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

The number of people presenting at ~~g~~Gender-Identity ~~c~~Clinics is increasing worldwide. Many people undergo a gender transition with subsequent improved psychological wellbeing (de Vries et al., 2014; ~~Smith, et al., 2005~~). However, some people choose to stop this journey, ‘desisters’, or to reverse their transition, ‘detransitioners’. It has been suggested that ~~there has been reluctance by~~ some professionals and activists ~~are reluctant~~ to acknowledge the existence of desisters and detransitioners, possibly ~~from a fearing~~ that they may delegitimise persisters’ experiences (Zucker, 2018). Certainly, despite their presence in all follow-up studies of young people who have experienced Gender Dysphoria (GD) (~~Steensma, et al., 2011~~), little thought has been given to how we might support this cohort. Levine (2017) reports that the 8th edition of the WPATH Standards of Care (~~Coleman et al., 2012~~) will include a section on detransitioning - ~~confirms~~suggesting that this is an increasingly witnessed phenomenon worldwide. It also highlights that compared to the extensive protocols for working with children, adolescents and adults who wish to transition, nothing ~~has been proposed exists~~ for ~~those people~~ working with ~~those who wish to desisters~~ or detransitioners; ~~yet to desist or detransition is a process that is at least as complex and in need of support~~. With very little research and no clear guidance on how to work with ~~this population~~ ~~ose who halt their transition~~, and with numbers of referrals to gender services increasing, this is a timely juncture to consider factors that should be taken into account within clinical settings; and areas for future research.

Key words: Gender identity, gender dysphoria, therapy

Prevalence of desisters/detransitioners

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

Theories of desistence/detransitioning

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

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found desisters have lower intensity GD, less cross-gendered behaviour, lower age at assessment and higher social class.

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

Problems with the existing research

There are higher levels of desistance reported prior to the year 2000. Ristori & Steensma (2016)

highlight that prior to 1980 (DSM-III) there was no diagnostic criteria for childhood GD and so children with gender non-confirming behaviour but who did not have GD might have been included in studies.

Similarly, studies post-2000 tend to be with clinical samples where GD is clearly established.

The adult literature is likely to have a sampling bias: those who are unhappy about their transition may be less likely to take part, and some of those who persist may relocate and so be lost to follow up. With high rates of drop out, follow-up studies often have low numbers making conclusions difficult (Dhejne et al, 2014). In addition, most follow-up studies are conducted within a year, whereas Dhejne et al. (2014) found an

average of 8 years before regret operationalized. If changes to the patient cohort over the past decade impact on regret rates, we may not have seen this yet.

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

1. An exponential increase in the numbers of children and adolescents seeking help for gender related distress.
2. [A significant increased in patients](#) assigned female at birth
3. More young people reject gender binaries altogether and present in 'fluid' or 'non-binary' ways ([Zucker, 2018](#)).
4. More young people are attending gender services having already 'socially transitioned', [i.e.](#) already living, at least in part, in their preferred gender role ([Zucker, 2018](#)).
5. More adolescents are presenting to clinics with [GD](#) that developed in puberty and not before (Kaitiala-Heino et al., 2015).

[Additionally](#), many of the current young cohort present with co-existing complexities, including psychiatric problems

and Autistic spectrum disorders ([Ristori & Steensma,](#)

[2016](#)). Sexual identity also intersects with gender identity:

most children who desist go on to identify as cisgendered and lesbian or gay in adolescence or adulthood (Ristori & Steensma, 2016). Interestingly, Steensma et al. (2011) reported that 100% of persisters were same-sex attracted but rather than consider themselves homosexual, this confirmed to them that they must be the

opposite sex than that assigned at birth and therefore heterosexual; the desisters did not consider their same-sex attraction a factor in gender identity.

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

Clinical implications

Not all of those who desist or detransition need help or support.

Some may experience their changing identifications as part of a healthy developmental process of exploration and creativity.

Nonetheless, some will also feel distress either in relation to their gendered identity

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also feel distress either in relation to their gendered identity (Steensma et al., 2011) or specifically in response to the interventions they received when transitioning (Levine, 2017).

As with all work in GD, the primary aim should be to reduce distress. Clinicians need experience in working with complex presentations and political and social

awareness of the psychosocial issues connected to gender diversity. It is useful

to view gender identity and expression as fluid to maintain

a non-pathologizing, non-judgement stance towards a wide range of gender expression, and to accept that some people may change their gender expression and/or

identity multiple times. Similarly, an open and accepting position on sexual identity that may also be **fluid** is **crucial**. Finally, attention to clients' contexts is essential in terms of family, friends, communities and institutions and whether these have accepted the person's gender presentation.

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

Conclusion

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

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Ethical information

No ethical approval was required for this article.

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