MEDICAL EXAMINER

What It *Actually* Means to Listen to Detransitioners

A pair of new studies from York University show how varied the experience can be.

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For most people, a gender transition is permanent. While the specific needs of individual trans people are diverse, changes to our appearance and/or bodies bring us into better harmony with how we want to be seen, and how we see ourselves. To reverse a transition would be incredibly unpleasant.

There are exceptions to this, as there are always exceptions to anything. In the media, particularly the right-wing press, stories from people who transitioned and then later shifted course have been shared widely. A small number of detransition activists have been testifying at statehouses across the country; this week they were in Ohio. The stories of detransition that they tell involve expressions of intense regret. They do not represent a common experience among trans people. But they have had a significant impact on policy decisions, particularly in states controlled by the Republican Party. These policies have been devastatingly restrictive to trans people seeking care, options, and autonomy over their bodies.

"Listen to detransitioners" has been a frequent refrain from both the right and segments of the left that are highly skeptical of health care that helps people transition. The best-faith interpretation of this refrain is that *everyone's* lived experience ought to be taken into account—that's how we give people who say they want to change genders the best possible shot at thriving.

OK. Let's take "listen to detransitioners" seriously. We certainly hear a lot from a small group of people who followed their detransition by flying from state to state in support of anti-trans laws. What about the rest?

Two recent papers from York University, from a team led by assistant professor Kinnon MacKinnon, offer a wider sampling. MacKinnon and his team interviewed 28 detransitioners who told them complicated stories of identity evolution, medical complications, and experiences with anti-trans and anti-nonbinary discrimination. Taken together, they suggest ways providers and society as a whole could better support trans,

nonbinary, and gender-nonconforming people. Spoiler: It's not by banning care.

Published in PLOS One on Nov. 29, the first paper sought to "qualitatively explore the care experiences and perspectives of individuals who discontinued or reversed their gender transitions." The second, published in Psychology of Sexual Orientation and Gender Diversity on Nov. 30, took those qualitative findings and attempted to demarcate four discrete subtypes or pathways for detransition.

Of 28 interviewees who answered a call for people in Canada who had shifted or discontinued a transition, 10 were at birth assigned male, and 18 female. They all had negative experiences during their initial transition. But most did not follow the typical sequence that widely shared detransitioner stories follow, of switching genders, then switching back to identifying as cis. A clear majority, 60 percent, had shifted from a binary trans identity when they began transitioning into a nonbinary identity at the time of the interview. By contrast, only six identified as female or a woman, and none identified as male or a man.

Crucially, the study reported that "a majority of participants reported satisfaction, and no decisional regret, with gender-affirming hormones/surgeries." That is: Though the participants had stopped or reversed the transition process, most felt that it was a path that had been worth exploring. Some were happy with the changes they had made but wished to stop making more, and to discontinue medications.

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So, why had the participants decided to detransition? The second paper described participants as falling into four discrete subcategories. One pathway through detransition, which the paper notes was found only among transfeminine interviewees, involved bowing to external pressures like family rejection or employment discrimination. These

participants detransitioned under duress, and then later resumed their transition in safer circumstances. This echoes a finding in the 2015 U.S. Transgender Survey, which found that about 13 percent of respondents had undergone a temporary detransition followed by a retransition; most of those respondents said discrimination was a factor.

The other three types of detransition were: a binary gender transition leading to a "nonbinary detransition"; a person's identity evolving after they stopped hormone therapy for other reasons (such as health concerns); and a person developing a detransitioner identity after seeking out detransition-focused content and online detransition communities.

Detransition, Mackinnon's work shows, can be incredibly nuanced—and taking it seriously can lead us into a world that's *more* gender diverse, not less. Take those in the "nonbinary detransition" category. They hadn't stopped transitioning altogether, they just approached the concept differently than they did before. Some of these detransitioners had felt pressured by society or medical providers to undertake a binary medical transition, rather than going down a nonbinary transition from the start, making changes to their body and appearance that aligned with an internal conception of who they were versus trying to fit into one gender ideal or another. This suggests that if nonbinary identities were more respected, it might significantly reduce the pressure some folks seem to feel to medically transition in a more rigid way for the sake of making others more comfortable with their appearance.

Most notably, participants *wanted* gender-affirming treatments to be available. They did not think that their experience should mean that no one can transition, or even that transition should be blocked by significant hurdles, like talk therapy that aims to avoid transition. They had one main suggestion for how gender-affirming care could be improved: They wanted to see longer, more detailed discussions with providers that happen prior to starting a new medication or undertaking surgery. They also wanted for providers to be more responsive to individual goals or fears about transition.

While the majority of participants in this study did not experience regret or dissatisfaction with treatment, a significant minority—12 of 28—did. Limiting regret as much as possible is a worthy goal for any kind of medical treatment, but it should not come at the expense of making a life-changing treatment accessible. These new papers suggest it does not have to.

Opening up more space for patients and providers to talk openly and honestly could improve care for everyone involved.

The bitter, regret-fueled advocacy of a few committed activists who want to end health care for others because it didn't work for them has left many in the trans community reluctant to accept that there are things that can be learned from detransitioners. But if sensible suggestions about more individualized care for all is what comes out of actually listening to detransitioners, perhaps we should listen to them a lot more often.