,793 people (4,432 birth-assigned male, 2,361 birth-assigned female) visited our gender identity clinic from 1972 through 2015. The number of people assessed per year increased 20-fold from 34 in 1980 to 686 in 2015.[760]

They also note:

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[756] O. J. Manrique, K. Adabi, J. Martinez-Jorge, P. Ciudad, F. Nicoli, and K, Kiranantawat, "Complications and Patient-reported Outcomes in Male-to-Female Vaginoplasty—Where are we Today?," *Annals of Plastic Surgery* 80/6 (2018), 684-91 (here p. 684).
[757] Ibid., 648.
[758] C. M. Wiepjes, N. M. Nota, C. J. M. de Blok, M. Klaver, M. de Vries, A. L. Wensing-Kruger, et al., "The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets," *Journal of Sexual Medicine* 15/4 (2018), 582-90.
[759] Ibid., 582.
[760] Ibid.

> Although historically more transwomen than transmen presented for treatment, more transmen than transwomen applied for treatment in 2015. This change in sex ratio was mainly due to the increase in adolescent transgender boys, because the ratio of transwomen to transmen in adults remained stable over time.[761]

In the "limitations" section of their study, Wiepjes, et al. report on participant attrition:

> A large number of transgender people who had initially received treatment in our center were lost to follow-up. Although transgender people receive lifelong care, a large group (36%) did not return to our clinic after several years of treatment.[762]

Regarding their findings in transition regret:

> Regret was identified in 0.6% of transwomen and 0.3% of transmen who underwent gonadectomy . . . . Their ages at start of HT ranged from 25 to 54 years, and they expressed their regrets 46 to 271 months after initiation of HT. Reasons for regret were divided into social regret, true regret, or feeling non-binary. Transwomen who were classified as having social regret still identified as women, but reported reasons such as "ignored by surroundings" or "the loss of relatives is a large sacrifice" for returning to the male role. People who were classified as having true regret reported that they thought gender-affirming treatment would be a "solution" for, for example, homosexuality or personal acceptance, but, in retrospect, regretted the diagnosis and treatment . . . . Despite the large increase in treated transgender people, the percentage of people who underwent gonadectomy but regretted their decision was still very small (0.5%).[763]

A final study published in 2018 is noteworthy for its focus on transmasculine adolescents and young adults. Specifically, this study compares two cohorts of transmasculine youth recruited from the Center for Transyouth Health and Development (Los Angeles) who experience chest dysphoria – one cohort who have undergone top surgery and one who have not (**Olson-Kennedy, et al. [2018]**).[764] Olson-Kennedy, et al. describe eligibility criteria for the study:

> Youth in the nonsurgical group and the postsurgical group were considered eligible to complete the survey if they were 13 to 25 years old, assigned female at birth, identified their gender as something other than female, were able to read and understand English, and were able to provide consent . . . . Youth were included in the nonsurgical group if they had not undergone chest reconstruction surgery and had chest tissue consistent with female development . . . . Youth were included in the postsurgical group if they had undergone chest reconstruction surgery. All participating youth who had undergone chest

[761] Ibid., 584-85.
[762] Ibid., 589.
[763] Ibid., 585, 589.
[764] J. Olson-Kennedy, J. Warus, V. Okonta, M. Belzer, and L. F. Clark, "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts," *JAMA Pediatrics* 172 (2018), 431-36.

> reconstruction surgery had done so after obtaining referral letters from medical and mental health professionals as required by the surgeons and insurance plans.[765]

Participants were recruited from among transmasculine youth visiting the center between June and December 2016, 332 of which were eligible for the study. The research team notes that "[n]onsurgical youth outnumbered postsurgical youth in active care at the clinic by a ratio of 3.5:1."[766] Of the postsurgical cohort eligible for the study, two of them "refused the survey, and 24 (26%) could not be contacted."[767] In the end, 68 eligible youth (72%) completed surveys – a lost to follow-up rate of 28%.

The authors provide relevant data on the two participant cohorts:

> At the time of survey, the mean (SD) age of postsurgical participants was 19 (2.5) years (range, 14-25 years). The length of time between survey and chest surgery varied from less than 1 year to 5 years (Table 2). The mean (SD) age at chest surgery in this cohort was 17.5 (2.4) years (range, 13-24 years), with 33 (49%) being younger than 18 years. Of the 33 postsurgical participants younger than 18 years at surgery, 16 (48%) were 15 years or younger (Figure). At the time of survey, the mean (SD) age of participants without surgery was 17 (2.5) years (range, 13-23 years), with 39 (57%) being younger than 18 years.[768]

Reported findings include:

> All postsurgical participants (68 of 68; 100%) affirmed the statement, "It was a good decision to undergo chest reconstruction." Sixty-seven of 68 postsurgical respondents reported no regret about undergoing the procedure. Only 1 participant (who was older than 18 years at the time of surgery) reported experiencing regret "sometimes" . . . . Interest in chest reconstruction among respondents was high, with nearly 70% responding to the question, "How important is having chest surgery to you?" with the description, "one of the most important things for [them] right now"; another 17 (25%) described it as "very important." The majority (59 of 68; 87%) were using testosterone at the time of survey.[769]

In light of their findings, this team concludes that changes are needed to the current standards of care for trans youth that restrict top surgery to those who have reached the age of legal adulthood:

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[765] Ibid., 433.
[766] Ibid.
[767] Ibid.
[768] Ibid., 433-34.
[769] Ibid., 434-35.

> Given the numerous complications associated with chest binding, the negative emotional and mental effects of chest dysphoria, and the positive outcome of chest surgery demonstrated in this study, changes in clinical practice and in insurance plans' requirements for youth with gender dysphoria who are seeking surgery seem essential. Youth should be referred for chest surgery based on their individual needs, rather than their age or time spent taking medication. Individualized, patient-centered care plans should be considered the standard of care for all transgender adolescents, and referrals should be made accordingly.[770]

In the final year of this decade, a U.S. team published a study on post-operative outcome and satisfaction rates for trans men who had undergone "[m]asculinizing top surgery (bilateral mastectomy with chest wall reconstruction)" (**Poudrier, et al. [2019]**).[771] The study involved surveying post-operative patients associated with the team's senior researcher. An anonymous, online survey was made available to 81 patients, 58 of which (72%) completed it – a lost to follow-up rate of 28%. Reported findings include:

> Following top surgery, measures of quality of life and sexual confidence improved significantly ($p < 0.001$). In addition, 86 percent reported improvement in gender dysphoria-related mental health conditions. All but one respondent reported that top surgery had an overall positive impact on their life . . . . Top surgery had major positive effects on all mental health and quality-of-life metrics.[772]

A 2019 prospective study by an Iranian research team, based at the Fertility Research Center of Tehran University of Medical Sciences, compared quality of life measurements of 41 "female-to-male (FTM) GID patients before and after gender reassignment surgery (GRS)" (**Naeimi, et al. [2019]**).[773] All participants were referred to the Research Center between December 2014 and December 2015. Reported findings include:

> Total mean score of QOL significantly improved from 26.43±6.81 to 37.52 ± 8.67 ($P < 0.001$), 6 months after surgery and also in all domains ($P < 0.001$), although the increase in emotional problem was not statistically significant ($P = 0.05$) . . . . In conclusion, as the results of the present study highlight, FTM GD patients have a low QOL before surgery that is significantly improved after surgery.[774]

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[770] Ibid., 436.
[771] Grace Poudrier, Ian T. Nolan, Tiffany E. Cook, Whitney Saia, Catherine C. Motosko, John T. Stranix, et al., "Assessing Quality of Life and Patient-Reported Satisfaction with Masculinizing Top Surgery: A Mixed-Methods Descriptive Survey Study," *Plastic and Reconstructive Surgery* 143 (2019), 272-79.
[772] Ibid., 272.
[773] S. Naeimi, M. Akhlaghdoust, S. Chaichian, Y. Moradi, F. Jesmi, N. Zarbati, et al., "Quality of Life Changes in Iranian Patients Undergoing Female-to-Male Transsexual Surgery: A Prospective Study," *Archives of Iranian Medicine* 22/2 (2019), 71-75 (here p. 71).
[774] Ibid. Another Iranian study published in 2019 also reported higher of levels of mental health and happiness after surgery than before. See E. Fallahtafti, M. Nasehi, R. Rasuli, D. D. Farhud, T. Pourebrahim, and H.

In 2019 a German team published a meta-analysis investigating quality of life – including satisfaction and regret rates – for trans women undergoing SRS (**Weinforth, et al. [2019]**).[775] This review used 13 articles (11 quantitative and 2 mixed quantitative/qualitative studies) that, together, included data on 1101 trans people. The authors note that the "number of trans women in each study ranged from 3 to 247," and that "the drop-out rates, insofar as they were given, ranged from 12% to 77% (median: 56%)."[776] Based on their analysis, the authors conclude "that sex reassignment surgery has an overall positive effect on partial aspects, such as mental health, sexuality, life satisfaction, and quality of life."[777]

A final 2019 study by researchers associated with the Stories of Gender-Affirming Care team – a group of researchers and clinicians in several gender affirmative clinics across Canada – reports on "the experiences of gender diverse and trans children and youth considering and initiating medical interventions" in Canada (**Sansfacon, et al. [2019]**).[778] Among the 35 youth who participated in this study:

> four were aged from 9 to 11 years, fourteen were aged from 13 to 15 years and seventeen were 16 and 17 years old. 14 youth were transfeminine (TF), i.e. had been assigned male at birth, and 22 where transmasculine (TM), i.e. had been assigned female at birth.[779]

The authors note that

> [m]edical interventions provided at the clinics include hormone suppression therapy/ blockers, hormone therapy (HT) in the form of estrogen or testosterone, and for some older youth, surgery. The medical interventions that participants sought and/or received, as well as the effects they expected or hoped for, varied considerably from one youth to another . . . . While a few were awaiting approval for top surgery, only one participant had had top surgery at the time of the interview. He reported that it had had the most

Zareeeimahmoodabadi, "Happiness and Mental Health in Pre-Operative and Post-Operative Transsexual People," *Iranian Journal of Public Health* 48/12 (2019), 2277-84.

[775] Géraldine Weinforth, Richard Fakin, Pietro Giovanoli, and David Garcia Nuñez, "Quality of Life Following Male-To-Female Sex Reassignment Surgery," *Deutsches Arzteblatt International* 116/15 (2019), 253-60.

[776] Ibid., 253.

[777] Ibid., 258.

[778] Annie Pullen Sansfacon, Julia Temple-Newhook, Frank Suerich-Gulick, Stephen Feder, Margaret L. Lawson, Jennifer Ducharme, et al. on behalf of the Stories of Gender-Affirming Care Team, "The Experiences of Gender Diverse and Trans Children and Youth Considering and Initiating Medical Interventions in Canadian Gender-Affirming Specialty Clinics," *International Journal of Transgenderism* 20/4 (2019), 371-87 (here p. 371).

[779] Ibid., 376.

> significantly positive impact on his well-being of all the interventions he had undergone.[780]

Reported findings include:

> [M]ost reported that the medical procedures they underwent led to positive outcomes and a greater sense of well-being. While some did report negative physical side-effects and/or times of questioning their decision to transition, such questioning was simply painted as "part of the journey," and none expressed regret for choosing any of the procedures . . . . Overall, medical interventions, whether in the form of hormone blockers, hormone therapy or surgery appear to be very positive in the lives of trans youth who participated in our study, even for those who reported side effects. They experienced improved general happiness or well-being and reported feeling that their body was better aligned with their gender identity.[781]

In 2020, a U.S. research team centered at Johns Hopkins University conducted a study involving 680 eligible trans men who had undergone surgical transition under the care of the senior researcher (**McNichols, et al. [2020]**).[782] A total of 246 patients (36%) completed the survey – a lost to follow-up rare of 64%. Regarding specific surgical procedures, the authors note:

> Of the patients surveyed, the following procedures were reported in descending popularity: 94% had a mastectomy, 20.5% had a hysterectomy, 1.5% had a phalloplasty (zero metoidoplasties, one anterio-lateral thigh flap, and 2 radial forearm free flaps), 0.5% had a scrotoplasty, and 0.5% had a prosthesis inserted to achieve an erection.[783]

Reported outcomes include:

> In regard to self-image, sex/dating life, and social life there was a significant improvement ($p < 0.001$) after undergoing gender affirming surgery. Patients reported significantly less difficulty with employment after having gender affirming surgery ($p < 0.001$). If present, the following psychiatric morbidities were self-reported to have a statistically significant improvement after surgery: depression, anxiety, substance abuse, suicidal ideation, panic disorder, social phobia, and obsessive-compulsive disorder.[784]

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[780] Ibid., 377, 379.
[781] Ibid., 371, 380.
[782] Colton H. L. McNichols, Devin O-Brien-Coon, and Beverly Fischer, "Patient-reported Satisfaction and Quality of Life after Trans Male Gender Affirming Surgery," *International Journal of Transgender Health* 21/4 (2020), 410-17. DOI: 10.1080/26895269.2020.1775159.
[783] Ibid.
[784] Ibid.

A 2020 systematic review and meta-analysis considers quality of life outcomes for surgical transition (**Passos, et al., [2020]**).[785] 14 studies involving 881 people met the inclusion criteria for the review, while 7 studies involving 420 people met the meta-analysis criteria. In regard to their findings:

> Statistical heterogeneity of the results was significant. Evidence of low quality suggests that gender affirmation surgery will likely improve the QoL of transgender individuals. Better overall QoL results were found in the trans men population that underwent chest surgery.[786]

The authors go on to note that studies involving trans women tended to show positive effects of surgical transition in regard to outcomes such as psychological health, social relationships, general satisfaction, satisfaction with body image, and self-esteem. However, they found that in other outcomes such as physical health and level of independence, outcomes were "significantly worse" after medical transition.[787]

A 2020 study by Richard Bränström and John Pachankis that sought to investigate the relationship between surgical transition and mental health proved to be unusually controversial (**Bränström and Pachankis [2020]**).[788] Using the Swedish Total Population Register (N = 9,747,324), which is linked to the National Patient Register and the Prescribed Drug Register, Bränström and Pachankis set out

> to ascertain the prevalence of mood and anxiety disorder health care visits and antidepressant and anxiolytic prescriptions in 2015 as a function of gender incongruence diagnosis and gender-affirming hormone and surgical treatment in the entire Swedish population.[789]

They reported the following results:

> Compared with the general population, individuals with a gender incongruence diagnosis were about six times as likely to have had a mood and anxiety disorder health care visit, more than three times as likely to have received prescriptions for antidepressants and anxiolytics, and more than six times as likely to have been hospitalized after a suicide

[785] T. S. Passos, M. S. Teixeira, and M. A. Almeida-Santos, "Quality of Life After Gender Affirmation Surgery: A Systematic Review and Network Meta-analysis," *Sexual Research and Social Policy* 17 (2020), 252-62.
[786] Ibid., 252.
[787] Ibid., 258.
[788] Richard Bränström and John E. Pachankis, "Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study," *American Journal of Psychiatry* 177/8 (2020), 727-34. The controversy broke out after its prior-to-print e-publication in October 2019.
[789] Ibid., 727.

> attempt. Years since initiating hormone treatment was not significantly related to likelihood of mental health treatment (adjusted odds ratio=1.01, 95% CI=0.98, 1.03). However, increased time since last gender-affirming surgery was associated with reduced mental health treatment (adjusted odds ratio=0.92, 95% CI=0.87, 0.98) . . . . In this first total population study of transgender individuals with a gender incongruence diagnosis, the longitudinal association between gender-affirming surgery and reduced likelihood of mental health treatment lends support to the decision to provide gender-affirming surgeries to transgender individuals who seek them.[790]

The publishing journal – the *American Journal of Psychiatry* – soon received a number of critical responses to the Bränström and Pachankis study that raised troubling questions regarding its methodology and conclusions.[791] In response, the journal sought out a "statistical consultation" on the original study, which led to the publication of a "correction" notice attached to the Bränström and Pachankis article.[792] The correction states, contrary to Bränström and Pachankis' original claim, that when the two groups – i.e., people with gender incongruence who had transition surgery vs. those who did not – were compared: "the results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or

[790] Ibid.

[791] Henrik Anckarsäter and Christopher Gillberg, "Methodological Shortcomings Undercut Statement in Support of Gender-Affirming Surgery [Letter to the Editor]," *American Journal of Psychiatry* 177/8 (2020), 764-65; David Curtis, "Study of Transgender Patients: Conclusions are Not Supported by Findings [Letter to the Editor]," *American Journal of Psychiatry* 177/8 (2020), 766; Ned H. Kalin, "Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender-Affirming Surgeries: A Comment by the Editor on the Process," *American Journal of Psychiatry* 177/8 (2020), 764; Mikael Landén, "The Effect of Gender-Affirming Treatment on Psychiatric Morbidity is Still Undecided [Letter to the Editor]," *American Journal of Psychiatry* 177/8 (2020), 767-68; William J. Malone and Sven Roman, "Calling into Question Whether Gender-Affirming Surgery Relieves Psychological Distress [Letter to the Editor]," *American Journal of Psychiatry* 177/8 (2020), 766-67; Sven C. Mueller, "Mental Health Treatment Utilization in Transgender Persons: What We Know and What We Don't Know," *American Journal of Psychiatry* 177/8 (2020), 657-59; Avi Ring and and William J. Malone, "Confounding Effects on Mental Health Observations after Sex Reassignment Surgery [Letter to the Editor]," *American Journal of Psychiatry* 177/8 (2020), 768-69; Andre Van Mol, Michael K. Laidlaw, Miriam Grossman, and Paul R. McHugh, "Gender-Affirming Surgery Conclusion Lacks Evidence [Letter to the Editor]," *American Journal of Psychiatry* 177/8 (2020), 765-66; Agnes Wold, "Gender-Corrective Surgery Promoting Mental Health in Persons with Gender Dysphoria Not Supported by Data Presented in Article [Letter to the Editor]," *American Journal of Psychiatry* 177/8 (2020), 768.

[792] "Correction to Bränström and Pachankis," *American Journal of Psychiatry* 177/8 (2020), 734. On which, see Society for Evidence Based Gender Medicine, "Correction of a Key Study: No Evidence of 'Gender Affirming' Surgeries Improving Mental Health: Allowing Scientific Debate in Transgender Medicine Improves Evidence Base," *segm.org* (August 30, 2020), https://segm.org/ajp_correction_2020

hospitalizations following suicide attempts in that comparison."[793] The journal also published a response by Bränström and Pachankis to the controversy.[794]

2021 brought a review and meta-analysis of studies involving expressions of regret after surgical transition (**Bustos, et al. [2021]**).[795] Data was drawn from 27 studies that, together, included "7,928 transgender patients who underwent any type of GAS."[796] Within this cohort, 33% of the people underwent transmasculine procedures and 67% underwent transfeminine procedures. Reported findings include:

> The prevalence of regret among patients undergoing transmasculine and transfemenine [sic] surgeries was <1% (IC <1%–<1%) and 1% (CI <1%–2%), respectively. A total of 77 patients regretted having had GAS. Twenty-eight had minor and 34 had major regret based on Pfäfflin's regret classification. The majority had *clear regret* based on Kuiper and Cohen-Kettenis classification. Conclusions: Based on this review, there is an extremely low prevalence of regret in transgender patients after GAS.[797]

The authors go on to note:

> However, there is high subjectivity in the assessment of regret and lack of standardized questionnaires, which highlight the importance of developing validated questionnaires in this population.[798]

A 2021 publication offers a critical narrative review of studies that report on satisfaction rates of trans men after penile implant surgery (**Manfredi, et al., [2021]**).[799] After conducting their review, the authors conclude:

> Despite the high satisfaction rate reported in the literature, most of the studies used suboptimal or non-validated questionnaires to assess patients undergoing penile implant surgery. Future research is needed to develop and validate a specific, complete and easy-to-use questionnaire.[800]

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[793] Ibid.
[794] Richard Bränström and John E. Pachankis, "Toward Rigorous Methodologies for Strengthening Causal Inference in the Association between Gender-Affirming Care and Transgender Individual's Mental Health: Response to Letters," *American Journal of Psychiatry* 177/8 (2020), 769-72.
[795] V. P. Bustos, S. S. Bustos, A. Mascaro, G. Del Corral, A. J. Forte, P. Ciudad, E. A. Kim, H. N. Langstein, and O. J. Manrique, "Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence," *Plastic and reconstructive surgery: Global open* 9/3 (2021), e3477. https://doi.org/10.1097/GOX.0000000000003477.
[796] Ibid.
[797] Ibid.
[798] Ibid.
[799] C. Manfredi, É. Fortier, A. Faix, and J. I. Martinez-Salamanca, "Penile Implant Surgery Satisfaction Assessment," *Journal of Sexual Medicine* 18/5 (2021), 868-74.
[800] Ibid., 868.

2021 also brought the studies of Turban, et al. (2021), Narayan, et al. (2021), and MacKinnon, et al. (2021), each of which focus on transition regret and/or detransition, and each of which have been discussed in detail earlier in this study (see above).

Finally, in 2022, a research team out of the University of Queensland, Australia, produced a systematic literature review of surgical and quality of life outcomes for trans people who are at least one-year post-surgery (**Javier, et al. [2022]**).[801] In their final analysis, 79 separate studies provided outcome data on several specific procedures, including "chest, genital, facial, voice and Adam's apple removal surgeries."[802] This research team summarizes their findings as follows:

> Seventy-nine low quality (e.g., small sample sizes, lack of control/comparison groups) studies suggest that most transgender patients are satisfied with surgical outcomes when assessed at least one-year post-surgery. Low quality research also indicates that transgender women and men typically report positive psychological and sexual wellbeing post-surgery, and similar wellbeing outcomes as those who have not had surgery . . . . While the results suggest promising surgical satisfaction and quality of life outcomes following surgery, many studies only draw on small samples, and most studies do not allow for causal conclusions. Further, few studies have compared surgical outcomes between transgender women and men.[803]

In summary – and in line with what we've seen in prior decades – the studies conducted in this decade-plus reveal that most people who respond to post-surgical surveys report generally positive outcomes following medical transition.

(2) A sub-set of people report various types of NTEs (e.g., negative psycho-social and surgical outcomes; transition regret and/or detransition; etc.)

Also in line with prior decades, these studies reveal that a sub-set of people continue to report various types of NTEs – including expressions of transition regret and decisions to detransition.

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[801] Christienne Javier, Charlie R. Crimston, and Finoa Kate Barlow, "Surgical Satisfaction and Quality of Life Outcomes Reported by Transgender Men and Women at Least One Year Post Gender-affirming Surgery: A Systematic Literature Review," *International Journal of Transgender Health* (2022) [online pub ahead of print] DOI: 10.1080/26895269.2022.2038334. For a brief summary of the study, see "Recent Findings from University of Queensland Provides New Insights into Transgender Health," *Health & Medicine Week* (April 22, 2022), 620.
[802] Javier, et al., "Surgical Satisfaction and Quality of Life Outcomes Reported by Transgender Men and Women."
[803] Ibid.

Regarding NTEs and less-than-satisfactory outcomes

(a) Johansson, et al. (2010) report that, while none of the Swedish participants in their study "regretted their reassignment, . . . 5–15% were dissatisfied with the hormonal treatment, results of surgery, total sex reassignment procedure, or their present general health."[804]

(b) The meta-analysis of Murad, et al. (2010) found that post-surgical outcomes of *something less than "significant improvement"* were reported by: 20% of people regarding their gender dysphoria; 20% of people regarding improvement of quality of life; 22% of people regarding improvement of psychological symptoms; and 28% of people regarding improvement in sexual function.[805] In a 2016 annual review of gender dysphoria and its treatment, Ken Zucker, Anne Lawrence, and B. P.C. Kreukels reference this study of Murad et al., noting that it serves to confirm

> both the benefits and limitations of [SRS]. About 86% of FtMs and 71% of MtFs reported improvement in quality of life. Thus, it appears that about 20% of clients do not experience significant benefit from sex reassignment.[806]

(c) In the study of Hess, et al. (2014) focusing on post-surgical satisfaction among trans women, roughly 10% of the participants could not affirm that their "expectations for life as a woman" were satisfied, with 15% still unable to report that they were could "[see] themselves as women."[807] Roughly 13% were not satisfied with their appearance as a woman, and 28% were less-than-satisfied with the functional outcomes of surgery. In terms over-all post-operative life, 65.7% reported that they were satisfied, leaving 34.3% as less-than-satisfied.

(d) In their study of 207 French people who had medically transitioned, Karpel, et al. (2015) found that 25% reported that they were dissatisfied, while another 15% said they were less-than-fully-satisfied.[808]

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[804] Johansson, et al., Five-year Follow-up Study of Swedish Adults with Gender Identity Disorder," 1429.
[805] Murad, et al., "Hormonal Therapy and Sex Reassignment," 214.
[806] Kenneth J. Zucker, Anne A. Lawrence, and Baudewijntje P.C. Kreukels, "Gender Dysphoria in Adults," *Annual Review of Clinical Psychology* 12 (2016), 217-47 (here p. 238).
[807] Hess, et al., "Satisfaction with Male-to-Female Gender Reassignment Surgery," 795.
[808] Karpel, et al., "Psychological and Sexual Well Being of 207 Transsexuals after Sex Reassignment in France" [French]," 511.

(e) In 2017, a team of Swedish researchers conducted a large "prospective cohort study on 190 patients undergoing male-to-female GRS at Karolinska University Hospital between 2003 and 2015" (**Lindqvist, et al. [2017]**).[809] Reported findings include:

> On most dimensions of the SF-36 questionnaire [i.e., the Short Form-36 Health Survey, which measures quality of life across eight domains], transgender women reported a lower QoL than the general population. The scores of SF-36 showed a non-significant trend to be lower 5 years post-GRS compared to pre-operatively, a decline consistent with that of the general population. Self-perceived health compared to 1 year previously rose in the first post-operative year, after which it declined.[810]

(f) A 2021 reports on patient-reported surgical outcomes following penile reconstruction (**Robinson, et al. [2021]**).[811] A survey of 129 post-surgical patients found:

> Seventy-nine patients (61 percent) underwent phalloplasty only, 32 patients (25 percent) underwent metoidioplasty only, and 18 patients (14 percent) underwent metoidioplasty followed by phalloplasty . . . . Patients reported 281 complications requiring 142 revisions. The most common complications were urethrocutaneous fistula (n = 51, 40 percent), urethral stricture (n = 41, 32 percent), and worsened mental health (n = 25, 19 percent) . . . . Conclusion: Complication rates, including urethral compromise and worsened mental health, remain high for gender affirming penile reconstruction.[812]

The authors go on to note:

> These results support anecdotal reports that complication rates following gender affirming genital reconstruction are higher than are commonly reported in the surgical literature . . . . These results are unique in that they are sourced from a large, heterogeneous group of transgender patients spanning 3 continents and dozens of surgical centers.[813]

Regarding psycho-social outcomes

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[809] E. K. Lindqvist, H. Sigurjonsson, C. Möllermark, J. Rinder, F. Farnebo, et al., "Quality of Life Improves Early After Gender Reassignment Surgery in Transgender Women," *European Journal of Plastic Surgery* 40/3 (2017), 223-226 (here p. 223).
[810] Ibid.
[811] Isabel S. Robinson, Gaines Blasdel, Oriana Cohen, Lee C. Zhao, and Rachel Bluebond-Langer, "Surgical Outcomes Following Gender Affirming Penile Reconstruction: Patient-Reported Outcomes from a Multi-Center, International Survey of 129 Transmasculine Patients," *Journal of Sexual Medicine* 18/4 (2021), 800-11.
[812] Ibid., 800.
[813] Ibid.

A number of studies report less-than-encouraging results on psycho-social outcomes. For example:

(a) A large Swedish population study (**Dhejne, et al. [2011]**) involving "[a]ll 324 sex-reassigned persons (191 male-to-females, 133 female-to-males) in Sweden" between the years of 1973 and 2003 found that

> [p]ersons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group.[814]

In her 2017 dissertation, Cecelia Dhejne reflects on the fact that this study had been used by some to call into question the efficacy of medical transition in the treatment of gender dysphoria.[815] She writes: "One could argue that the results should never have been published due to the hurt caused to transgender persons. However, not publishing the results would also hurt the transgender group and take away an opportunity to receive better health care."[816]

(b) A 2016 study by a research team based at the University of Copenhagen conducted a long-term follow-up of "psychiatric morbidity and mortality" among a cohort of medically transitioned Danish people (**Simonsen, et al. [2016]**).[817] This sizable cohort consisted of "104 individuals (56 MtF and 48 FtM), diagnosed by a psychiatrist according to ICD-8/ICD-10 criteria of transsexualism" and approved for SRS by the Danish Health and Medicines Authority between 1978 and 2010.[818] This cohort represents "98% of all individuals who have undergone SRS in Denmark during the period" – a remarkably small lost to follow-up rate.[819] The authors

[814] C. Dhejne, P. Lichtenstein, M. Boman, A. Johansson, N. Langstrom, and M. Landon, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One* 6/2 (2011): e16885. https://doi.org/10.1371/journal.pone.0016885..
[815] E.g., Ryan T. Anderson, "Sex Reassignment Doesn't Work. Here Is the Evidence," *Heritage Foundation* (March 9, 2018), https://www.heritage.org/gender/commentary/sex-reassignment-doesn t-work-here-the-evidence.
[816] Cecelia Dhejne, "On Gender Dysphoria," PhD dissertation (Karolinska Institute, 2017), 65.
[817] Rikke Kildevaeld Simonsen, Annamaria Giraldi, Ellids Kristensen, and Gert Martin Hald, "Long-term Follow-up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity and Mortality," *Nordic Journal of Psychiatry* 70/4 (2016), 241-47.
[818] Ibid., 243.
[819] Ibid., 246.

report that, "[o]verall, 27.9% of the sample were registered with psychiatric morbidity before SRS and 22.1% after SRS."[820] More specifically, reported findings include:

> [I]ndividuals undergoing SRS in the Danish public health system hold considerable psychiatric morbidity besides GID both pre- and post-SRS. Using psychiatric diagnoses as an indicator of psychological/psychiatric well-being, our findings did not support previous studies that found FtM to be better functioning than MtF . . . . Seven individuals had psychiatric morbidity pre- and post-inception, indicating that 23 individuals had been cured of psychiatric suffering from the start of the study period until the time of SRS. Seventeen individuals without psychiatric morbidity pre-SRS, were given a psychiatric diagnosis post-SRS. Further studies are needed to explore this issue. Anxiety, depression, and neurotica personalis constituted the majority of psychiatric diagnoses found in the present study . . . . [A]lmost 10% of the study population died at a mean age less than 60 years where the life-expectancy of assigned females and males in Denmark is 81.9 years, and 78.0 respectively . . . . Clinically, the results of the present study stress the importance of social and psychiatric counselling, support and follow-up of individuals preparing for or having undergone SRS.[821]

Simonson, et al. conclude that "SRS may reduce psychological morbidity for some individuals while increasing it for others."[822]

(c) In their 2018 study of post-transition quality of life outcomes, Jellestad, et al. (2018) report that "[c]ompared to the general population, these findings indicate poor quality of life in trans persons who had performed those medical interventions that they deem necessary for their transition."[823] To the surprise of this research team – and in contradiction to a number of prior studies – their data showed "[no] relevant predictive impact on the mental [quality of life]" for post-transition outcomes of such socio-demographic variables as "age, work situation and relationship status."[824]

(d) The study by van de Grift, et al (2018) notes the relationship between pre-operative psychological problems and post-operative regret:

> 6% of the participants reported dissatisfaction and/or regret, which was associated with preoperative psychological symptoms or self-reported surgical complications (OR= 6.07). Satisfied respondents' QoL scores were similar to reference values; dissatisfied or

[820] Ibid., 241.
[821] Ibid., 245.
[822] Ibid., 241.
[823] Jellestad, et al., "Quality of Life in Transitioned Trans Persons," 5.
[824] Ibid., 7.

> regretful respondents' scores were lower. Therefore, dissatisfaction after GAS may be viewed as indicator of unfavorable psychological and QoL outcomes.[825]

Regarding regret and/or detransition rates

(a) The WPATH's very influential SOC-7 states that regrets related to medical transition are "extremely rare," specifically "1–1.5% of MtF patients and <1% of FtM patients."[826] The sole documentation cited for these statistics is Pfäfflin's 1993 study.[827]

(b) A 2013 publication reports on a particularly unusual case of transition regret (**Karpel and Cordier [2013]**).[828] This case study involves an assigned/natal male, who, after "8 years of follow-up in the psychiatric transgender unit," underwent SRS. However,

> [t]wenty days after the operation, his surgeon received an email from him announcing his desire to undergo revision surgery to reverse back to his original gender. If this was not obtained, he threatened to start drinking again, along with other vague and aggressive threats.[829]

The patient's demand for a reversal continued until, after about a year and a half, he broke off all contact with the medical provider. The psychiatrist involved eventually "concluded that the patient was suffering from a particular form of body dysmorphic disorder."[830] As the authors note, the patient did fall within many of the categories commonly described in the literature as predictive of less successful transitions, including: "aged more than 30 when they first request SRS"; "have characterised personality disorders with personal and social instability"; "lived previously as heterosexuals, with marriage and/or parenthood"; "lacking family support"; lack of "gender identity disorders during childhood"; "lacking sexual experience with men"; "lacking sexual activity"; and expression of "dissatisfaction with the results of surgery."[831]

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[825] van de Grift, et al., "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery," 138.
[826] WPATH, SOC-7, 8.
[827] Pfäfflin, "Regrets After Sex Reassignment Surgery."
[828] L. Karpel and B. Cordier, "Postoperative Regrets After Sex Reassignment Surgery: A Case Report," *Sexologies* 22/2 (2013), e55-e59.
[829] Ibid., e56.
[830] Ibid.
[831] Ibid., e57.

(c) Slightly higher than the SOC-7 estimate, Judge, et al. (2014) found that "[r]egret following hormonal or surgical treatment" was 1.83%.[832]

(d) Dhejne, et al.'s (2014) study based on all Swedish applications for legal and surgical transition from 1960 to 2010 found that out of 681 total people, "[t]here were 15 (5 MF and 10 MF) regret applications corresponding to a 2.2 % regret rate for both sexes."[833] Important to note here is the definition of "regret" used is this study:

> A total of 15 individuals (5 FM and 10 MF) out of 681 who received a new legal gender between 1960 and 2010 applied for reversal to the original sex (regret applications). This corresponds to a regret rate of 2.2 % for both sexes (2.0 % FM and 2.3 % MF).[834]

In other words, "regret" is defined as formally applying to legally detransition. And so, *this 2.2% regret rate equates to a 2.2% detransition rate.*

(e) In their French study, Karpel, et al. (2015) reported that 4.5% of their 207-person post-surgical cohort "sometimes felt regret, especially given the surgical results."[835] Two people (1%) reported "deep regret" to the point of pursuing a legal-social detransition, with one of them (0.5%) also seeking medical detransition.[836]

(f) In their long-term follow-up study, Ruppin and Pfäfflin (2015) report that, of the 101 post-operative trans people invited to take part in their study, eight of them "declared that transsexualism was not an issue for them anymore, and therefore, they did not want to participate."[837] While the authors do not provide detailed clarification as to what this sub-cohort meant by "transsexualism was not an issue for them anymore," a face-value reading suggests that these people no longer identified as transgender. In other words, this appears to be *a sub-cohort of detransitioners – and one that represents 7.9% of the total 101-person cohort.*

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[832] Judge, et al., "Gender Dysphoria – Prevalence, and Co-morbidities in an Irish Adult Population."
[833] Dhejne, et al., "Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010," 1535.
[834] Ibid., 1540.
[835] Karpel, et al., "Psychological and Sexual Well Being of 207 Transsexuals after Sex Reassignment in France" [French], 511.
[836] Ibid.
[837] Ruppin and Pfäfflin, "Long-Term Follow-Up of Adults with Gender Identity Disorder," 1322.

(g) In 2016, a Serbian team led by Miroslav Djordjevic, an internationally recognized transition surgeon,[838] published a unique study in which they

> analyze retrospectively seven patients who underwent reversal surgery after regretting their decision to undergo male-to-female SRS elsewhere. From November 2010 through November 2014, seven men 33 to 53 years old with previous male-to-female SRS underwent reversal phalloplasty (**Djordjevic, et al. [2016]**).[839]

The follow-up period was 13 to 61 months, with a mean of 31 months. Reported results include:

> Good postoperative results were achieved in all patients. In four patients, all surgical steps were completed; two patients are currently waiting for penile implants; and one patient decided against the penile prosthesis. Complications were related to urethral lengthening: two fistulas and one stricture were observed. All complications were repaired by minor revision. According to patients' self-reports, all patients were pleased with the esthetic appearance of their genitalia and with their significantly improved psychological status.[840]

They conclude that "[f]urther insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for SRS."[841]

(h) Concerning regret rates of the studies under review – studies of "gender transition, including medical treatments such as hormone therapy and surgeries" published in English between 1991 and 2017 – the meta-analysis conducted by the What We Know Project (2018) offers the following summary:

> Regrets following gender transition are extremely rare and have become even rarer as both surgical techniques and social support have improved. Pooling data from numerous studies demonstrates a regret rate ranging from .3 percent to 3.8 percent. Regrets are most

[838] On Djordjevic and his work, see Lizette Borreli, "Transgender Surgery: Regret Rates Highest in Male to Female Reassignment Operations," *Newsweek* (October 3, 2017), https://www.newsweek.com/transgender-women-transgender-men-sex-change-sex-reassignmentsurgery-676777; Joe Shute, "The New Taboo: More People Regret Sex Change and Want to 'Detransition,' Surgeon Says," *National Post* (October 2, 2017), http://nationalpost.com/news/world/the-new-taboo-more-people-regret-sex-change-and-want-to-detransition-surgeon-says.

[839] Miroslav L. Djordjevic, Marta R. Bizic, D. Duisin, M. B. Bouman, and M. Buncamper, "Reversal Surgery in Regretful Male-to-Female Transsexuals after Sex Reassignment Surgery," *Journal of Sexual Medicine* 13 (2016), 1000-07. For other publications from this team that touch on transition regret and/or reversal surgery, see Bizic, et al., "Gender Dysphoria: Bioethical Aspects of Medical Treatment"; Miroslav L. Djordjevic, "Regrets in Transgender Female: Reversal Phalloplasty," in *Urological Care for the Transgender Patient: A Comprehensive Guide,* eds. D. Nikolavsky and S. A. Blakely (New York: Springer, 2021), 229-36.

[840] Ibid., 1000.

[841] Ibid.

> likely to result from a lack of social support after transition or poor surgical outcomes using older techniques.[842]

(i) van de Grift, et al.'s (2018) study of 136 people "diagnosed with gender dysphoria (DSM-IV-TR) who applied for medical interventions from 2007 until 2009" at one of three European gender clinics reports that "eight people . . . reported dissatisfaction or/and [minor] regret with GAS," among whom "both genders and most surgical procedures were represented."[843] This equates to roughly a 6% dissatisfaction/ minor regret rate (here, the dissatisfaction vs. regret reports are not differentiated). Of this sub-cohort, they write:

> None of the respondents reported major regret. Eight respondents reported minor regrets (disappointment) or/and dissatisfaction with the outcomes of surgery. The group included five trans women and three trans men.[844]

(j) Zavlin, et al. (2018) observe that one out of their 40-person cohort of "MTF transgender patients who underwent two-stage SRS . . . between September 2012 and January 2014" reported regret – representing 2.5% of the sample.[845]

(k) In their meta-analysis of a set of vaginoplasty outcomes reported in studies published from 1985 to 2017, Manrique, et al. (2018) found an average regret rate of "1% (0% - 3%)."[846]

(l) In their study of transition regret among the 6,793 people seen at their Amsterdam-based gender identity from 1972 to 2015, Wiepjes, et al. (2018) report that "[o]nly 0.6% of transwomen and 0.3% of transmen who underwent gonadectomy were identified as experiencing regret."[847]

(m) In their study of adolescents and young adults who visited their Los Angeles gender center between June and December 2016 – 68 of whom composed their "postsurgical cohort," i.e.,

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[842] What We Know Project, *What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-being?*
[843] van de Grift, et al., "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery," 138, 145.
[844] Ibid., 144.
[845] Zavlin, et al., "Male-to-Female Sex Reassignment Surgery," 178.
[846] Manrique, et al., "Complications and Patient-reported Outcomes in Male-to-Female Vaginoplasty," 684.
7[847] Wiepjes, et al., "Amsterdam Cohort of Gender Dysphoria Study (1972-2015)," 582.

those who had undergone masculinizing top surgery – Olson-Kennedy, et al. (2018) report that "[s]elf-reported regret was near 0."[848]

(n) In their U.S. study on post-operative outcome and satisfaction rates for trans men who had undergone masculinizing top surgery, Poudrier, et al. (2019) report that "[a]ll but one respondent reported that top surgery had an overall positive impact on their life."[849]

(o) In a 2021 study, a Los Angeles-based team explored an issue that is gaining increasing visibility in the conversation about medical transition: *fertility preservation and related regret*.[850] The authors note that, of a total cohort of 397 people who underwent intake at their gender clinic from January 2018 to March 2019, 70 of them completed a survey during September to October 2019 (a lost to follow-up rate of 82.4%) in which they clarified their "reproductive desires or intentions" (**Vyas, et al. [2021]**).[851] Among reported findings:

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[848] Olson-Kennedy, et al., "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults," 431.

[849] Poudrier, et al., "Assessing Quality of Life and Patient-Reported Satisfaction with Masculinizing Top Surgery," 272.

[850] On fertility preservation and/or related regret, see A. Condat, N. Mendes, V. Drouinead, N. Gründler, C. Lagrange, C. Chiland, et al., "Biotechnologies that Empower Transgender Persons, to Self-actualize as Individuals, Partners, Spouses, and Parents are Defining New Ways to Conceive a Child: Psychological Considerations and Ethical Issues," *Philosophy, Ethics, and Humanities in Medicine* 13/1 (2018). doi: 10.1186/s13010-018-0054-3; Rebecca W. Persky, Siobhan M. Gruschow, Ninet Sinaii, Claire Carlson, Jill Ginsberg, and Nadia L. Dowshen, "Attitudes Toward Fertility Preservation Among Transgender Youth and Their Parents," *Journal of Adolescent Health* 67/4 (2020), 583-89; K. Wierckx, E. Van Caenegem, G. Pennings, E. Elaut, D. Dedecker, F. Van de Peer, et al., "Reproductive Wish in Transsexual Men," *Human Reproduction* 27/2 (2012), 483-87. Research has shown that "the majority of transsexual men desire to have children," and, in hindsight, 37.5% of trans men wish they could have pursued FP. See Wierckx, et al., "Reproductive Wish in Transsexual Men," 483. Yet, recent studies are showing an extremely low rate of fertility preservation (FP) among trans adolescents who decide to undergo medical treatments that can leave them sterile – i.e., 0 – 3%. See Lyne Noelle Chiniara, Christine Viner, Mark Palmert, and Herbert Bonifacio, "Perspectives on Fertility Preservation and Parenthood among Transgender Youth and Their Parents," *Archives of Disease in Childhood* 104/8 (2019), 739–44; L. Nahata, A. C. Tishelman, N. M. Caltabellotta, and G. P. Quinn, "Low Fertility Preservation Utilization among Transgender Youth," *Journal of Adolescent Health* 61 (2017), 40-44. This concern is heightened in light of broader findings that correlate youthful decisions with later adult regret – both in regard to sterilization/fertility and beyond. See K. M. Curtis, A. P. Mohllajee, H. B. Peterson, "Regret Following Female Sterilization at a Young Age: A Systematic Review," *Contraception* 73 (2006), 205-10; S. D. Hillis, P. A. Marchbanks L. R. Tylor, and H. D. Peterson, "Poststerilization Regret: Findings from the United States Collaborative Review of Sterilization," *Obstetrics and Gynecology* 93 (1999), 889- 95; M. Jokisaari , "Regret Appraisals, Age, and Subjective Well-being," *Journal of Research in Personality* 37 (2003), 487-503; Richard L. Dukes, "Regret Among Tattooed Adolescents," *Social Science Journal* 53/4 (2016), 455-58.

[851] Nina Vyas, Christopher R. Douglas, Christopher Mann, Amy K. Weimer, and Moll M. Quinn, "Access, Barriers, and Decisional Regret in Pursuit of Fertility Preservation among Transgender and Gender-diverse Individuals," *Fertility and Sterility* 115/4 (2021), 1029-34 (here p. 1029). Recent studies are showing an extremely low rate of fertility preservation (FP) among trans adolescents who decide to undergo medical treatments that can leave them sterile – i.e., 0 – 3%. See Lyne Noelle Chiniara, Christine Viner, Mark Palmert, and Herbert Bonifacio,

> 37% stated that their family planning goals were not adequately addressed. Those who had made a firm decision to pursue or not pursue fertility treatment had mild decisional regret. Moderate-to-severe decisional regret was noted in those who were undecided regarding the pursuit of fertility perseveration before transition and in those who were interested in referral to reproductive endocrinology.[852]

(p) In 2021, Miroslav Djordjevic published a piece in which he reports on the rarely discussed procedure of reversal phalloplasty (**Djordjevic, [2021]**).[853] In introducing his study, Djordjevic writes:

> Gender affirming surgery (GAS) has proven to be an effective intervention for patients with gender dysphoria. However, patients sometimes regret their decision and request reversal surgery. The objective of this chapter is to describe current aspects about regret after gender affirming surgery, possible factors associated with regret, treatment options, and outcomes.[854]

(q) A study published in 2022 investigated hormone continuation vs. discontinuation (i.e., a form of medical detransition) rates by conducting a "secondary analysis of 2009 to 2018 medical and pharmacy records from the US Military Healthcare System (**Roberts, et al. [2022]**)."[855] The authors report that the "4-year gender-affirming hormone continuation rate was 70.2%," with transfeminine people having "a higher continuation rate than transmasculine individuals" – specifically 81.0% vs 64.4%.[856] This suggests that the overall cohort rate of hormone discontinuation was almost 30%, while the discontinuation rate among transmasculine people was even higher at over 35%.

In summary – depending upon a range of factors such as the specific medical procedures under investigation, the surgical time-period considered, specific forms of regret (which, unfortunately, few studies specify using a robust regret typology), etc. – reported regret rates from these studies

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"Perspectives on Fertility Preservation and Parenthood among Transgender Youth and Their Parents," *Archives of Disease in Childhood* 104/8 (2019), 739–44; L. Nahata, A. C. Tishelman, N. M. Caltabellotta, and G. P. Quinn, "Low Fertility Preservation Utilization among Transgender Youth," *Journal of Adolescent Health* 61 (2017), 40-44.

[852] Vyas, et al., "Access, Barriers, and Decisional Regret in Pursuit of Fertility Preservation," 1029.

[853] Djordjevic, "Regrets in Transgender Female: Reversal Phalloplasty."

[854] Ibid., 229.

[855] Christina M. Roberts, David A. Klein, Terry A. Adirim, Natasha A. Schvey, and Elizabeth Hisle-Gorman, "Continuation of Gender-affirming Hormones among Transgender Adolescents and Adults," *Journal of Clinical Endocrinology and Metabolism* (2022), dgac251, https://doi.org/10.1210/clinem/dgac251 [online ahead of print].

[856] Ibid.

published between 2010 and 2022 range from near zero to 7.9%. And, while not configured in terms of "regret" per se, the Roberts, et al. (2022) study reported a hormone discontinuation rate of roughly 30% after four years.

(3) Some studies – although noticeably fewer than in past decades – report a set of pre-transition factors predicting positive vs. negative transition outcomes

In comparison to studies from the previous decades, the studies published between 2010 and 2022 considered above appear less likely to highlight pre-transition factors that predict positive vs. negative outcomes. One could speculate that this new tendency to avoid proposing such predictive criteria – criteria that, historically speaking, are often tied to psychological assessments and psychiatric co-morbidities – is a result of the complementary tendencies toward the depathologization of trans experience and an informed consent model of trans care. In any case, several of the studies mentioned above do make mention of some predictive factors.

(a) Johansson, et al. (2010) found that, contrary to many prior studies, "[m]ost outcome measures were rated positive and substantially equal for MF and FM." They also note that "[l]ate-onset transsexuals differed from those with early onset in some respects: these were mainly MF (88 vs. 42%), older when applying for sex reassignment (42 vs. 28 years), and non-homosexually oriented (56 vs. 15%)" – observations that can be read as aligning with features of autogynephilia theory.[857]

(b) In 2014, a Spanish team published a study involving a cohort of 193 trans people (119 trans women and 74 trans men) (**Gómez-Gil, et al. [2014]**).[858] The purpose of the study was to

> evaluate the self-reported perceived quality of life (QoL) in transsexuals attending a Spanish gender identity unit before genital sex reassignment surgery, and to identify possible determinants that likely contribute to their QoL.[859]

[857] Johansson, et al., Five-year Follow-up Study of Swedish Adults with Gender Identity Disorder," 1429.
[858] Esther Gómez-Gil, Leire Zubiaurre-Elorza, Isabel Esteva de Antonio, Antonio Guillamon, and Manel Salamero, "Determinants of Quality of Life in Spanish Transsexuals Attending a Gender Unit before Genital Sex Reassignment Surgery," *Quality of Life Research* 23/2 (2014), 671–78.
[859] Ibid., 671.

The study concluded that "[c]ross-sex hormonal treatment, family support, and working or studying are linked to a better self-reported QoL in transsexuals."[860] Additionally, they report that "FM transsexuals have higher social domain QoL scores than MF transsexuals."[861]

(c) Karpel, et al. (2015) found that "a greater number of FtM are satisfied with their social and family life, whereas a greater number of MtF is [sic] satisfied with the result of the surgery and their sexual life."[862]

(d) Djordjevic, et al. (2016) observe that they found "higher regret rates in MtFs over 30."[863]

(e) The What We Know Project (2018) meta-analysis concludes:

> Factors that are predictive of success in the treatment of gender dysphoria include adequate preparation and mental health support prior to treatment, proper follow-up care from knowledgeable providers, consistent family and social support, and high-quality surgical outcomes (when surgery is involved).[864]

(f) Similar to many earlier studies, van de Grift, et al. (2018) note the correlation between pre-operative psychological problems and less positive transition outcomes:

> Participants experiencing more psychological problems at clinical entry (along with and/or resulting from gender dysphoria) seem to differ from those with fewer psychological problems with regard to treatment evaluation. Earlier studies pointed out that pretreatment psychological functioning influences evaluation of the outcomes of medical transition (de Vries et al., 2014; Smith et al., 2005). Psychological symptoms, mostly depression, are associated with impaired treatment outcomes (Mayou et al., 2000), but also with disappointment (Saisto, Salmela-Aro, Nurmi, & Halmesmaki, 2001) and poor coping behavior (Kelly, Tyrka, Price, & Carpenter, 2008), albeit these studies did not include surgical samples.[865]

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[860] Ibid.
[861] Ibid.
[862] Karpel, et al., "Psychological and Sexual Well Being of 207 Transsexuals after Sex Reassignment in France" [French], 511.
[863] Djordjevic, et al., "Reversal Surgery in Regretful Male-to-Female Transsexuals after Sex Reassignment Surgery," 1000.
[864] What We Know Project, *What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-being?*
[865] van de Grift, et al., "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery," 146.

(g) Finally, as mentioned above – and in contrast to a number of prior studies – Jellestad, et al. (2018) found "[no] relevant predictive impact on the mental [quality of life]" for post-transition outcomes of such socio-demographic variables as "age, work situation and relationship status."[866]

(4) Ongoing methodological problems associated with post-transition outcome research

One point of continuity between many of the studies published in previous decades and a good number of those produced between 2010 and 2022 is the recognition of a range of methodological problems associated with medical transition outcome studies. For example, the meta-analysis of Murad, et al. (2010) provides a window into the methodological state of affairs of transition-related research at the beginning of the decade. Regarding the 28 studies that serve as the database for their review, they note that "all the studies were observational and most lacked controls." They conclude that the studies to date are based on "[v]ery low quality evidence."[867] Similarly, when Zavlin, et al. (2018) reported on the level of evidence quality undergirding their study – a report required by the journal that published their work[868] – they assigned it a level IV.[869] In the five-level evidence scale used by this journal, this is the second to lowest level. In their review and meta-analysis of studies on post-surgical quality of life outcomes, Passos, et al. (2020) comment on the "[e]vidence of low quality" that characterizes the field.[870]

Reflecting these issues, the study produced by the What We Know Project concludes:

> An inherent limitation in the field of transgender health research is that it is difficult to conduct prospective studies or randomized control trials of treatments for gender dysphoria because of the individualized nature of treatment, the varying and unequal circumstances of population members, the small size of the known transgender

[866] Jellestad, et al., "Quality of Life in Transitioned Trans Persons," 7.
[867] Murad, et al., "Hormonal Therapy and Sex Reassignment," 214.
[868] I.e., this journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266."
[869] Zavlin, et al., "Male-to-Female Sex Reassignment Surgery," 178.
[870] Passos, et al., "Quality of Life After Gender Affirmation Surgery," 252.

> population, and the ethical issues involved in withholding an effective treatment from those who need it.[871]

To this list, they could have added other methodological concerns including sample sizes issues, relatively short follow-up periods, high lost to follow-up rates, potential social desirability bias, etc. In reviewing the methodological issues that arise in these studies, we will, once again, consider these problems under several commonly cited categories.

(a) Lack of randomized controlled trials (RCTs)

As discussed above, RTCs are simply not available for contemporary trans-related medicine.[872]

(b) Standardization problems

In a 2018 review of the use of hormone therapy in trans care, a U.S. team (**Nguyen, et al. [2018]**) concludes that studies involving GAHT (gender-affirming hormone therapy) are "encouraging, particularly for MTFs." However, they go on to confront methodological issues endemic to the field, including standardization problems:

> [T]his literature is limited greatly by studies with small sample sizes and extensive variations in methodology (i.e., age at which GAHT was initiative, duration of treatment, pharmacologic regimen, documentation of hormone levels post GAHT).[873]

Similar concerns are expressed in a 2015 review of vaginoplasty techniques and outcomes (**Horbach, et al. [2015]**), and in a 2020 study reporting on the general lack of good quality data on transition-related surgeries (**MacKinnon, et al. [2020]**).[874]

As one specific example of the lack of field-wide standardization, Zavlin, et al. (2018) note that, when it comes to post-transition outcomes studies, "standardized and validated SRS-specific

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[871] What We Know Project, *What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-being?*

[872] A factor that continues to be pointed out in methodological assessments of the field. E.g., H. B. Nguyen, J. Loughead, E. Lipner, L. Hantsoo, S. L. Kornfield, and C. N. Epperson, "What Has Sex Got to Do with It? The Role of Hormones in the Transgender Brain," *Neuropsychopharmacology* 44/1 (2019), 22-37 (here p. 37).

[873] Nguyen, et al., "What Has Sex Got to Do with It? The Role of Hormones in the Transgender Brain," 33.

[874] Sophie E. R. Horbach, Mark-Bram Bouman, Jan Maerten Smit, Müjde Özer, Marlon E. Buncamper, and Margriet G. Mullender, "Outcome of Vaginoplasty in Male-to-female Transgenders: A Systematic Review of Surgical Techniques." *Journal of Sexual Medicine* 12/6 (2015), 1499-512; K. R. MacKinnon, E. Grober, and Y. Krakowsky, "Lost in Transition: Addressing the Absence of Quality Surgical Outcomes Data in Gender-affirming Surgeries," *Canadian Urological Association Journal* 14/6 (2020), 157-58.

questionnaires are lacking."[875] Similarly, Manfredi, et al. (2021) observe that "[d]espite the high satisfaction rate [regarding penile implant surgery] reported in the literature, most of the studies used suboptimal or non-validated questionnaires to assess patients undergoing penile implant surgery."[876] In their review and meta-analysis of studies reporting on post-surgical regret, Bustos, et al. (2021) also recognize this field-wide problem:

> However, there is high subjectivity in the assessment of regret and lack of standardized questionnaires, which highlight the importance of developing validated questionnaires in this population.[877]

(c) A high number of studies using a retrospective – as opposed to the more robust prospective – method

While a few studies do make use of a prospective method – Lindqvist, et al. (2017); Zavlin, et al. (2018); and Naeimi, et al. (2019) – a retrospective study design continues to characterize most of the studies done in this decade. The concern, again, is that, compared to prospective studies, retrospective studies are of lower quality evidence due to the innate weaknesses of any method that depends upon people's self-report on their own pasts – i.e., memory distortion, confounding errors, bias, etc.

(d) Sample sizes

It must be pointed out that almost all of this decade's studies surveyed above have significantly larger sample sizes than the studies with concerningly small samples noted for the previous decades. This is an important growth step for the field.

To begin, by their very nature, meta-analyses tend to involve a large number of people. For example, the meta-analysis of Murad, et al. (2010) involved data drawn from 28 separate studies 1,833 people (1,093 trans women and 801 trans men). The meta-analysis of Manrique, et al. (2018) drew from 46 studies involving 3,716 cases of vaginoplasty. Finally, the meta-analysis of Weinforth, et al. (2019) synthesized data from 13 articles that, together, included data on 1101 trans people. However, a large cumulative number of cases considered within a Meta-analysis

[875] Zavlin, et al., "Male-to-Female Sex Reassignment Surgery," 178.
[876] Manfredi, et al., "Penile Implant Surgery Satisfaction Assessment," 868.
[877] Bustos, et al., "Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence."

does not mean that, in turn, the separate studies under investigation themselves represent significant sample sizes. As Weinforth, et al. (2019) report regarding the 13 studies that power their review, the "number of trans women in each study ranged from 3 to 247."[878]

Beyond meta-analyses, a number of the other studies also work with an impressive sample size. For example: Dhejne, et al. (2014) is based on all applications within the population of Sweden for legal and surgical transition from 1960 to 2010 – a 681-person cohort. Even more impressive, Wiepjes, et al. (2018) is based upon data drawn from the medical records of all people seen at their gender clinic from 1972 to 2015 – a cohort of 6,793 people (4,432 assigned males and 2,361 assigned females). Other studies, while working with less robust samples than these two exceptional longitudinal studies, are nonetheless reflective of respectable sample sizes: Close (2012) = 448 people[879]; Judge, et al. (2014) = 218 people; Karpel, et al. (2015) = 207 people; Jellestad, et al. (2018) = 143 people; van de Grift, et al. (2018) = 136 people; and Hess, et al. (2014) = 119 people.

While advances have been made in growth of sample sizes, this doesn't mean the problem has been entirely resolved. In their review of studies on HRT, Nguyen, et al. (2018) observe that "this literature is limited greatly by studies with small sample sizes."[880] Similarly, in their 2022 systematic literature review of surgical and quality of life outcomes for people who are at least one-year post-surgical transition, Javier, et al. state that the field is filled with "low quality evidence," which is in part due to the fact that "many studies only draw on small samples."[881]

Reflective of this concern, many of the remaining studies surveyed above work with sample sizes of less than 100 people, some of them significantly less. For example: Ruppin and Pfäfflin (2015) = 71 people; Olson-Kennedy, et al. (2018) = 68 young people; Castellano, et al. (2015) = 60 post-operative people; Poudrier, et al. (2019) = 58 people; Wierckx, et al. (2011) = 49 people;

[878] Weinforth, et al., "Quality of Life Following Male-To-Female Sex Reassignment Surgery," 253.
[879] Although it is important to remember, as Close (p. 7) notes: "the survey did not undergo a university-based Institutional Review Board process, the results are not eligible for publication in peer-reviewed academic or research journals."
[880] Nguyen, et al., "What Has Sex Got to Do with It? The Role of Hormones in the Transgender Brain," 33.
[881] Javier, et al., "Surgical Satisfaction and Quality of Life Outcomes Reported by Transgender Men and Women at Least One Year Post Gender-affirming Surgery."

Papadopulos, et al. (2017) = 47 people; Johansson, et al. (2010) = 42 people; Naeimi, et al. (2019) = 41 people; Zavlin, ert al. (2018) = 40 people; and Sansfacon, et al. (2019) = 35 youth.

(e) A wide variation in follow-up time-spans, with many representing relatively short follow-up duration periods

Once again, we find a range of follow-up periods represented in this decade's studies. For example, the case study by Cohen-Kettenis, et al. (2011) involves an impressive 22-year follow-up of a trans man. Moving beyond single case studies, Ruppin and Pfäfflin (2015) also boast a robust follow-up period of between 10 and 24 years, with a mean of 13.8 years. Wierckx, et al.'s (2011) study also reported a respectable average follow-up period of eight years post-SRS.

Two longitudinal studies published during this decade are especially important. First, the study of Wiepjes, et al. (2018) – involving people seen at their clinic from 1972 to 2015 – naturally includes a sub-cohort representing a significant follow-up period. That being said, the authors note that the "number of people assessed per year increased 20-fold from 34 in 1980 to 686 in 2015."[882] This means that the number of people in their overall cohort representing significantly lengthy follow-up periods is far smaller than the number representing shorter assessment intervals. This observation of Wiepjes, et al. (2018) is, no doubt, generalizable to other studies that span several decades. Another important finding of this study for the question of length of follow-up period emerges in their report that "in our population the average time to regret was 130 months [i.e., 10.8 years], so it might be too early to examine regret rates in people who started with HT in the past 10 years."[883]

This observation of Wiepjes, et al. (2018) is reinforced by a similar finding reported in Dhejne, et al.'s (2014) longitudinal study covering a period of over 50 years (1960 to 2010), which, of course, allows for the inclusion of a sub-cohort representing a similarly lengthy follow-up period. As mentioned above, this research team found that the

[882] Wiepjes, et al., "Amsterdam Cohort of Gender Dysphoria Study (1972-2015)," 582.
[883] Ibid., 589.

> median (range) time elapsed from attaining a new legal gender to the regret application was 7.5 years (90 months, range 75–137) for FM, and 8.5 years (102 months, range 22–177) for MF.[884]

This means that the median length of time between a person's legal transition and their subsequent decision to apply for an official detransition was 8 years. Putting these two unusually high-powered longitudinal studies together, it appears that *the average timespan from a person's medical transition to taking steps to officially initiate detransition is somewhere between eight to eleven years*.

This finding has made an impression on other researchers. For example, in their review of gender dysphoria and its treatment, the international team of Zucker, Lawrence, and Kreukels refer to this finding when they note that "[o]nly 2.2% of these clients submitted regret applications . . . . But regret applications were made a median of eight years after SRS, so some clients who underwent SRS recently may yet submit applications."[885]

This finding also has significant repercussions for our assessment of transition outcome studies with follow-up periods of less than eight to 11 years – and this includes *the vast majority* of such studies. For example, length of follow-up period for other studies published in this decade are as follows:

- Hess, et al. (2014) – a mean follow-up period of 5.05 years post-surgery
- Johansson, et al. (2010) – two or more years post-surgery
- Olson-Kennedy, et al. (2018) – one to five years post-surgery
- van de Grift, et al. (2018) – an average assessment period of four to six years after first clinical contact (i.e., the actual length of time between completion of surgery and assessment would be significantly less than four to six years)
- Papadopulos, et al. (2017) – an average of 19 months post-surgery
- Zavlin, ert al. (2018) - 6 months post-surgery

Suffice to say that the follow-up period of each of these studies is significantly shorter than the crucial eight-to-eleven-year period determined by Dhejne, et al. (2014) and Wiepjes, et al. (2018). The implications of this observation will be considered below in the summary and conclusions section.

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[884] Dhejne, et al., "Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010," 1540-41.
[885] Zucker, Lawrence, and Kreukels, "Gender Dysphoria in Adults," 237.

(f) High participant attrition rates (lost to follow-up)

Once again, we find in this decade's transition outcome studies significantly high rates of participant attrition. While not every study reports on their lost to follow-up rate, among those that do we find these statistics:

- Simonsen, et al. (2016) - 2%
- Karpel, et al. (2015) - 22%
- Zavlin, et al. (2018) - 22.5%
- Olson-Kennedy, et al. (2018) - 28%
- Poudrier, et al. (2019) - 28%.
- Johansson, et al. (2010) - 30%
- Wiepjes, et al. (2018) - 36%
- Ruppin and Pfäfflin (2015) - 49.3%[886]
- Hess, et al. (2014) - 53.1%
- Weinforth, et al. (2019) - 56%[887]
- Papadopulos, et al. (2017) - 61.2%.
- van de Grift, et al. (2018) - 63%
- McNichols, et al. (2020) - 64%
- Jellestad, et al. (2018) - 82.3%[888]

As can be seen from this summary of attrition rates, the lost to follow-up problem remains a serious one for recent medical transition outcome studies. Interestingly, one study appears to sustain a remarkably low lost to follow-up rate. In their long-term study of post-transition psychological health, Simonsen, et al. (2016) access a cohort representing 98% of all Danish people who underwent SRS between 1978 and 2010 – *an apparent lost to follow-up rate of only 2%*.

[886] Ruppin and Pfäfflin ("Long-Term Follow-Up of Adults with Gender Identity Disorder," 1322) report that

> [a]ltogether, a total of 140 persons received letters of which 101 (72.1 %) made contact with the authors and, thereupon, were informed about the study and asked for their participation . . . . Finally, 71 persons decided to take part in the study which corresponds to 50.7 % of all contacted persons and 70.3 % of the persons who got back to the authors.

This appears to amount to a lost to follow-up rate (vis-à-vis the original 140 people contacted) of 49.3%. However, there is some ambiguity here – i.e., are the total number of people who underwent SRS equal to the total number of people who "received letters?"

[887] This meta-analysis found "the drop-out rates, insofar as they were given, ranged from 12% to 77% (median: 56%)." Weinforth, et al., "Quality of Life Following Male-To-Female Sex Reassignment Surgery," 253.

[888] This was the reported lost to follow-up rate among their clinical cohort.

This consideration of a decade's worth post-transition outcomes studies will conclude with a look at a 2015 study by Britt Colebunders, Griet De Cuypere, and Stan Monstrey with the purpose of weighing in with proposed revisions for the WPATH's SOC-8 (**Colebunders, et al. [2015]**).[889] Griet De Cuypere is also one of the two co-authors of the De Cuypere and Vercruysse, Jr. (2009) piece mentioned above, which was designed to offer input on the prior revision (SOC-7).[890] The difference in tone from the 2009 article to the 2015 article speaks to the cultural sea-change regarding trans experience/identity that took place in these six years. As discussed above, a primary concern of De Cuypere and Vercruysse, Jr.'s 2009 proposal vis-à-vis the then-current SOC-6 focused on its relative neglect of co-occurring psychological problems:

> Although psychiatric co-morbidity is consistently mentioned in the literature as a negative predictive factor, it is barely addressed in the eligibility and readiness criteria for SRS [in the SOC-6]. Therefore this paper suggests some changes and a shift in emphasis in the eligibility and readiness criteria of the *Standards of Care* . . . . The case studies of persons who regret SRS lead us to conclude that inadequate diagnosis and major psychiatric co-morbidity are the major indicators for regret. [891]

It is instructive to compare this 2009 concern with the recommendations of the 2015 article. In the latter piece, the authors note that among the criteria for medical transition being reconsidered for inclusion in the SOC-8 are

> the necessity for two referrals from qualified mental health professionals who have independently assessed the patients, prior to performing genital surgery, especially for hysterectomy and salpingo-oophorectomy, [and] the minimum age of 18 as eligibility to undergo irreversible (genital) surgery procedures.[892]

They observe that, within the trans community, full compliance with SOC-7 criteria is a "minority" phenomenon.[893] While still holding the importance of the eligibility criteria of a clinical diagnosis of gender dysphoria and the absence of any co-occurring mental health problems,[894] regarding the question a reduction from two referral letters to one (based on analogy

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[889] Britt Colebunders, Griet De Cuypere, and Stan Monstrey, "New Criteria for Sex Reassignment Surgery: WPATH *Standards of Care, Version 7,* Revisited," *International Journal of Transgenderism* 16/4 (2015), 222-33.
[890] De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery: Recommendations for Revision of the WPATH *Standards of Care*."
[891] Ibid., 194, 197.
[892] Colebunders, et al., "New Criteria for Sex Reassignment Surgery," 222.
[893] Ibid., 226.
[894] Ibid., 231.

with other surgical operations), the authors end up concurring with the call for reduction.[895] And regarding the contested question of whether the minimum age for eligibility to undergo irreversible (genital) surgery procedures should be lowered to allow this option for minors, the authors suggest that this issue should be decided by taking a "case-by-case approach."[896] The more noticeably relaxed tone of the 2015 article and its less stringent approach to medical transition and related eligibility criteria reflects wider cultural impulses that emerged more strongly in the 2010s toward the reduction of psychiatric gate-keeping, leniency with regard to SOC requirements and minor-age limits; etc.

3. Conclusion: Reflections on Six-plus Decades of Transition Outcome Studies and NTE/Detransition Prevalence Rates

From the six-plus decades' worth of data surveyed above, we can draw the following conclusions.

a. Most people providing responses for post-transition studies over the last six-plus decades have reported generally positive outcomes and satisfaction rates.

Judging from the results of a wide range of outcome studies over these six-plus decades – and depending on such variables as the decade, the procedure, the specific outcomes measured, and the particular assessment instrument used – positive post-transition satisfaction rates tend to range in the 60-90 percentiles.[897] This much is generally agreed upon by all parties. Today, the areas of real contestation within the field of post-transition studies revolve around the sub-set of people who report something other than positive and satisfactory outcomes.

[895] Ibid., 226-27. It is not entirely clear whether they are calling for just one letter, or no letters and a signed informed consent form by the patient themself (p. 227). Interestingly, however, in their conclusions they only apply this new proposal to trans men seeking hysterectomies, with no mention of trans women (p. 230).
[896] Ibid., 229, 231.
[897] Given that a large portion of each decade's analysis has been devoted to documenting the specifics of this broad statement, see above for details.

b. Over the last six-plus decades, a sub-set of people providing responses for post-transition studies have consistently reported various types of NTEs (e.g., negative psycho-social and surgical outcomes; transition regret and/or detransition; etc.)

Decade by decade, we've seen that a sub-group of people who choose the path of transition eventually express some level of dissatisfaction with this decision. From the time of Harry Benjamin's landmark 1966 book, *The Transsexual Phenomenon*, reports of transition regret and/or detransition have been scattered among the literature.[898] Unfortunately, throughout the decades, the concepts of transition dissatisfaction and transition regret have generally been used in broad, unnuanced ways.

The four-fold typology of transition regret proposed by Kuiper and Cohen-Kettenis in 1998 offered a more nuanced set of categories, which – using more contemporary terms – can be summarize as (1) Regret leading to detransition; (2) Regret without detransition; (3) Detransition without expressed regret); and (4) No expressed regret or detransition, but regret (potentially) detected by others via indirect signals.[899] While a few studies over the last 25 years have made use of this typology – or some other heuristic – most have continued to work with less nuanced categories. This general lack of a clear, nuanced and standardized typology has led to such things as the conflation of the concepts of regret and detransition. For example, Dhejne, et al. (2014) report a 2.2 % "regret" rate, and then ascertain regret by tracking those who have formally applied for what amounts to a legal detransition.

But things don't have to be this way. Throughout this study, Hildebrand-Chupp's very helpful concept of *negative transition experience (NTE)* has been used as an umbrella category that contains such sub-phenomena as post-transition difficulty, dissatisfaction, and regret – in some cases leading eventually to detransition. Further, drawing inspiration from Narayan and colleagues' typology of transition-related regret, even more categorical nuance has been proposed: gender-related regret, social regret, medical regret – this last category being further sub-divided into medical complication-induced regret, long-term functional outcome-related

[898] Benjamin, *Transsexual Phenomenon*, 124.
[899] Kuiper and Cohen- Kettenis, "Gender Role Reversal among Postoperative Transsexuals.".

regret, and preoperative decision-making-related regret. And finally, inspired by Hildebrand-Chupp once again, the sub-typology of surgical transition regret, HRT transition regret, and social transition regret. These categories and sub-categories could supply the framework needed for the very sort of nuanced, standardized typology so desperately needed within the field of transition outcome studies today.

(1) Conclusions regarding NTEs and less-than-satisfactory outcomes

The statistical specificities regarding the group of people who experience NTEs are, of course, to be found in analyses of that segment of the post-transition population who fall outside of the 60-90 percent that report generally positive outcomes. So, to draw just a few examples from over a four-decade period (1980s – 2010s):

- Sörensen (1981) found that while 66% were satisfied with their transition surgeries, 34% were less than satisfied. And while 83% reported feeling better psychologically, 17% reporting otherwise.
- Bodlund and Kullgren (1996) report that 16% of their post-transition Swedish cohort were judged as unsatisfactory outcomes.
- In their review of the field, Michel, et al. (2001) report that 10% of people initially reported some level of dissatisfaction with their transition, if only temporarily.
- In their study based at a UK gender identity clinic, Udeze, et al. (2008) failed to substantiate the positive post-surgical psychological outcomes they had hypothesized. Instead, they found that no significant change in SCL-90R scores within six months of surgery. On the other hand, they did find an increase in post-surgical anger/hostility measures.
- In their study of a post-operative French cohort, Karpel, et al. (2015) found that 25% reported dissatisfaction, while another 15% were less-than-fully-satisfied.
- In their long-term study of post-transition psychological health among a cohort representing 98% of all Danish people who underwent SRS between 1978 and 2010, Simonsen, et al. (2016) report that "[o]verall, 27.9% of the sample were registered with

psychiatric morbidity before SRS and 22.1% after SRS."[900] The authors go on to conclude that "SRS may reduce psychological morbidity for some individuals while increasing it for others."[901]

- In their study of post-transition quality of life outcomes, Jellestad, et al. (2018) report that "[c]ompared to the general population, these findings indicate poor quality of life in trans persons who had performed those medical interventions that they deem necessary for their transition."[902] Surprisingly, their data found "[no] relevant predictive impact on the mental [quality of life]" for post-transition outcomes of such socio-demographic variables as "age, work situation and relationship status."[903]

(2) Conclusions regarding transition regret rates

As the typology offered above emphasizes, *transition dissatisfaction* does not necessarily equate to *transition regret*, which in turn does not necessarily correlate with *detransition*. Each of these phenomena must be distinguished from each other (including potential sub-types) and analyzed separately. When it comes to explicit statements of *transition regret* – though not necessarily leading to *detransition* – the statistics are lower than those simply involving various types of reported post transition *difficulty* or *dissatisfaction.* As mentioned above, ever since the publication of Pfäfflin and Junge's (1992) review of transition outcome studies up to 1991, their overall reported regret rate of 1% - 1.5% has been regularly cited and appealed to in various studies over the years – e.g., Kuiper and Cohen-Kettenis (1998), Michel, et al. (2001), WPATH's SOC-7 (2012), Judge, et al. (2014), Manrique, et al. (2018).

However, while often repeated, this 1%-2% regret rate is not a stable statistic across all studies and decades. Occasionally, an even lower regret rate has been reported. For example, more recently it is the regret rate reported by Wiepjes, et al. (2018) of 0.3% (trans men) - 0.6% (trans women) that is being offered by many as the newly established – and commonly generalized – regret rate. On the other hand, a number of studies have found higher regret rates. For example,

[900] Simonsen, et al., "Long-term Follow-up of Individuals Undergoing Sex Reassignment Surgery," 241.
[901] Ibid.
[902] Jellestad, et al., "Quality of Life in Transitioned Trans Persons," 5.
[903] Ibid., 7.

Dhejne, et al.'s (2014) rate of 2.2% is another commonly cited transition regret statistic.[904] However, it is important to recognize that, over the years, other studies have reported even higher regret rates:

- Zavlin, et al. (2018) - 2.5%
- Landén, et al. (1998) - 3.8%[905]
- Weyers, et al. (2009) - 4%
- Imbimbo, et al. (2009) - 6%
- Ruppin and Pfäfflin (2015) - 7.9%[906]
- Baranyi, et al. (2009) - up to 8%
- Green & Fleming (1990) - 3% (FtM) – 13% (MtF)[907]

Of course, even unifying this set of statistics by branding them "regret rates" easily obscures the apples-to-oranges comparisons that take place under this broad rubric – i.e., different types of regret, different regret-period lengths, different transition procedures being regreted, etc. This, again, is the inevitable result of things such as the lack of standardized outcome measures, a shared, nuanced typology of transition regret, etc. In light of these considerations, the fact that many studies today quickly, and without qualification, cite Wiepjes, et al.'s (2018) 0.3% - 0.6% rate – or, alternatively, Dhejne, et al.'s (2014) 2.2% rate – as an established and broadly generalizable transition regret statistic is troubling. Both the definitional equivocation around the use of the term "regret" and the presence of studies with higher regret rate reports that typically

[904] Again, by defining regret as formally applying to legally detransition, this 2.2% regret rate equates to a 2.2% detransition rate.

[905] It was most likely Landén, et al.'s (1998) reported rate that led the What We Know Project (2018) to propose a regret rate span of 0.3% - 3.8%.

[906] As discussed previously, this statistic is based on the fact that Ruppin and Pfäfflin (2015) began with a post-operative cohort of 101 trans people who were invited to take part in their study, eight of which then "declared that transsexualism was not an issue for them anymore, and therefore, they did not want to participate." While the authors do not provide detailed clarification as to what this-sub-cohort meant by "transsexualism was not an issue for them anymore," a face-value reading suggests that these people no longer identified as transgender. In other words, this appears to be a sub-cohort of detransitioners – and, in this case, one that would represent 7.9% of the total 101-person cohort. See Ruppin and Pfäfflin, "Long-Term Follow-Up of Adults with Gender Identity Disorder," 1322.

[907] As noted previously, Green & Fleming (1990) report that 3% of the 130 FtM people in their study – and roughly 13% of the 220 MtF people – considered their transition outcome "unsatisfactory." However, given their specifically regret-oriented definition of "unsatisfactory," this appears to amount to a 13% regret rate for the trans women in their study. See Green and Fleming, "Transsexual Surgery Follow-Up," 164.

go unmentioned suggest that *the actual transition regret rates are much more complex – and probably higher – than most of the literature in the field tends to acknowledge*.

(3) Conclusions regarding detransition rates

In turning to detransition rates, once again we run into familiar problems. One major problem is simply the lack of robust data. As one detransitioner wrote in a 2016 open letter:

> It is far more honest to say that currently no one knows how many detransitioned people there are because there is not sufficient information. I know of no clinic or practitioner providing hormones who even attempts to keep track of how many people stay on them long-term. From my own experience, I can say that there are many more detransitioned women now than there were only a few years ago and it seems most likely that our numbers will continue to increase.[908]

Among 21st-century studies that do provide data on detransition-specific rates, we can find the following range of reports (in a roughly ascending statistical order):

- A study (**Deutsch, 2012**) using a convenience sample of almost 2,000 people undergoing HRT, drawn from 12 U.S. gender clinics that use an informed consent model of treatment, found an average regret rate of 0.8% and a detransition rate of 0.1%.[909] The two methods used for determining these outcome statistics were a retrospective survey instrument and a "legal literature search" to determine if any of these people eventually filed a malpractice lawsuit against one of the associated clinics.[910] However, Hildebrand-Chupp has raised serious questions about this approach and the resulting statistics:

  > Insofar as this study is an attempt to 'reveal' the 'regret rate', it is significantly flawed. Anecdotally, many detransitioners who have NTEs report that they did not confront their previous doctors; they simply stopped showing up at the clinic they previously received services from (e.g. crashchaoscats, 2018). In fact, when a well-funded socially conservative legal organisation began approaching detransitioners looking for potential plaintiffs for lawsuits against professionals providing transition-related care, prominent members of the detransitioned women's community circulated a statement online urging other members not to

[908] CrashChaosCats, "Open letter to Julia Serano."
[909] Madeline B. Deutsch, "Use of the Informed Consent Model in the Provision of Cross-sex Hormone Therapy: A Survey of the Practices of Selected Clinics," *International Journal of Transgenderism* 13/3 (2012), 140-46.
[910] Ibid., 140.

> get involved (Callahan et al., 2017). Thus, any methodological design that relies on adding up all the complaints lodged or lawsuits filed is profoundly limited.[911]

- In their anonymous survey of surgeons who registered for the 2016 WPATH conference and the 2017 USPATH conference regarding their experience with patients who medically transitioned and later detransitioned, Danker, et al. (2018) report that of the estimated 22,725 patients seen by this group of surgeons, only 62 went on the detransition – an apparent estimated detransition rate of 0.27%. There are a number of flags that arise regarding this survey report, however. First, as mentioned above, this report does not represent a publication that went through the peer-reviewed article process, but rather is simply a published abstract drawn from a conference presentation. Furthermore, Jesse Singal reminds us:

  > this is a very rough number, at best, drawn from the self-reports of a group whose members are motivated to think they are doing a good job. And as detransitioners will tell you, they often don't go back to the clinicians they feel offered them subpar care.[912]

- A UK study (**Richards and Doyle, 2019**) of detransition rates drawn from of "a random sample of patient files (N=303)" associated with people seen at the Nottingham Centre for Transgender Health reports that "[o]nly one case of a detransition was found (0.33 per cent). An additional two cases had noted a history of detransition before coming to the Nottingham Centre for Transgender Health specifically (0.99 per cent).[913]
- Based on data from the Tavistock's Gender Identity Clinic during 2016 – 2017 and summarized at a presentation associated with the 2019 EPATH conference in Rome, another UK study (**Davies, et al., 2019**) reports that of 3,398 patients, only 16 – or 0.47% – "expressed transition-related regret or detransitioned."[914] This language, of course, does not sufficiently distinguish and disaggregate regret and detransition.

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[911] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 806.
[912] Jesse Singal, "How Science-Based Medicine Botched Its Coverage of the Youth Gender Medicine Debate: The site fell into an all-too-familiar trap," jessesingal.substack.com (July 10, 2021), https://jessesingal.substack.com/p/how-science-based-medicine-botched.
[913] C. Richards and J. Doyle, "Detransition Rates in a Large National Gender Identity Clinic in the UK," *Counselling Psychology Review* 34/1 (2019), 60-66 (here p. 60).
[914] Skye Davies, Stephen McIntyre, and Craig Rypma, "Detransition Rates in a National UK Gender Identity Clinic," 3rd Biennial EPATH Conference: Inside Matters: On Law, Ethics and Religion, April 11-13, 2019, Rome, Italy. *Book of Abstracts*, 118. available at: https://epath.eu/wp-content/uploads/2019/04/Boof-of-abstracts-EPATH2019.pdf.

- A presentation delivered at the 68th Annual Meeting of the American Academy of Child & Adolescent Psychiatry in October 2021 by Andrea Giedinghagen weighs in on the detransition rate question and some of the related issues:

> Many studies have looked at surgical intervention/gonadectomy as the "sine qua non" of transition, and thus have only counted those who later desire reversal of surgical intervention as detransitioning. By this metric, only 0.6% of transwomen and 0.3% of transmen who underwent gonadectomy reported detransition . . . . However, these numbers are from a cohort of patients treated at the Utrecht gender clinic, where there are very particular requirements for provision of health transition (HT) and surgical intervention.[915]

  While the published abstract for this presentation contains no documentation, it seems a safe bet that the Dutch study the author refers to is Wiepjes, et al. (2018), which reports the precise statistics cited (i.e., 0.6% for trans women and 0.3% for trans men). However, Wiepjes, et al. (2018) never mention "detransition" per se. Rather, they exclusively use the language of "regret." Thus, once again, in Giedinghagen's report we find the conflation of regret and detransition, *leaving us with no clear statistics on detransition per se*.

- In their French study, Karpel, et al. (2015) reported that 1% of their cohort experienced "deep regret" to the point of pursuing a legal-social detransition, with half of this sub-cohort (0.5%) also seeking medical detransition.[916]
- Dhejne, et al. (2014) – As noted previously, by defining "regret" as formally applying for legal detransition, this study's reported 2.2% regret rate equates to a 2.2% detransition rate.
- The retrospective case-note review done by Hall, et al. (2021) for the expressed purpose of "quantify[ing] 'detransitioning,'" involved 175 people seen at a UK adult gender clinic between September 2017 and August 2018.[917] They carefully defined detransitioners as: "those who had lived in an alternative gender role, reverting to their original role either during or after this care episode."[918] By this definition, they found that "[t]welve service users (6.9%) met our case definition of detransitioning. A further six (3.4%) service users

[915] Giedinghagen, "Quantitative Perspectives on 'Detransition' and Transition Regret."
[916] Ibid.
[917] Hall, et al., "Access to Care and Frequency of Detransition," 1.
[918] Ibid., 2.

had some overlap of experience though they did not strictly meet the case definition."[919] They go on to state:

> As data collection occurred for only 16 months after the most recent discharge, we may have underestimated the frequency of detransitioning. There is some evidence that people detransition on average 417 or 8 years18 after completion of transition, with regret expressed after 10 years. Furthermore, as there is no automatic mechanism to inform GICs of service users who subsequently detransition, other instances may have been missed. We gleaned only a limited understanding of those who detransitioned, owing to our reliance on notes.[920]

In conclusion, they observe that "[d]etransitioning might be more frequent than previously reported."[921]

- In their long-term follow-up study, Ruppin and Pfäfflin (2015) report that, of the 101 post-operative trans people invited to take part in their study, eight of them "declared that transsexualism was not an issue for them anymore, and therefore, they did not want to participate."[922] As we have observed above, a face-value reading suggests that these people no longer identified as transgender. In other words, this 7.9% of the cohort appears to represent a group of people who detransitioned.
- In the "De-transition" section of the *Report of the 2015 U.S. Transgender Survey* (2016), we find this report:

> Respondents were asked whether they had ever "de-transitioned," which was defined as having "gone back to living as [their] sex assigned at birth, at least for a while." *Eight percent (8%) of respondents reported having de-transitioned at some point*. Most of those who de-transitioned did so only temporarily: 62% of those who had de-transitioned reported that they were currently living full time in a gender different than the gender they were thought to be at birth. Transgender women were more likely to report having de-transitioned (11%), in contrast to transgender men (4%). Rates of de-transitioning also differed by race and ethnicity, with American Indian (14%), Asian (10%), and multiracial (10%) respondents reporting the highest levels of detransitioning.[923]

It is important to remember the nature of the population sample for this study. This survey was *only taken by people currently identifying as trans*. Thus, any people reporting an experience of detransition could, by definition, only represent people who

[919] Ibid., 6.
[920] Ibid., 7.
[921] Ibid., 1.
[922] Ruppin and Pfäfflin, "Long-Term Follow-Up of Adults with Gender Identity Disorder," 1322.
[923] James, et al., *Report of the 2015 U.S. Transgender Survey*, 111 (emphasis added).

either detransitioned while still identifying as trans or – much more likely – those who temporarily detransitioned but later retransitioned and re-embraced a trans identity. Crucially, this means that *this survey's report on detransition does not include the voices – or statistical representation – of any people who detransitioned and no longer identify as trans*.

- Using this same study (i.e., *2015 U.S. Transgender Survey* [2016]), Turban, et al., (2021) conduct a secondary analysis of relevant data related to detransition. As noted above, the *2015 U.S. Transgender Survey* reports that 8% of the total cohort of 27, 715 U.S. adults responded positively to the relevant question (i.e., "Have you ever de-transitioned? In other words, have you ever gone back to living as your sex assigned at birth, at least for a while?"). However, Turban, et al. offer a more finely-grained analysis of the data to arrive at an adjusted detransition rate of 13.1%:

  > In total, 10,508 respondents reported that they had never undergone gender affirmation ("transitioned") and were excluded from the analyses. Fifty-six respondents did not answer this question and were also excluded, leaving a sample of 17,151 [61.9%] participants, of whom 2242 (13.1%) responded "Yes," which was coded as a history of detransition.[924]

  Again, it is important to note that, given that the sample population of this survey all currently identified as transgender, this 13.1% detransition rate would (at the very least) predominantly represent a cohort of people who experienced *temporary detransition and, apparently, some form of subsequent retransition*.[925] In any case, this statistic – by definition – excluded any people who identified as a detransitioner at the time of the survey.
- Roberts, et al. (2022), while not articulating their findings in terms of "regret" or "detransition," nonetheless report that roughly 30% of their sizeable cohort chose to discontinue HRT within four years of initiating it – which certainly appears to indicate the taking of a step of medical detransition.

[924] Turban, et al., "Factors Leading to 'Detransition,'" 273, 274.
[925] We should probably stop short of definitively claiming this cohort *entirely* represents temporary detransition, since it is possible for someone to medically detransition while continuing to socially identify in some sense as trans.

In light of this set of detransition rate reports, it is clear that the often cited "1%-1.5%" statistic does not capture the range of diverse findings. This statistic represents a segment of the lower end of the broader range of detransition rate reports – although this fact is usually not mentioned when this statistic is cited. *This means that the actual aggregate detransition rate drawn from all published reports is higher than the most commonly cited statistics*. And the problems don't end here.

As noted in several of these reports on regret and/or detransition rates, methodological problems can significantly affect the likely accuracy of their conclusions. Other researchers have drawn attention to additional factors that likely contribute to an under-estimation of dissatisfaction and/or regret/detransition rates in current studies. For example, Wiepjes, et al. (2018) observe:

> Our findings could be an underestimation of people with regret after gonadectomy, because some might choose to go elsewhere for reversal therapy or might experience regret without pursuing reversal surgery or HT. Regret might not always result in a desire for reversal therapy, as it may be hidden from others.[926]

To these considerations, Zucker, Lawrence, and Kreukels add suicidality as a potentially complicating factor:

> whereas only 10 clients who underwent SRS between 1972 and 2000 submitted regret applications, 10 others who underwent SRS between 1973 and 2003 died by suicide, and another 29 made documented suicide attempts (Dehejne, et al. 2011). This suggests that regret applications underestimate the prevalence of genuine regret or dissatisfaction after sex reassignment.[927]

Below, we will return to a more thorough consideration of common methodological problems associated with transition outcome studies and the implications for regret and/or detransition rates.

Before we leave this section, it is worth asking: *What, really, is at stake in the question of transition regret and/or detransition rates?* Judging from how things are playing out in the culture war, the simple answer would seem to be: The higher these rates, the better for the cultural conservatives who consistently critique the gender affirmative model. Conversely, the

[926] Wiepjes, et al. "Amsterdam Cohort of Gender Dysphoria Study (1972-2015)," 589.
[927] Zucker, et al., "Gender Dysphoria in Adults," 237-38.

lower these rates, the better for the cultural progressives who champion the gender affirmative model. And so, for example, in reaction to the threat of bans on youth access to transition medicine, an international group of gender affirmative researchers write in a 2020 publication:

> Some critics have claimed high rates of regret regarding irreversible treatments or procedures such as reconstructive surgeries, implying that children are forced to undergo treatments they may regret. There are no studies to support these claims. However, recent studies show only a very small percentage of people who undergo gender transition as adults (when irreversible procedures may be administered) regret doing so: less than 2.2%, which is a small number compared with rates of regret reported for much more common procedures.[928]

This rhetorical strategy has led detransitioners and their allies to pose some troubling questions to gender affirmative scholars who seem to believe that the detransitioner community must be statistically reduced to the smallest possible size in order to safe-guard the wider trans community's access to medical care. One person poses the problem in this manner:

> I've been reading the articles trans activists write about detransition for years now and I've yet to see an accurate portrayal of our issues and experience . . . . You never fail to exclaim on our supposed rarity and cite studies that supposedly prove how uncommon we are. . . . . Furthermore, there is a lot of irony in your implication that because we are a numerical minority, that makes our issues less important. As a trans person, you are a member of a numerical minority in relation to the general population, but I doubt you would appreciate having your own issues dismissed on that basis . . . .[929]

Similarly, Alexander Yoo, a scholar sympathetic to the detransitioner community, writes:

> Assuming the accuracy of the oft-cited "less than 5 percent" figure (keeping in mind the lack of consistency defining "detransition" or "transition regret"), how does one reconcile the dismissive phrases (e.g., "almost negligible," "irrelevant") used to describe this group of people? . . . . What is behind the dismissiveness implied by citing the "rarity" of "transition regret" (never mind that most studies do not address nonsurgical transition regret)?[930]

At what point does a statistic merit being taken seriously? In the piece authored by the international coalition of gender affirming researchers mentioned above, the "2.2%" regret rate is

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[928] S. Leibowitz, J. Green, R. Massey, A. M. Boleware, D. Ehrensaft, W. Francis, C. Keo-Meier, A. Olson-Kennedy, S. Pardo, G. Nic Rider, E. Schelling, A. Segovia, V. Tangpricha, E. Anderson, G. T'Sjoen, and WPATH, USPATH, and EPATH Executive Committee and Board of Directors, "Statement in Response to Calls for Banning Evidence-based Supportive Health Interventions for Transgender and Gender Diverse Youth," *International Journal of Transgender Health* 21/1 (2020), 111–112. https://doi.org/10.1080/15532739.2020.1703652.
[929] CrashChaosCats. "open letter to Julia Serano."
[930] Yoo, "Transition Regret and Detransition," 189.

cited in order to down-play the significance of the number of people who experience transition regret. However, virtually the same statistic, 2.15%, precipitated the UN's World Health Organization (WHO), on January 30, 2020, to upgrade the threat of the corona virus to a global health emergency (i.e., a "public health emergency of international concern"), the highest warning-level it can give. This was only the fifth time in its history that the WHO has issued this level of warning. At that time, around 9,900 cases had been reported and 213 deaths confirmed: a death rate of 2.15%. At what point is 2.2% a significant statistic? When indexed to what people group experiencing which negative outcomes does 2.2% matter?

Or, to put the question differently: If it were discovered in the future that the regret and/or detransition rate was not around 2.2% but rather around 50% – would that matter? And if so, to whom and to what end? One gender affirmative research team has signaled an answer to this very question:

> [R]espect for autonomy encompasses an individual's right to be wrong. Consider if there was not a 1%, but a 50% risk of regret for adolescents undertaking medical or surgical gender affirmation. Alone, this statistic says little about the ethics of providing such treatment, since the risk of regret has to be balanced against the risk of not providing treatment.[931]

So, if even a 50% regret or detransition rate would not change the ethical calculus regarding gender affirmative medical transition for adolescents, then the question is left hanging in the air: *Why, then, the current tendency of many within the field to down-play the numbers of – and even stigmatize – people who report experiencing transition regret and/or detransition?*

c. Some studies continue to report a set of pre-transition factors predicting positive vs. negative transition outcomes – but the number doing so has decreased noticeably over the last decade-plus.

[931] Ken C. Pang, Simona Giordano, Nikita Sood, and S. Rachel Skinner, "Regret, Informed Decision Making, and Respect for Autonomy of Trans Young People,' *Lancet Child Adolescent Health* 5/9 (2021), e34-e35. doi: 10.1016/S2352-4642(21)00236-4 (here p. e34)

As discussed above, from the early years of medical transition, researchers began to document pre-transition factors that could serve as predictive indicators of both positive and negative outcomes. Up through the first decade of the new millennium, commonly mentioned predictive factors and associated dynamics include:

(a) Early (i.e., prepubertal) onset of gender dysphoria generally predicts better transition outcomes than late onset. This observation led to the construction of the primary transsexual vs. secondary transsexual typology, and the claim that the former generally has better outcomes than the latter.

(b) Pre-transition fetishistic (i.e., erotic) cross-dressing is associated with worse outcomes, particularly for trans women.

(c) Pre-transition homosexuality (vis-à-vis one's assigned/natal sex) is associated with poorer outcomes, particularly for trans women (although the data here is not uniform).

(d) Trans men generally report better outcomes than trans women.

(e) The absence of pre-transition mental health problems / psychiatric co-morbidities predicts better outcomes, while their presence predicts worse outcomes.

(f) A documented pre-transition diagnosis of gender dysphoria (or, prior to the DSM-5, gender identity disorder) is associated with better outcomes.

(g) Pre-transition and/or post-transition psychotherapy/counseling is associated with better outcomes.

(h) A supportive family structure is associated with better outcomes, while social isolation is predictive of poorer outcomes.

(i) Disappointing surgical results – i.e., aesthetically, functionally, or in terms of medical complications – is predictive of worse outcomes.

Over the last decade-plus, the number of studies that focus on elucidating pre-transition predictive factors has decreased. It has been speculated above that this more recent trend of avoiding a focus on predictive criteria – criteria often tied historically to psychological assessments and co-occurring mental health problems – is fed, at least in part, by the complementary tendencies toward the depathologization of trans experience and an informed consent model of trans care. This line of speculation is supported by MacKinnon, et al.'s critical reflections on current clinical practices in several Canadian gender clinics:

> Strict clinical assessment practices may . . . reflect a projection of cisgender people's priorities and anxieties, rather than the concerns of trans people . . . . We uncovered that clinical work involves applying standard transition "readiness" assessments (e.g., the DSM; the WPATH-SOC) together with additional psychosocial evaluations (e.g., housing status; mental health coping strategies) which are deployed as proxy measures to predict future transition satisfaction/regret . . . . We conclude that the logic organizing clinicians' assessment work reflects cisnormativity and transnormativity in biomedicine.[932]

In addition, the rise of the minority stress theory – which posits that the higher rates of mental health issues among trans people is primarily due to societal stigma and oppression – would naturally encourage a turn from seeking out predictive factors that focus on trans people themselves, and, instead, toward a consideration of societal factors that either foster, or degrade, transphobia in the wider culture.[933]

d. A substantial number of methodological problems have plagued transition outcome research over the decades and continue to do so up to today – the effect of which significantly compromises its evidence base

Before moving into this summary, a brief word of caution about methodological assessments and critiques within any field of study is in order. Methodological critiques often consider various types of bias within a disciplinary field and its research programs. However, the very use of methodological critique can, itself, be plagued by bias. For example, research has shown that "[w]hen reviewers read manuscripts in which the data supported their presumed perspective, they rated its methodology as 'adequate' or 'excellent,' and recommended that it be published." Conversely, "[w]hen the same procedures yielded negative results, they were rated as

[932] MacKinnon, et al., "Preventing Transition 'Regret,'" 7, 8.
[933] Ilan Meyer was key to the development of the minority stress theory (MST). See Ilan H. Meyer, "Minority Stress and Mental Health in Gay Men," *Journal of Health and Social Behavior* 36/1 (1995), 38-56; idem, "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence," *Psychological Bulletin* 129/5 (2003), 674-97. For an early application of the MST to trans-identified people, see M. L. Hendricks and R. J. Testa, "A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model," *Professional Psychology: Research and Practice* 43/5 (2012), 460-67.

'inadequate,' and the reviewers recommended rejection of the manuscript."[934] This is to say, we must strive to self-monitor our own biases in the midst of evaluating the potential biases of others. Related to this, Jack Drescher has pointed out that politically charged issues – which, of course, transition outcomes studies certainly are within our culture war context – invite people to resort to various "techniques of distortion" to undermine research findings that do not support their worldview and its presuppositions. Drescher writes:

> Political distortions of science can occur on the right and left wings of the political spectrum and are causes of concern, not only to scientists and policy makers but also to physicians, psychiatrists, and mental health professionals seeking empirical support for clinical interventions . . . . Also troubling is the publicizing of "research" created solely to support political agendas. Such activities raise the troubling question of whether science as we know it can survive politicization.[935]

One such "technique of distortion" mentioned by Drescher is "Confuse the Public with Pseudo-Science." Under this category, Drescher lists several specific tactics, including: "Criticizing a study's methodology or the methodology of a body of scientific studies to argue that there is little scientific support for a mainstream theory (there are, after all, no perfect studies)."[936]

Drescher's observation is an important one. At the same time, his way of framing the issue could lead to the conclusion that anyone challenging mainstream science in regard to methodological flaws is, virtually by definition, resorting to "pseudo-science" for political/ideological purposes. Both the fields of philosophy of science and history of science would call this claim into serious question.[937] Nonetheless, Drescher's important warning about purely politically motivated charges of methodological flaws is one that should be taken to heart by all parties. These concerns also suggest that Duarte, et al. are correct in asserting that political diversity will tend to improve the social sciences.[938]

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[934] Michael J. Mahoney, "Psychology of the Scientist: An Evaluative Review," *Social Studies of Science* 9 (1979), 349-75 (here p. 353).
[935] Jack Drescher, "When Politics Distorts Science: What Mental Health Professionals Can Do," *Journal of Gay & Lesbian Mental Health* 13 (2009), 213–26 (here p. 223).
[936] Ibid.
[937] E.g., Thomas Kuhn, *The Structure of Scientific Revolutions*, 2nd ed. (Chicago: University of Chicago Press, 1970 (1962).
[938] José L. Duarte, Jarret. T. Crawford, Charlotta Stern, Jonathan Haidt, Lee Jussim, and Philip E. Tetlock, "Political Diversity Will Improve Social Psychological Science," *Behavioral and Brain Sciences* 38 (2015), 1-58.

Turing now to our summary: The transition outcome studies considered above have given evidence of a range of significant methodological problems, which researchers have expressed concerns over for decades. Reporting on this issue in a 1981 review, Ira Pauly observed that these methodological problems had been consistently documented since the 1960s:

> Numerous authors have commented upon the obvious procedural and methodological difficulties of these kinds of studies (Kubie and Mackie, 1968; Lothstein, 1978; 1979; Tiefer and Zitrin, 1977; Pauly, 1965; 1968; 1974).[939]

Almost 30 years later, a 2009 study by a leading research team, entitled "Is Gender Reassignment Surgery Evidence Based?," concluded that the then-current data-base

> offers no evidence based-research above level B or C . . . . Overall it seemed, and this has not changed since the publication of the [SOC-6], that the quality of evidence was poor due to the lack of concealment of allocation, completeness of follow-up, and blinding . . . . [T]aking into consideration the difficulties in interpretation of review evidence, the magnitude of benefit and harm cannot be estimated accurately using the current available evidence.[940]

A decade later, Carl Heneghan – director of the University of Oxford's Center for Evidence-Based Medicine – drew similar conclusions regarding the evidence base for use of HRT in the medical transition process:

> There are significant problems with how the evidence of Gender-affirming cross-sex hormone has been collected and analysed that prevents definitive conclusions to be drawn . . . . [T]he evidence is limited by small sample sizes, retrospective methods, and loss of considerable numbers of patients in the follow-up period. The majority of studies also lack a control group (only two studies used controls). Interventions have heterogeneous treatment regimes complicating comparisons between studies. Also, adherence to the interventions is either not reported or inconsistent. Subjective outcomes, which are highly prevalent in the studies, are also prone to bias due to lack of blinding.[941]

As we have seen, the same types of methodological problems that Heneghan notes in relation to hormonal transition have also characterized a wide variety of surgical transition outcome studies, decade after decade. For example, as Djordjevic (2021) observes:

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[939] Pauly, "Outcome of Sex Reassignment Surgery for Transsexuals," 48.
[940] Monstrey, et al., "Is Gender Reassignment Surgery Evidence Based?," 206, 212, 213.
[941] Carl Heneghan and Tom Jefferson, "Gender-affirming Hormone in Children and Adolescents." *BMJ EBM Spotlight* (February 25, 2019), https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/.

> [I]t is impossible to define the best available techniques for gender affirmation surgery due to a lack of evidence of adequate quality and variety of surgical techniques, groups of candidates, and non-standardized outcome measures.[942]

Apparently, these are the very sorts of methodological and evidence-base problems that led the Centers for Medicare and Medicaid Services in August 2016 to conclude – given the "inconclusive" nature of the evidence – that there was an insufficient basis to make a national coverage determination (NCD) for gender reassignment surgery.[943] In the words of the report:

> The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population . . . . Thirty-three papers were eligible based on our inclusion/exclusion criteria for the subsequent review (Figure 1). All studies reviewed had potential methodological flaws which we describe below . . . . Overall, the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding (a situation where the association between the intervention and outcome is influenced by another factor such as a co-intervention), small sample sizes, lack of validated assessment tools, and considerable lost to follow-up . . . . The majority of studies were non-longitudinal, exploratory type studies (i.e., in a preliminary state of investigation or hypothesis generating), or did not include concurrent controls or testing prior to and after surgery.[944]

The following is a summary of common methodological problems associated with transition outcome studies over the last several decades.

(1) Lack of randomized controlled trial (RCT) studies

For decades now, researchers have pointed out that transition-related outcome research is completely devoid of the gold standard in evidence-based medicine – the randomized controlled trial (RCT) method.[945] As Monstrey, et al. (2009) observe: "Because the literature shows a lack

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[942] Djordjevic, "Regrets in Transgender Female: Reversal Phalloplasty," 229.
[943] Tamara Syrek Jensen, Joseph Chin, James Rollins, Elizabeth Koller, Linda Gousis, and Katherine Szarama, "Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)," *Center for Medicare and Medicaid Services* (August 30, 2016), https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282&bc=ACAAAAAAQAAA&.
[944] Ibid.
[945] Among the studies mentioned above that point out the lack of RCTs are the ARIF review; Monstrey, et al., "Is Gender Reassignment Surgery Evidence Based?," 209; De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery," 203; What We Know Project, "What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-being?"; Sutcliffe, et al., "Evaluation of Surgical

of randomized clinical trials or high-quality follow-up studies on large numbers of operated transsexuals, it offers no evidence based-research above level B or C . . . ."[946] Smith, et al. (2001) note this same methodological weakness for their own study, as well as the primary reason for it:

> a different research design in which, on a random basis, half of the applicants who are eligible for treatment would be treated and the other half not, would have been better methodologically. Clearly, however, for ethical reasons such a study is impossible to conduct.[947]

As Smith, et al. aver, by the very nature of the case RTCs are not being done in this area of research for both practical and ethical reasons.[948] This leaves the field of transition-related medicine in the unenviable position of having to operate without access to the highest quality of relevant medical evidence. As a 2021 study by the UK's National Institute for Health and Care Excellence states, the lack of RTCs in transition-related research today means that:

> [s]tudies that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance.[949]

(2) Standardization problems

Over 30 years ago, Green and Fleming (1990) comment on standardization problems that plagued the field of transition-related studies, including the "lack of reported standardized selection criteria for surgery, and the infrequent use of standardized outcome instruments and

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Procedures for Sex Reassignment: A Systematic Review," 294; and Nguyen, et al., "What Has Sex Got to Do with It? The Role of Hormones in the Transgender Brain." To these can be added: Richard Byng, William J. Malone, and David Curtis, "Misinterpretation of the Findings of this Study May Limit Safe, Ethical Treatment Options for Gender-questioning and Gender-diverse People [Comment]," *JAMA Psychiatry* (October 8, 2019), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2749479; C. G. Streed, O. Harfouch, F. Marvel, R. S. Blumenthal, S. S. Martin, and M. Mukherjee, "Cardiovascular Disease Among Transgender Adults Receiving Hormone Therapy: A Narrative Review," *Annals of Internal Medicine* 167/4 (2017), 256-67;J. M. White Hughto and S. I. Reisner, "A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals," *Transgender Health* 1 (2016), 21-31.

[946] Monstrey, et al., "Is Gender Reassignment Surgery Evidence Based?," 206.

[947] Smith, et al., "Adolescents with Gender Identity Disorder," 480.

[948] This type of problem has led to the argument that in some clinical contexts there needs to be a shift from evidence-based medicine to other approaches. E.g., see Sophie Van Baalen and Mieke Boon, "An Epistemological Shift: From Evidence-based Medicine to Epistemological Responsibility," *Journal of Evaluation in Clinical Practice* 21/3 (2015), 433-39.

[949] National Institute for Health and Care Excellence (NICE), **"**Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria," (March 11, 2021), file:///C:/Users/16514/Downloads/20210323_Evidence+review_GnRH+analogues_For+upload_Final%20(1).pdf.

rating criteria."[950] Several years earlier, Lundström, et al. (1984) had already noted the lack of uniformity in follow-up methods.[951] Two decades after Green and Fleming (1990), Sutcliffe, et al. (2009) are still found having to comment on the fact that "lack of validated assessment measures" remained a significant problem in the field.[952]

As we have seen, more recent studies continue to report on standardization problems. For example:

- Regarding the Italian SRS outcomes studies they analyzed, Angela Caldarera and Friedemann Pfäfflin report that "[v]arious problems were encountered in data collection, mainly due to the missing standardization of the record procedures in the clinics.[953]
- In their systematic review of outcome research on facial feminization surgeries, Morrison, et al. (2016) remark that "most studies did not use validated or quantified approaches to address satisfaction."[954]
- Zavlin, et al. (2018) note that, when it comes to post-transition outcomes studies, "standardized and validated SRS-specific questionnaires are lacking."[955]
- Manfredi, et al. (2021) observe that "[d]espite the high satisfaction rate [regarding penile implant surgery] reported in the literature, most of the studies used suboptimal or non-validated questionnaires to assess patients undergoing penile implant surgery."[956]
- In their review and meta-analysis of studies reporting on post-surgical regret, Bustos, et al. (2021) also recognize this field-wide problem:

> However, there is high subjectivity in the assessment of regret and lack of standardized questionnaires, which highlight the importance of developing validated questionnaires in this population.[957]

[950] Green and Fleming, "Transsexual Surgery Follow-Up," 163.
[951] Lundström, Pauly, and Wålinder, "Outcome of Sex Reassignment Surgery," 289-90.
[952] Sutcliffe, et al., "Evaluation of Surgical Procedures for Sex Reassignment," 294.
[953] Angela Caldarera and Friedemann Pfäfflin, "Transsexualism and Sex Reassignment Surgery in Italy," *International Journal of Transgenderism* 13/1 (2011), 26-36.
[954] S. D. Morrison, K. S. Vyas, S. Motakef, K. M. Gast, M. T. Chung, V. Rashidi, et al., "Facial Feminization: Systematic Review of the Literature," *Plastic & Reconstructive Surgery* 137/6 (2016), 1759-70.
[955] Zavlin, et al., "Male-to-Female Sex Reassignment Surgery," 178.
[956] Manfredi, et al., "Penile Implant Surgery Satisfaction Assessment," 868.
[957] Bustos, et al., "Regret after Gender-affirmation Surgery."

Standardization problems appear at the heart of MacKinnon, et al.'s (2020) concerns about current transition outcome studies:

> There are factors confounding GAS outcomes data quality with respect to surgical outcomes, quality of life, and psychosocial functioning in Canada and globally. One 2015 systematic review concludes that it is impossible to know "the 'best available' technique for vaginoplasty due to a lack of high-quality evidence and heterogeneity" of outcome measures. A 2019 systematic review of phalloplasty outcomes identifies that inconsistent outcomes reporting and a lack of comparative studies are significant limitations. Other areas of concern are that the defining principles of each surgical technique are not standardized, validated trans patient quality-of-life measures have yet to be developed, and the available data are divergent. Thus, reporting is unclear due to inconsistency with respect to surgical language and the absence of standardized validated GAS outcome tools. Ostensibly, patients and surgeons alike lack access to robust data reporting on the full spectrum of patient outcomes, including psychosocial and quality-of-life outcomes.[958]

The standardization problem is abundantly clear from even a cursory consideration of the variety of survey instruments used to measure medical transition satisfaction levels and outcomes. This range of different instruments – and the differing questions they use to get at various measures – means that "apples-and-oranges" comparative equivocation most likely riddles the field of post-transition outcome research. In this sense, little has changed since Green and Fleming pointed out this problem in their 1990 review of post-SRS outcomes over 30 years ago.

(3) The dominance – and inherent weaknesses – of retrospective studies

As discussed previously, the vast majority of transition-related outcome studies involve a retrospective study design in which people are asked to reflect on and report about their past experience throughout the pre-transition – transition – post-transition process, in an after-the-fact manner. Conversely, a prospective study design – which is relatively rare in transition outcome studies – collects data from people multiple times over the course of the transition process. Compared to prospective studies, retrospective studies are generally considered to be of lower quality evidence due to the inherent weaknesses that naturally occur when people are asked to report on their own pasts – i.e., memory distortion, confounding errors, bias, etc.

[958] MacKinnon, et al., "Lost in Transition," 157.

As long ago as 1969, Harry Benjamin warned about the inherent weakness of retrospective reporting for assessing transition outcomes:

> Ninety-five of my male transsexual patients have undergone sex reassignment surgery. I have seen most of them before and after. The results of the operation are not easily evaluated. We have to depend mostly on what the patient tells us and that can vary according to his mood from month to month, if not from day to day. A happy love affair with a satisfactory sex experience including orgasm and the seventh heaven is open. The operation is a magnificent success. A fight with husband or lover, an unsuccessful attempt at intercourse, perhaps due to a contracted vagina, the loss of a job, and despondency, pessimism and regret may prevail.[959]

Two decades later, Kuiper and Cohen-Kettenis (1988) reiterated similar concerns about the inherent problems associated with "ex post facto" studies based solely on subjects' self-reports.[960] Again, another two decades later finds Griet De Cuypere and Vercruysse, Jr. (2009) pointing out the same problem: "All the studies mentioned here [i.e., in their end -of-the-decade systematic literature review] are retrospective studies."[961] Today, over a decade on, the status remains largely unchanged. In their recent systematic review of patient-reported outcome measures used in association with transition surgery, **Andréasson, et al. (2018)** speak to concerns at the intersection of the problems presented by retrospective reporting and lack of standardized outcome measures:

> There is a lack of patient-reported outcome measures that are valid for the transgender population and concurrently sensitive enough to evaluate gender confirmation surgery without the influence of other gender confirming interventions. Basing research on instruments without confirmed validity decreases the validity of the study itself; thus, previous research using patient-reported outcome measures to evaluate gender confirmation surgery can be considered to have a low level of evidence. To obtain valid patient-reported outcome measures, specific for evaluating the results of gender confirmation surgery, development of new instruments or adaptation of existing instruments is needed.[962]

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[959] Benjamin, "Newer Aspects of the Transsexual Phenomenon," 139.
[960] Kuiper and Cohen-Kettenis, "Sex Reassignment Surgery," 439.
[961] De Cuypere and Vercruysse, Jr., "Eligibility and Readiness Criteria for Sex Reassignment Surgery," 198.
[962] My Andréasson, Konstantinos Georgas, Anna Elander, and Gennaro Selvaggi, "Patient-Reported Outcome Measures Used in Gender Confirmation Surgery: A Systematic Review," *Plastic and Reconstructive Surgery* 141/4 (2018), 1026-39 (here p. 1026).

Relevant here too is the observation that "[s]ubjective outcomes, which are highly prevalent in the [transition outcome] studies, are also prone to bias due to lack of blinding."[963]

Several decades ago, a team of anthropologists reflected on the fact that the social sciences are commonly forced to rely upon data drawn from subjects' retrospective reports. Their conclusions are relevant to contemporary transition outcomes research:

> From our perspective, then, the evidence of informant inaccuracy ought not to lead to complaints or to despair. It ought to lead instead to a rich, relatively unexplored arena of research. Surely our informants are not to blame for being inaccurate. It is not even their problem. People everywhere get along quite well without being able to dredge up accurately the sort of information that social scientists ask them for. If we have a great deal of inaccuracy in our data, then we have only ourselves to blame for using the instruments of our craft – that is, the questions that we use to tap our informants' memories – so uncritically.[964]

(4) Small sample sizes

As mentioned earlier, many of the transition outcomes studies produced in the last decade-plus have done a remarkable job of increasing their subject sample sizes compared to prior decades. This is an important growth step for the field. A major issue of concern here is that the smaller the sample size, the more likely that it reflects *sample size bias*.[965] While progress has been made, we have also noted that many studies continue to show the need for improvement in this area.

(5) Sample specificity and the problem of generalizability

A second subject sample-related issue that arises in transition-related research is not actually a problem per se – unless the inherent limitations of particular samples are forgotten and findings drawn from them are uncritically generalized to other contexts. The inherent particulars of any subject sample include chronological, geographical, cultural, and medical specificities and

[963] Heneghan and Jefferson, "Gender-affirming Hormone in Children and Adolescents." On the lack of blinding problem and associated bias, see D. Nunan and C. Heneghan, "Lack of Blinding," *Catalogue Of Bias* (2018), www.catalogueofbiases.org/biases/lackofblinding.
[964] H. R. Bernard, P. Killworth, D. Kronenfeld, and L. Sailor, "The Problem of Informant Accuracy: The Validity of Retrospective Data," *Annual Review of Anthropology* 13 (1984), 495-517 (here p. 513).
[965] Spencer, et al., "Wrong Sample Size Bias."

dynamics. For example, regret and/or detransition rates obtained from older studies – and/or current studies done in contexts where assessment protocols are stringently followed – cannot be simply extrapolated to contemporary contexts where the informed consent model has reduced or eliminated more stringent screening standards. For example, and in the words of Hildebrand-Chupp: "[T]he rigid clinical protocol and other features of the system for providing transition-related care in . . . European countries may not generalise to some other countries, like the United States."[966] This observation is crucial in that *relatively low regret/detransition rates – drawn from times and places characterized by stricter screening criteria – can easily be used to justify an abandonment of the very screening criteria that provided the context for low regret/detransition rates in the first place*.

Another case involves the lack of standardized criteria for what defines "transition," "regret," "detransition," etc. To understand the practical import of this dynamic, it will be helpful to consider its ramifications in relation to an observation made by several researchers regarding transition regret and/or detransition rates. In the words of Andrea Giedinghagen, "Detransition . . . becomes rarer the more extensive medical/surgical transition has been."[967] In other words, it appears that, generally speaking, reported satisfaction rates rise – and thus regret/detransition rates fall – the more invasive the type/level of transition. Thus, we should expect to see a pattern of falling reported regret/detransition rates as we move from considering social transition to hormonal transition to top surgery to bottom surgery. Various reasons for this have been suggested. For example, the more irreversible and invasive the transition procedure: (1) the more time, care, and consideration are likely given by the subject to making the transition decision process; (2) the more likely it is that attending medical personnel offer more preoperative attention and counsel; and (3) the more "highly motivated" the person choosing to undergo the procedure, "after which disappointment may be more difficult to admit."[968]

Whatever the reason, however, it is important to recognize the practical implications of this phenomenon. Up until the last decade-plus, regret and detransition rates were primarily assessed

[966] Hildebrand-Chupp, "More than 'Canaries in the Gender Coal Mine,'" 806.
[967] Giedinghagen, "Quantitative Perspectives on 'Detransition' and Transition Regret."
[968] van de Grift, et al., "Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery," 146.

for people who had undergone *surgical – usually genital – transition*. According to the dynamic observed by Giedinghagen and others, this would lead to relatively lower regret/detransition rates due to the invasive nature of the procedures. However, in more recent years – due in large part to the increasing cultural recognition of trans-identified people, regardless of whether that identification correlates with surgical transition or not – an increasing number of trans people are deciding not to undergo the types of more invasive transition that have led, historically, to lower regret/detransition rates. This relatively recent trend of broadening the vista of trans identification can be seen in a 2019 essay on gender dysphoria:

> Definitions are important, as they determine who is included or excluded from the population of interest and are often used to determine who receives care. For many years, the medical literature focused on counting trans people who sought gender-affirming medical interventions to transition from their assigned sex at birth to another gender. Other studies included individuals who met DSM diagnostic criteria for "Gender Identity Disorder" or "Gender Dysphoria" or who had received an International Classification of Diseases (ICD) code for "transsexualism". This practice implicitly, or explicitly, excludes gender diverse people who do not seek gender transition services in a medical setting or at all.[969]

The crucial point here is that, as the cultural understanding of trans identity has broadened to include an ever-increasing number of gender diverse people – including many who choose not to pursue invasive surgical procedures (especially genital surgeries) – this same broad understanding of trans identity increasingly characterizes academic definitions of transition. And as social and hormonal transition are increasingly included, alongside surgical transition, under the umbrella of "transition," it seems likely – according to the principle of "less invasive/arduous transition processes and procedures lead to higher dissatisfaction/regret/detransition rates" – that *we should expect to see increasing dissatisfaction/regret/detransition rates on into the future*. Carey Callahan, a female detransitioner, explains this dynamic using her own life-situation as an example:

> In fact, we have no idea how prevalent detransition is in America. The most widely used estimate, that 2.2% of people who transition later detransition, comes from a study in a completely different place (Sweden) and time (1960-2010), when gatekeeping was much stricter. Moreover, that study defined a "detransitioner" as someone who had changed their name and gender legally (an arduous process in Sweden at the time) and then had

[969] Tonia Poteat, Katherine Rachlin, Sean Lare, Aron Janssen and Aaron Devor, "History and Prevalence of Gender Dysphoria," in *Transgender Medicine: A Multidimensional Approach*, eds. L. Poretsky and W. C. Hembree (New York: Humana/Springer Nature, 2019) 1-24 (here p. 7).

> the motivation and money to go through the name change process in reverse, a standard so strict that I wouldn't be counted, and nor would 90% of the detransitioners I know.[970]

Another detransitioner has expressed it very similarly:

> You never fail to exclaim on our supposed rarity and cite studies that supposedly prove how uncommon we are. As a detransitioned woman, I can tell you that many of those studies are based on criteria that exclude our actual circumstances and that I don't trust their accuracy. For example, there is a study presently being conducted in the UK on people who surgically reverse previous sex-reassignment surgery. They include both genital surgery and also mastectomy. Some detransitioned women would not qualify for this study because they took hormones but never got mastectomies. Of those who did get a mastectomy, the majority do not chose to get breast reconstruction. I would not meet the criteria for this study and neither would any of the detransitioned women I know personally. [971]

(6) A wide variation in follow-up time-spans, with many representing relatively short follow-up duration periods.

A relatively short duration between the inauguration of a phenomenon being studied and the assessment of that phenomenon can lead to what has been called "short follow-up bias."[972] With regards to medical transition, a relatively short duration between the medical procedure itself and the assessment of its outcomes can lead to this very problem. As post-transition data has increased over time, it has become clear that certain NTEs tend to be indexed to the length of the transition-to-assessment timeframe. For example, from at least the early 1960s, it was not uncommon to find that people's self-reported transition outcomes (e.g., difficulty, satisfaction, regret, and/or detransition) within the first year of transition could differ significantly from their later outcome reports between year one and five. Alternatively, people's outcome reports in the first five years could differ significantly from their subsequent reports at ten years or longer.[973] Just using these three longitudinal time-points, a heuristic typology emerges: (1) *short-range assessment* (i.e., up to one-year post-transition); (2) *medium-range assessment* (i.e., between

[970] Carey Callahan, "Gender Identity is Hard but Jumping to Medical Solutions is Worse," *The Economist: Open Future* (December 3, 2019), https://www.economist.com/open-future/2019/12/03/gender-identity-is-hard-but-jumping-to-medical-solutions-is-worse.
[971] CrashChaosCats, "Open letter to Julia Serano."
[972] Ivana Vodopivec and Sashank Prasad, "Short Follow-up Bias Confounds Estimates of the 'Typical' Clinical Course of Susac Syndrome," *Journal of Neuro-Ophthalmology* 37/2 (2017), 149-53.
[973] This can be seen as far back as Hertz, et al, (1961), 286 (case #1 - outcome). The evidence backing this concern has now been well documented in Dhejne, et al, (2014) and especially Wiepjes, et al. (2018).

one-and-five-years post-transition); and (3) *long-range assessment* (i.e., ten years or more post-transition). Using this typology, the vast majority of transition outcome studies surveyed above have been either short-range or medium-range in length. In comparison, long-range longitudinal studies have been relatively rare over the decades – right up to today.

As far back as 1982, Lothstein can be found ruing the lack of longitudinal follow-up studies of significant length.[974] Especially over the last decade-plus, the issue of the length of time-period between transition and outcome assessment has been increasingly recognized as a significant factor affecting the quality of longitudinal outcome studies. One specific concern here is that short follow-up periods can tend to magnify relatively positive subjective experiences in the earlier stages of post-transition life, while missing more negative experiences that can manifest over time. As discussed above, two of the most robust longitudinal studies published in the last decade have been especially important to this question:

- Dhejne, et al.'s (2014) longitudinal study covering an unusually long period of over 50 years (1960 to 2010) reports that the

  > median (range) time elapsed from attaining a new legal gender to the regret application was 7.5 years (90 months, range 75–137) for FM, and 8.5 years (102 months, range 22–177) for MF.[975]

  This means that the median length of time between a given person's legal transition and their subsequent decision to apply for an official detransition was roughly 8 years.
- Wiepjes, et al.'s (2018) study of people seen at their gender clinic over more than a 40-year period (1972 to 2015) found that "the average time to regret was 130 months [i.e., 10.8 years], so it might be too early to examine regret rates in people who started with HT in the past 10 years."[976]

Putting these two unusually high-powered longitudinal studies together, it appears that the average timespan from a person's medical transition to their taking steps to officially initiate detransition is somewhere between eight to eleven years – which means *any regret or detransition rate assessment of shorter duration than ten years or more (i.e., a long-range assessment) is likely to under-estimate actual regret/detransition rates*.

[974] Lothstein, "Sex Reassignment Surgery," 417.
[975] Dhejne, et al., "Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010," 1540-41.
[976] Wiepjes, et al., "Amsterdam Cohort of Gender Dysphoria Study (1972-2015)," 589.

To review follow-up periods for some of the studies published in the last decade:

- Hess, et al. (2014) – a mean follow-up period of 5.05 years post-surgery
- Johansson, et al. (2010) – two or more years post-surgery
- Olson-Kennedy, et al. (2018) – one to five years post-surgery
- van de Grift, et al. (2018) – an average assessment period of four to six years after first clinical contact (i.e., the actual length of time between completion of surgery and assessment would be significantly less than four to six years)
- Papadopulos, et al. (2017) – an average of 19 months post-surgery
- Zavlin, ert al. (2018) - 6 months post-surgery

It is apparent that this finding of the importance of a long-range assessment period for attaining accurate regret/detransition rates raises significant concerns regarding the reliability of the majority of transition outcome studies, since most represent short- to medium-range assessment periods. Simply put: *Since the majority of transition outcome studies have follow-up periods of less than ten years (i.e., long-range assessments), it is quite likely that they are under-estimating the actual transition regret and detransition rates.*

(7) High participant attrition rates (lost to follow-up)

Decade by decade, we have seen that one of the most wide-spread and enduring methodological problems associated with transition outcomes studies involves the exceedingly high rates of participant attrition – the lost to follow-up problem. The problem posed by high participant attrition rates for any medical study seeking to establish a robust evidence-base has been clearly articulated by Joseph Dettori.[977] In response to the question: "How important is loss to follow-up?," Dettori writes:

> The simple answer to this question is "very important" because loss to follow-up can severely compromise a study's validity. Incomplete follow-up biases the results when either: The dropout rates are different between study groups; or The patients who drop out are different from those who do not drop out. Why do these situations make a difference? Because in each situation, those lost to follow-up often have a different prognosis than those who complete the study.[978]

[977] Joseph R. Dettori, "Loss to Follow-up," *Evidence-Based Spine-Care Journal* 2/1 (2011), 7-10.
[978] Ibid.

In response to the crucial question: "How many patients can be lost to follow-up without mistrusting the results?," Dettori offers this assessment:

> A good rule of thumb is that <5% loss leads to little bias, while >20% poses serious threats to validity. However, even less than 20% loss to follow-up can be a problem. Considering a worst-case scenario can help determine whether loss to follow-up poses a potential threat to validity . . . . One way to determine if loss to follow-up can seriously affect results is to assume a worst-case scenario with the missing data and look to see if the results would change.[979]

In light of Dettori's advice, it is important to stop for a moment to consider why, specifically, high lost to follow-up rates could significantly affect transition regret or detransition rate reports. As discussed above, recent studies have demonstrated that people who regret their transition and/or who choose to detransition are far less likely to remain in contact with their medical transition providers than those who report positive outcomes. In other words, a high percentage of people who experience transition regret and/or detransition are "lost to follow-up" – which means their experiences go unrecognized in outcome studies. As discussed above, Vandenbussche reported that only 29% of detransitioners report receiving support for their detransition from the medical providers who facilitated their transition.[980] Similarly, Littman's study found that "[o]nly a small percentage of detransitioners (24.0%) informed the clinicians and clinics that facilitated their transitions that they had detransitioned." Related to this, two leading figures in trans medical care – Laura Edwards-Leeper and Erica Anderson – have stated that "three-quarters" of study subjects "who reversed their gender transitions did not report this change to their doctors."[981] *These statistics suggest that, due to the lost to follow-up problem, actual detransition rates are most likely significantly higher than commonly reported*.

Hearing these reports from researchers calls to mind the words of one detransitioner quoted earlier:

> [A]nxiety, fear and other intense feelings [can] get in the way of a detransitioned person contacting their old medical providers and informing them of their detransition. People often overlook how many detransitioned people don't trust their old providers, feel shame about transitioning or otherwise experience strong emotions that could prevent them from coming forth and how this could lead providers into thinking that detransition is much

[979] Ibid.
[980] Vandenbussche, "Detransition-Related Needs and Support," 1609.
[981] Edwards-Leeper and Anderson, "The mental health establishment is failing trans kids."

> less common than it is. How can you accurately gauge how many people detransition if many of us don't want to talk about it for one reason or another?[982]

Thus, we find clear evidence suggesting that a sizable percentage of people who detransition are, in fact, among the sub-cohorts of study participants who are lost to follow-up.

Now, in this light, to review the lost to follow-up rates of the some of the key studies surveyed over two decades:

- Simonsen, et al. (2016) - 2%
- Imbimbo, et al. (2009) – 15%
- Karpel, et al. (2015) - 22%
- Zavlin, et al. (2018) - 22.5%
- Olson-Kennedy, et al. (2018) - 28%
- Poudrier, et al. (2019) - 28%.
- Nelson, et al. (2009) - 30%
- Johansson, et al. (2010) - 30%
- Krege, et al. (2001) - 32.6%
- Wiepjes, et al. (2018) - 36%
- De Cuypere, et al. (2006) - 42%
- Ruppin and Pfäfflin (2015) - 49.3%[983]
- Hess, et al. (2014) - 53.1%
- Weinforth, et al. (2019) - 56%[984]
- Papadopulos, et al. (2017) - 61.2%.
- van de Grift, et al. (2018) - 63%
- McNichols, et al. (2020) - 64%
- Lawrence (2003) - 68%
- Jellestad, et al. (2018) - 82.3%[985]

Instantly visible is the fact that only one of these studies has a lost to follow-up rate under 5%, and only two are under 20%. Seen in light of Dettori's assessment that a "good rule of thumb is

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[982] Crashchaoscats. "Follow-up to 'Lost to Follow-up.'"

[983] Ruppin and Pfäfflin ("Long-Term Follow-Up of Adults with Gender Identity Disorder," 1322) report that

> [a]ltogether, a total of 140 persons received letters of which 101 (72.1 %) made contact with the authors d, thereupon, were informed about the study and asked for their participation . . . . Finally, 71 persons decided to take part in the study which corresponds to 50.7 % of all contacted persons and 70.3 % of the persons who got back to the authors.

Again, this appears to amount to a lost to follow-up rate (vis-à-vis the original 140 people contacted) of 49.3%. However, the ambiguity here should be noted: It is not entirely clear whether the total number of people who underwent SRS is equal to the total number of people who "received letters."

[984] This meta-analysis found "the drop-out rates, insofar as they were given, ranged from 12% to 77% (median: 56%)." Weinforth, et al., "Quality of Life Following Male-To-Female Sex Reassignment Surgery," 253.

[985] This was the reported lost to follow-up rate among their clinical cohort.

that <5% loss leads to little bias, while >20% poses serious threats to validity," it would seem that the only sensible conclusion one can arrive at is that *the evidence-base for transition-related outcome research has been seriously compromised by the remarkably high lost to follow-up rates that have characterized this field for decades*.[986]

It is this type of consideration that led Jesse Singal to remark:

> Any study of regret that doesn't attempt to track down patients who are *not* currently in contact with their clinicians risks undershooting the mark (though contacting such lost-to-follow-up patients is, to be fair, a difficult task for researchers to pull off).[987]

The fact that the field of transition studies does not, generally speaking, seem seriously concerned about this data problem is itself concerning. For example, in referring to their lost to follow-up rate of 64%, McNichols, et al. (2020) state: "We had an acceptable response rate of 36%."[988] One is forced to ask the question: If a 64% lost to follow-up rate is "acceptable," just what would an "unacceptable" rate look like?

(8) Social desirability bias

Another methodological concern, one rarely mentioned specifically in the literature, is that of *social desirability bias*.[989] First, a few words about this specific type of bias. In a recent article, Bruce King unpacks the nature of social desirability bias and its potential effects upon sexuality-related studies today. He writes:

> Research in fields for which self-reported behaviors can be compared with factual data reveals that misreporting is pervasive and often extreme. The degree of misreporting is correlated with the level of social desirability, i.e., the need to respond in a culturally appropriate manner. People who are influenced by social desirability tend to over-report

[986] Dettori, "Loss to Follow-up."
[987] Singal, "How Science-Based Medicine Botched Its Coverage of the Youth Gender Medicine Debate."
[988] McNichols, et al., "Patient-reported Satisfaction and Quality of Life after Trans Male Gender Affirming Surgery."
[989] On the phenomenon of social desirability bias see: Jessica Den Haese and Bruce M. King, "Oral-Genital Contact and the Meaning of 'Had Sex': The Role of Social Desirability," *Archives of Sexual Behavior* 61/3 (2022), 1503-08; Cindy M. Meston, Julia R. Heiman, Paul D. Trapnell, and Delroy L. Paulhus. "Socially Desireable Responding and Sexuality Self-Reports," *Journal of Sex Research* 35/2 (1998), 148-57; Martin Seehuus, Amelia M. Stanton, and Ariel B. Handy, "On the Content of 'Real World' Sexual Fantasy: Results from an Analysis of 250,000+ Anonymous Text-Based Erotic Fantasies," *Archives of Sexual Behavior* 48/3 (2019), 725-37; P. S. Brenner and J. D. DeLamater, "Social Desirability Bias in Self-reports of Physical Activity: Is an Exercise Identity the Culprit?," *Social Indicators Research* 117/2 (2014), 489-504; Robert B. Larson, "Controlling Social Desirability Bias," *International Journal of Market Research* (October 14, 2018), https://doi.org/10.1177/1470785318805305.

> culturally desired behaviors and under-report undesired behaviors . . . . Among the general population, several studies have now reported that even with anonymous responding, there are significant correlations between a variety of self-reported sexual behaviors (e.g., use of condoms, sexual fantasies, exposure to pornography, penis size) and social desirability, with evidence that extreme under- or over-reporting is as common as is found in other fields.[990]

Some may surmise that anonymous, online survey methods – which are now quite common in social science research – curtail the expression of social desirability bias. In light of the data, however, King concludes otherwise:

> [R]ecent meta-analyses of web-based assessments indicate that social desirability responding was no less with computerized assessments than for paper-and-pencil surveys (Gnambs & Kaspar, 2017). In summary, although one can point to individual studies that claim web-based assessment decreases social desirability responding, the whole of these studies finds little to no effect.[991]

One transition outcome study that recognizes the potential problem of social desirability bias is Smith, et al. (2001), when, in reference to their own study, they remark:

> [A]lthough the posttreatment interviews were not conducted by the clinicians who had been involved in the treatment, the patients may still have emphasized the positive effects because of their belief that the examiner had a stake in the outcome by virtue of being associated with the same clinic.[992]

In other words, Smith, et al. are cognizant of the fact that people's reports of their own transition outcomes can be influenced by the perceived expectations of others – including their medical providers and those associated with them.

Why should we suspect that social desirability bias influences transition outcome research? The thesis can be simply stated in a series of propositions:

- Issues involving trans experience and identity have become highly charged, politically speaking, within the context of the culture war.
- This includes issues related to gender transition; e.g., the recent increase in legislative attempts to restrict medical transition procedures for young people.

[990] Bruce M. King, "The Influence of Social Desirability on Sexual Behavior Surveys: A Review," *Archives of Sexual Behavior* 51/3 (2022), 1495–1501.
[991] Ibid., 1497-98.
[992] Smith, et al., "Adolescents with Gender Identity Disorder," 480.

- In a polarized climate such as this, people within the trans community are likely to be highly attuned to dynamics that can influence cultural attitudes for or against trans-related concerns and medical care.
- One factor that can significantly influence cultural attitudes toward trans medical care involves conclusions drawn from academic studies of post-transition satisfaction and outcomes.
- It would not be surprising to find, then, that within the trans community it is socially desirable to offer positive satisfaction and outcome reports when queried by academic researchers, because of the potential community benefits that can come in the wake of such reports.
- Thus, there is reason to expect a form of social desirability bias at work within transition outcome studies.

Focused research, of course, would be required to corroborate such speculation.

(9) Additional methodological problems that likely influence contemporary transition outcome studies – with a focus on publication bias and the file drawer effect.

In light of other methodological concerns being addressed today within the wider fields of biomedical and psychological research[993] – and given the unusually intense politicization of sexuality-related research itself[994] – it would be not surprising to find that additional methodological problems are common within the field of transition-related medicine, including volunteer/respondent bias (e.g., participation bias, impression management, etc.) and error (e.g., misunderstanding of terminology, survey fatigue, random response or straightlining, etc.),[995]

[993] E.g., Richard Horton, "Offline: What is Medicine's 5 Sigma?," *The Lancet* 385/9976 (April 11, 2015), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60696-1/fulltext; Wiggins and Christopherson, "Replication Crisis in Psychology."
[994] J. Richard Udry, "The Politics of Research," *Journal of Sex Research* 30/2 (1993), 103-10; Bailey, "How to Ruin Sex Research"; Bruce Rind, "Sexual Science versus Progressive Advocacy: The Need for Resistance." *Archives of Sexual Behavior* 48/6 (2019), 1649-50; Qazi Rahman, "A Step in the Right Direction But We Must Resist Identity Politics," *Archives of Sexual Behavior* 48/6 (2019), 1637-38; Florence Ashley, "Science Has Always Been Ideological, You Just Don't See It," *Archives of Sexual Behavior* 48/6 (2019), 1655-57; Duarte, et al., "Political Diversity Will Improve Social Psychological Science."
[995] Bouchard, et al., "Sexuality and Personality Correlates of Willingness to Participate in Sex Research"; R. L. Boughner, "Volunteer Bias," in *Encyclopedia of Research Design*, ed. Neil J. Salkind (Thousand Oaks, CA: Sage,

selection bias,[996] publication bias,[997] questionable research practices (QRPs) including p-hacking (i.e., presenting a statistically insignificant result in a way that makes it appear significant) and HARKing (i.e., creating an hypothesis *after* the study has been done and the results have been obtained, but presenting it as if it had been formulated *in advance* of the study),[998] and various methodological challenges (and temptations) related to data cleaning, the presentation of statistics in light of data skew issues, etc.[999]

2010), 1609-09; Cimpian, "Classification Errors and Bias," 521; Samantha J. Dawson, Jackie S. Huberman, Katrina S. Bouchard, Meghan K. McInnis, Caroline F. Pukall, and Meredith L. Chivers, "Effects of Individual Difference Variables, Gender, and Exclusivity of Sexual Attraction on Volunteer Bias in Sexuality Research," *Archives of Sexual Behavior* 48/8 (2019), 2403-17; D. S. Strassberg and K. Lowe, "Volunteer Bias in Sexuality Research," *Archives of Sexual Behavior* 24/4 (1995), 369-82; T. A. Peterman, "Can We Get People to Participate in a Study of Sexual Behavior?," *Sexually Transmitted Diseases* 22/3 (1995), 164-68; C. M. Meston, J. R. Heiman, P. D. Trapnell, and D. L. Paulhus, "Socially Desirable Responding and Sexuality Self-Reports," *Journal of Sex Research* 35/2 (1998), 148-57; J. Suler, "The Online Disinhibition Effect," *Cyberpsychology & Behavior* 7/3 (2004), 321-26; S. R. Porter, M. E. Whitcomb, and W. H. Weitzer, "Multiple Surveys of Students and Survey Fatigue," *New Directions for Institutional Research* 121 (2004), 63-73; J. Henrich, S. J. Heine, and A. Norenzayan, "The Weirdest People in the World?," *Behavioral and Brain Sciences* 33/2–3 (2010), 61–83. A number of studies suggest that self-administered computerized surveys provide increased reporting accuracy compared to face-to-face interviews, presumably due to increased privacy and anonymity, etc. E.g., see D. C. Des Jarlais, D. Paone, J. Milliken, et al., "Audio-computer Interviewing to Measure Risk Behaviour for HIV among Injecting Drug Users: A Quasi-randomised Trial," *Lancet* 353 (1999), 1657–61. However, as Schroder, Carey, and Vanable point out, computerized assessment itself "may work as a normative cue and may bias responses," and may in fact "elicit over-reporting instead of higher accuracy." K. E. E. Schroder, M. P. Carey, and P. A. Vanable, "Methodological Challenges in Research on Sexual Risk Behavior: II. Accuracy of Self-reports," *Annals of Behavioral Medicine* 26/2 (2003), 104-23.

[996] On the concern of selection bias within a transition-related study, see Smith, et al. (2001), 479-80. More broadly, see Jonas H. Ellenberg, "Selection Bias in Observational and Experimental Studies," *Statistics in Medicine* 13/5-7 (1994), 557-67.

[997] On publication bias see Annie Franco, Neil Malhotra, and Gabor Simonovits, "Publication Bias in the Social Sciences: Unlocking the File Drawer," *Science* 345 (2014), 1502-05; Anne M. Scheel, Mitchell R. M. J. Schijen, and Daniël Lakens, "An Excess of Positive Results: Comparing the Standard Psychology Literature with Registered Reports," *Advances in Methods and Practices in Psychological Science* 4/2 (2021), 1-12. https://doi-org.ezproxy.bethel.edu/10.1177/25152459211007467; Gregory Francis, "Too Good to be True: Publication Bias in Two Prominent Studies from Experimental Psychology," *Psychonomic Bulletin and Review* 19/2 (2012), 151-56.

[998] On QRPs, see Peter Holtz, "Two Questions to Foster Critical Thinking in the Field of Psychology: Are There Any Reasons to Expect a Different Outcome, and What are the Consequences if We Don't Find What We are Looking For?," *Metapsychology* 4 (2020), 1–13; Leslie K. John, George Loewenstein, and Drazen Prelec, "Measuring the Prevalence of Questionable Research Practices with Incentives for Truth Telling," *Psychological Science* 23/5 (2012), 524-32; L. Jussim, J. T. Crawford, S. M. Anglin, S. T. Stevens, and J. L. Duarte, "Interpretations and Methods: Towards a More Effectively Self-correcting Social Psychology," *Journal of Experimental Social Psychology* 66 (2016), 116–33; J. P. Simmons, L. D. Nelson, and U. Simonsohn, "False-Positive Psychology: Undisclosed Flexibility in Data Collection and Analysis Allows Presenting Anything as Significant," *Psychological Science* 22/11 (2011), 1359-66; Daniele Fanelli, "How Many Scientists Fabricate and Falsify Research? A Systematic Review and Meta-analysis of Survey Data," *PLoS One* 4/5 (2009), e5738, https://doi.org/10.1371/journal.pone.0005738.

[999] J. Van den Broeck, S. A. Cunningham, R. Eeckels, and K. Herbst, "Data Cleaning: Detecting, Diagnosing, and Editing Data Abnormalities," *PLoS Medicine* 2/10 (2005), e267, https://doi.org/10.1371/journal.pmed.0020267; Ana Gonzalez-Blanks, Jessie m. Bridgewater, and Tuppett M. Yates, "Statistical Approaches for Highly Skewed Data: Evaluating Relations between Maltreatment and Young Adults' Non-Suicidal Self-injury," *Journal of Clinical Child and Adolescent Psychology* 49/2 (2020), 147-61.

To reflect for a moment on just one of these potential methodological areas of concern – that of *publication bias and the file draw effect*. To fully understand this potential problem within sexuality/gender research, we must begin with a bit of context. There is no doubt that scientific findings can have significant political impact upon people's actual lives. Today's "scientific discovery" quickly becomes tomorrow's headline broadcast around the world in popular media – and then becomes next year's evidential basis for public policy decisions. All of this is true. And, as John Sakaluk has rightly observed: "[S]exual science is one of the more – if not *the* most – politicized areas of research."[1000] Nonetheless, if scientific inquiry into human sexuality is to remain anything more than an academic veneer for political propaganda, this politicization of scientific research must be seriously confronted.

The solution, conceptually at least, seems simple. Scientists will naturally have their own personal worldview persuasions and political commitments, like all human beings. But the very foundations of modern science were built upon the conviction that personal human biases must be collectively recognized and methodologically controlled to a sufficient degree for science to progress. Now, it only takes an afternoon of reading in any history of the philosophy of science textbook to realize that the early – and, in many contexts, ongoing – framing of science as a value-free, "objective" endeavor was, and is, a myth.[1001] And yet, there is a wide gulf between recognizing the persistent presence of personal and cultural biases within scientific research, on one hand, and, on the other, willingly subjecting the scientific enterprise to the dictums and dictates of particular political agendas.

When the ideological convictions and political allegiances of scientists trump their commitment to strive (always asymptotically of course) for personally disinterested empirical results, then the

[1000] John Kitchener Sakaluk, "Promoting Replicable Sexual Science: A Methodological Review and Call for Metascience," *Canadian Journal of Human Sexuality* 25/1 (2016), 1-8 (here p. 2), doi: 10.3138/cjhs.251-CO1.
[1001] Key works here include Kuhn, *Structure of Scientific Revolutions*; Paul Feyerabend, *Against Method: Outline of an Anarchistic Theory of Knowledge*, 4th ed. (London: Verso, 2010 [1975]); Imre Lakatos, *The Methodology of Scientific Research Programmes*; *Philosophical Papers*: Volume 1; eds. J. Worrall and G. Currie (New York: Cambridge University Press, 1978). On the unavoidability of values-driven science, see K. C. Elliott, *A Tapestry of Values: An Introduction to Values in Science* (New York: Oxford University Press, 2017).

scientific enterprise has come to an end.[1002] And worse – it comes to an end while appearing to the surrounding public as if it is doing just fine. There are an incredible number of ways of fudging the science – intentionally or subconsciously – while making it look solid from the outside. This is especially true in the social-psychological sciences, where the human factor(s) can be easily manipulated. Among the potential problem areas involved are sample problems (i.e., small sample sizes, convenience sampling, sample selection bias), participant problems (i.e., volunteer bias, social desirability and "good subject" biases), and – the issue we are about to consider here – *publication and dissemination bias*.[1003]

These sorts of research biases and other replication and reliability problems have intensified the call for robustly "evidence-based" research and have triggered warnings throughout the scientific community. For example, Richard Horton, Editor-in-Chief of the renowned medical journal, *The Lancet*, writes of

> one of the most sensitive issues in science today: the idea that something has gone fundamentally wrong with one of our greatest human creations. The case against science is straightforward: much of the scientific literature, perhaps half, may simply be untrue. Afflicted by studies with small sample sizes, tiny effects, invalid exploratory analyses, and flagrant conflicts of interest, together with an obsession for pursuing fashionable trends of dubious importance, science has taken a turn towards darkness. As one [person] put it, "poor methods get results."[1004]

Horton continues:

> The Academy of Medical Sciences, Medical Research Council, and Biotechnology and Biological Sciences Research Council have now put their reputational weight behind an

[1002] Larry E. Beutler and T. Mark Harwood, "Antiscientific Attitudes: What Happens When Scientists are Unscientific?," *Journal of Clinical Psychology* 57/1 (2001), 43-51; Bernard Barber, "Resistance by Scientists to Scientific Discovery," *Science* 134/3479 (1961), 596-602.

[1003] A. Plüddemann, A. Banerjee, and J. O'Sullivan, "Positive Results Bias," *Catalogue Of Biases* (2017). https://www.catalogueofbiases.org/biases/positive-results-bias. For helpful studies on publication and dissemination bias over the last several decades (beyond the sources cited above), see Kay Dickersin, "The Existence of Publication Bias and Risk Factors for Its Occurrence," *Journal of the American Medical Association* 263/10 (1990), 1385-89; P. J. Easterbrook, R. Gopalan, J. A. Berlin, and D. R. Matthews, "Publication Bias in Clinical Research," *The Lancet* 337/8746 (April 1991), 867-72; F. Song, S. Parekh, L. Hooper, Y. K. Loke, J. Ryder, A. J. Sutton, et al., "Dissemination and Publication of Research Findings: An Updated Review of Related Biases," *Health Technology Assessment* 14/8 (2010), ix-xi, 1-193. doi: 10.3310/hta14080; K. Dwan, C. Gamble, P. R. Williamson, and J. J. Kirkham, "Systematic Review of the Empirical Evidence of Study Publication Bias and Outcome Reporting Bias: An Updated Review," *PLoS One* 8/7 (2013), e66844. doi: 10.1371/journal.pone.0066844; A. A. Ayorinde, I. Williams, R. Mannion, F. Song, M. Skrybant, R. J. Lilford, and Y-F Chen, "Publication and Related Biases in Health Services Research: A Systematic Review of Empirical Evidence," *BMC: Medical Research Methodology* 20/137 (2020), https://doi.org/10.1186/s12874-020-01010-1.

[1004] Horton, "Offline: What is Medicine's 5 Sigma?"

> investigation into these questionable research practices. The apparent endemicity of bad research behaviour is alarming. In their quest for telling a compelling story, scientists too often sculpt data to fit their preferred theory of the world. Or they retrofit hypotheses to fit their data.[1005]

These broad scientific concerns lead to particular foci in specific disciplines. For example, what has come to be known as *the "replication" or "reproducibility" crisis* within the psychological sciences has forced discipline-wide attention on the fact that, all too often, studies in the sub-fields of psychology – including various areas of sexuality and gender research – have published results that, in light of follow-up investigations, are shown to *not be reproducible*. This is a significant problem for any field of science, given that reproducibility is a quintessential hallmark of the scientific method. Brian Resnick succinctly summarizes the essence of the replication crisis:

> About a decade ago [i.e., 2011-2012], many scientists realized that their standard research methods were delivering them false, unreliable results. When many famous and textbook psychological studies were retested with more rigorous methods, many failed. Other results simply looked less impressive upon reinspection. It's possible around 50 percent of the published psychological literature fails upon retesting, but no one knows precisely the extent of the instability in the foundations of psychological science. The realization provoked a painful period of introspection and revision.[1006]

In regard to sexual/gender research in particular, no one has been more forceful in recent years about the need for a field-wide wake-up call to these problems than John Sakaluk. In a 2016 article, Sakaluk observes that, whereas the wider discipline of psychological science has started to seriously face the challenges of the replication crisis:

> [s]exual scientists, however, with few exceptions, have yet to formally participate in the published discourses about replicability . . . . [R]eplicability is important for science in general, . . . [but] sexual science could be uniquely and negatively impacted without more direct involvement in the replicability movement from those within our field.[1007]

More recently, in a 2020 article, Sakaluk explains the tenacity of disciplinary inertia and maintenance of the status quo, and the profound challenges that lie ahead for the sexual science –

[1005] Ibid.
[1006] Brian Resnick, "The Replication Crisis Devastated Psychology: This Group is Looking to Rebuild It," *Vox* (April 7, 2021), https://www.vox.com/science-and-health/22360363/replication-crisis-psychological-science-accelerator.
[1007] Sakaluk, "Promoting Replicable Sexual Science," 1.

individually, collectively, and structurally – if these problems are to truly be addressed: "The combined individual and structural forces against admitting mistakes and/or weak evidence and correcting it is therefore tremendous." The replicability problem in sexual science – including the methods and practices that feed it – is "a problem we have delayed grappling with, and which will require specific, actionable, systems-level interventions at journals alongside grassroots changes in practices used among researchers."[1008] And while, thus far, few sexual science researchers are taking up these matters as seriously as Sakaluk, he is not alone.[1009] It is in the spirit of taking these sorts of issues seriously that the following reflections on publication bias are offered.

Publication and dissemination bias – or positive results bias – has often been referred to as the "file drawer effect."[1010] This refers to the fact that any time researchers conduct a study whose results they don't appreciate, they can simply toss the study in their file drawer, lock it, and forget about it. So, the problem is simple and understandable: "Authors do not write up and submit null findings."[1011] Refusing to publish negative or null findings in any particular field of research can significantly distort that field's database: "The selective publication of positive or significant results against negative or nonsignificant results is so distressing because it can distort a picture of gathered evidence."[1012] Dickerin and Min explain:

> Conclusions about the efficacy and safety of medical interventions are based on data presented in the scientific literature. The validity of these conclusions is threatened if publication bias results from investigators or editors making decisions about publishing study results on the basis of the direction or strength of the study findings.[1013]

[1008] John Kitchener Sakaluk, "Getting Serious About the Assessment and Promotion of Replicable Sexual Science: A Commentary on Wisman and Shrira (2020) and Lorenz (2020)," *Archives of Sexual Behavior* 49 (2020), 2743-54 (here p. 2749).
[1009] E.g., Tierney K. Lorenz, "Reproducibility and Registration in Sexuality Research," *Archives of Sexual Behavior* 49/2 (2020), 367-72.
[1010] For one of the early studies, see Robert Rosenthal, "The File Drawer Problem and Tolerance for Null Results," *Psychological Bulletin* 86/3 (1979), 638–41.
[1011] Annie Franco, Neil Malhotra, and Gabor Simonovits, "Publication Bias in the Social Sciences: Unlocking the File Drawer," *Science* 345 (2014), 1502-05 (here p. 1502). See also G. Praveen, A. Anitha, and M. Ramesh, "Negating the Negativity: Spotlight on 'File Drawer Effect' in Health Care Research," *Journal of Indian Association of Public Health Dentistry* 14/2 (2016), 243.
[1012] Praveen, Anitha, and Ramesh, "Negating the Negativity: Spotlight on 'File Drawer Effect' in Health Care Research," 243.
[1013] Dickersin, K., and Y. I. Min. "Publication Bias: The Problem that Won't Go Away." *Annals of the New York Academy of Sciences* 31/703 (1993), 135-46.

The file drawer effect, then, is a form of *data suppression* – an activity that has regularly been categorized as a form of *academic fraud*.[1014] Obviously, publication bias and the file drawer effect also taint results of one of the most respected methods of scientific research: the meta-analysis.[1015] One research team has dubbed this problem of publication bias that promotes a field of "unrepresentative literature" the "Chrysalis Effect."[1016]

But just how serious is the file drawer effect? Robert Rosenthal asked this question in one of the stage-setting studies of this methodological problem.[1017] Rosenthal concludes that it is likely that for every published study on a given topic, there are 19 additional studies – studies that delivered unfavorable results – that never see the light of day.

Incidences of publication bias and the file drawer effect will naturally be exacerbated in highly politicized areas of research – e.g., *sexuality and gender research, including transition outcome studies*. To take just one example from a different area of sexuality research: Both Geoffrey Ream and Lisa Diamond have pointed out that pro LGBTQ+ researchers have been reluctant to seriously investigate the efficacy of sexual orientation change efforts (SOCE) because of concerns about what conservatives would do with the findings.[1018] No doubt there have been conservatives who are just as concerned about what liberals would do if the results broke in favor of their political agendas. In either case, fear of the potential political implications of certain

[1014] On data suppression, see Brian Martin, "Suppressing Research Data: Methods, Context, Accountability, and Responses," *Accountability in Research* 6/4 (1999), 333-72; James S. Coleman, "On Self-Suppression," in *Fraud and Fallible Judgement: Deception in the Social and Behavioural Sciences*; reprint ed.; eds. N. J. Pallone and J. J. Hennessey (New York: Routledge, 2017 [1995]), pp. 87-94; K. F. Schaffner, "Ethics and the Nature of Empirical Science," in *Research Fraud in the Behavioral and Medical Sciences*, eds. D. J. Miller and M. Hersen (New York: Wiley, 1992).

[1015] Praveen, Anitha, and Ramesh, "Negating the Negativity: Spotlight on 'File Drawer Effect' in Health Care Research": J. A. Sterne, D. Gavaghan, and M. Egger, "Publication and Related Bias in Meta-analysis," *Journal of Clinical Epidemiology 53/11 (*2000), 1119–29; Alison Thornton and Peter Lee, **"**Publication Bias in Meta-analysis: Its Causes and Consequences," *Journal of Clinical Epidemiology* 53/2 (2000), 207-16.

[1016] Ernest Hugh O'Boyle Jr., George Christopher Banks, and Erik Gonzalez-Mulé, "The Chrysalis Effect: How Ugly Initial Results Metamorphosize into Beautiful Articles," *Journal of Management* 43/2 (2017), 376-99.

[1017] Rosenthal, "The File Drawer Problem and Tolerance for Null Results."

[1018] Geoffrey L. Ream, "Concepts of Sexual Orientation and Gender Identity," in *Violence Against LGBTQ+ Persons: Research, Practice and Advocacy*, eds. E. M. Lund, C. Burgess, and A. J. Johnson (New York: Springer Nature, 2021), 5-23 (here p. 8); Lisa M. Diamond and Clifford J. Rosky, "Scrutinizing Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities," *Journal of Sex Research* 53/4-5 (2016), 363-91.

study results can lead to publication bias or even what we can call *research avoidance bias*, another form of data suppression.

The challenge of identifying publication bias in any given field is, of course, that the evidence itself, by definition, is generally hidden from detection. Again, highly politicized areas of research, such as sexuality and gender studies, are especially prone to the problem. And these fields are rendered even more vulnerable when political concerns are intensified, as they often are, by *explicitly ethical considerations* – again, precisely the situation that the field of transition outcome studies finds itself in.[1019]

Cecelia Dhejne offers us a rare example of a researcher letting us in on her own inner wrestling with the temptation of the file drawer. As mentioned above, in her 2017 dissertation, Dhejne reflects on the fact that one of her previous studies had been used by conservative cultural commentators to call into question the efficacy of medical transition in the treatment of gender dysphoria.[1020] She writes:

> One could argue that the results should never have been published due to the hurt caused to transgender persons. However, not publishing the results would also hurt the transgender group and take away an opportunity to receive better health care.[1021]

It turns out that, in this case, Dhejne decided to risk publishing results that could be used by others in ways she deemed inappropriate, even unethical. But the motivations that fuel the file drawer effect do not stop with ethics. There are other very pragmatic and personal concerns, including: one's reputation in the academic field and within the sexual/gender minority community that one is devoted to studying, the risk to one's future ability to be hired for a position or to have one's research and writing funded and/or chosen for publication, etc.

[1019] See e.g., the recent editorial: "Science Must Respect the Dignity and Rights of All Humans," *Nature Human Behavior* 6 (2022), 1029-31; and Jesse Singal's critical reflections upon it in "It Is Bad to Alter or Retract Published Research That Has No Factual Errors, Even If You are Doing It "For Social Justice": You want MORE injection of political values in science?," jessesingal.substack.com (August 29, 2022), https://jessesingal.substack.com/p/it-is-bad-to-alter-or-retract-published?utm_source=email.
[1020] E.g., Anderson, "Sex Reassignment Doesn't Work. Here Is the Evidence."
[1021] Dhejne, "On Gender Dysphoria," 65.

It is important to note that the temptations of publication bias and data suppression do not fall upon researchers alone. Journal editors and referees are also susceptible. One can only imagine this is increasingly the case in the wake of several recent trans-related journal articles that have caused significant socio-political fall-out – leading to massive public outcries, countless Letters to the Editor, open letters of protest with hundreds of signatories, independent party reviews, official correction statements, and even publication retractions.[1022] Naturally, no journal editor wants to find themselves and their journal embroiled in a similar academic fiasco. Unfortunately, however, the very understandable desire to avoid becoming the centerpiece of a political fracas can easily lead to editorial decisions amounting to publication bias and data suppression.

To put the matter as it relates to transition outcome studies simply: In today's socio-political climate, including within the academic fields of sexuality and gender research, *there are few up-sides, and many down-sides – whether as a researcher or a journal editor – to publishing research findings that serve to support higher-than-expected transition regret or detransition rates*. Recognizing this fact, alone, raises the likelihood that publication bias and the file drawer effect are alive and well within the field of transition outcome studies today, and that they are potentially contributing to *an under-estimation of the actual regret and detransition rates*.

Although, by the nature of the case, we cannot know to what degree publication bias and the file drawer effect are influencing current transition-related outcome studies and regret/detransition rates, we do have an idea of what can help better safe-guard the field from these potential problems. One antidote seems clear: *Preregistration*. Brian Nosek – co-founder and director of the Center for Open Science and co-founder of the Society for the Improvement of Psychological Science – and colleagues have argued for the need for a "preregistration revolution" as part of the necessary response to the replication crisis. They describe the nature and benefits of preregistration:

[1022] For three examples of trans-related studies that caused a heated response and eventual intervention on the part of the publishing journal , see Lisa Littman, "Correction: Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," *PLoS One* 14(3): e0214157. https://doi.org/10.1371/journal.pone.0214157; Rebecca Tuvel, "In Defense of Transracialism," *Hypatia* 32 (2017), 263-78; Bränström and Pachankis, "Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study."

> Progress in science relies in part on generating hypotheses with existing observations and testing hypotheses with new observations. This distinction between postdiction and prediction is appreciated conceptually but is not respected in practice. Mistaking generation of postdictions with testing of predictions reduces the credibility of research findings. However, ordinary biases in human reasoning, such as hindsight bias, make it hard to avoid this mistake. An effective solution is to define the research questions and analysis plan before observing the research outcomes—a process called preregistration. Preregistration distinguishes analyses and outcomes that result from predictions from those that result from postdictions.[1023]

In simpler terms: "At the level of the scientific community, preregistration is an antidote against publication bias."[1024] If preregistration were to become the standard in sexuality and gender research – including transition outcome research – this would mean that every preregistered transition outcome study would make a public record of its existence, its hypotheses, and its methodology and protocols before beginning the research phase. Among other things, this would enable field-wide tracking of studies that were (potentially) conducted but whose findings were never published – a first step in *unlocking the file drawer*. Preregistration is increasingly being called for throughout the wider scientific community in general and within the psychological sciences specifically.[1025] It is also beginning to be called for within the fields of sexuality/gender research.[1026] Preregistration offers one concrete example of the types of discipline-wide methodological adjustments that could be made in order to foster increasing confidence in future sexuality/gender research – and, with it, future transition outcome, transition regret, and detransition studies.

[1023] Brian A. Nosek, Charles R. Ebersoleb, Alexander C. DeHavena, and David T. Mellora. "The Preregistration Revolution," *Proceedings of the National Academy of Sciences of the United States of America* 115/11 (2018), 2600-06 (here p. 2600).
[1024] "Preregistration," *Open Science*, https://www.kuleuven.be/open-science/what-is-open-science/responsible_research_and_innovation/reproducibility/preregistration/preregistration.
[1025] E.g., Horton, "Offline: What is Medicine's 5 Sigma?"; Thornton and Lee, **"**Publication Bias in Meta-analysis"; Manikya Alister, Raine Vickers-Jones, David K. Sewell, and Timothy Ballard, "How Do We Choose Our Giants? Perceptions of Replicability in Psychological Science," *Advances in Methods and Practices in Psychological Science* 4/2 (2021), 1–21 (see p. 2); Alison Ledgerwood, "The Preregistration Revolution Needs to Distinguish between Predictions and Analyses," *Proceedings of the National Academy of Sciences* 115/45 (2018), e10516-e10517.
[1026] E.g., Lorenz, "Reproducibility and Registration in Sexuality Research."