

BRIEFINGS ON TRANS HEALTHCARE

EVIDENCE BRIEF: DETRANSITION

2024



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Background

Sometimes, trans people may later re-identify with their birth-registered sex, and no longer identify as trans. This is often referred to as “detransition” or “desistance.” The phenomenon of re-identification is becoming increasingly utilised by those who advocate against the provision of gender-affirming healthcare. It is an area of gender-affirming healthcare provision that is particularly prone to misinformation and sensationalism.^{1,2} The existence of re-identification is often used as supposed evidence that gender-affirming healthcare—particularly hormone therapy and surgery—have become too widespread and easy to access.

“Detransition” and “desistance” while frequently used in older literature are poorly and inconsistently defined. Some studies define it as anyone who decides to stop receiving gender-affirming healthcare, even if they still identify as trans.^{1,2} Some classify it as anyone who changes their mind about gender-affirming surgery, regardless of their gender identity.² Others still equate it with regret; however, a person who regrets aspects of their care may still identify as trans, those who stop their gender-affirming care may not experience regret, and those who re-identify with their birth-registered sex may not regret having received gender-affirming care.³ We prefer terminology of re-identification with birth-registered sex, which is defined as including “people who have discontinued a trans identity, regardless of what (if any) social or legal changes or medical or surgical treatments have been accessed during transition.”^{4(p447)} Re-identification thus does not include anyone who still identifies as trans, even if they have stopped gender-affirming treatment.⁴

Much of the research on re-identification, particularly older research, is highly flawed and not scientifically sound.^{1-3,5,6} Because “detransition” and “desistance” are so poorly and inconsistently defined, they are also poorly and inconsistently measured. Older research on “detransition” focused on feminine expression in children assigned male at birth, who did not identify as trans, with the implicit or explicit objective of “preventing homosexuality and transsexualism.”^{5(p213)} In both the older and newer studies on “detransition,” many of the participants included in these pieces of research would not meet the current criteria for a gender dysphoria diagnosis, and did not even meet the (now outdated) criteria in use at the time; other studies recruited participants from anti-trans websites, which would have an impact on the sample studied.^{2,3,5} Additionally, research has been criticised for how “desisters” have

been identified; there are multiple studies in which people who were unable to be contacted by researchers for follow-up were automatically presumed to be “desisters,” and people who later identify as non-binary have been classified as “desisting.”⁵ When those seeking to restrict access to gender-affirming care report high rates of re-identification, it is based on this poor-quality research which grossly over-estimated the rates of re-identification, and has been widely criticised and refuted.^{1,5}

Current research illustrates that rates of re-identification are, in actuality, incredibly low. While differences in definition and measurement still exist, the current research indicates that approximately 2-10% of people re-identify with their birth-registered sex, and that of those, only a smaller subset had ever started to medically transition.^{4,7-11} Qualitative research with adults shows that for those who have stopped or reversed gender-affirming treatments, many (67%) saw the such treatments as a helpful experience that was right for them at the time, and either had no regrets or positive feelings associated with past treatments.¹² Specific Australian research shows that only 5.3% of young people attending at a Western Australian clinic were discharged due to subsequently re-identified with their birth-registered sex, and of all young people who had begun gender-affirming hormone therapy, **only 1%** later re-identified with their birth-registered sex while enrolled at the clinic.⁴ This is an ongoing area of research in Australia, with several clinics planning to conduct similar audits of data.

Recommendations

- The rates of people re-identifying with their birth-registered sex are very low. Concerns about re-identification should not overshadow existing clinical care frameworks.
- Clinical practice in Australia includes ongoing discussions regarding treatment wishes and identity development. Re-identification is neither encouraged nor discouraged, with the goal that people can discuss any changing needs in a non-judgemental environment.
- Young people and their carers should be supported to embrace acceptance, regardless of whether or not a young person’s gender identity remains stable or continues to evolve.
- Clinicians should continue to support and affirm patients regardless of how a patient’s identity or treatment wishes may evolve and change over time.

What does the Cass Review say?

The Cass Review expresses concern about people “detransitioning,” asserting that although in the UK rates of people who access gender-affirming hormone therapy and subsequently “detransition” are unknown, “there is suggestion that numbers are increasing.”^{13(p33)} However, the Cass Review’s own audit data of over 3,000 patient records indicates a “detransition” rate of 0.3%.³ As for the suggestion that numbers are increasing, the Cass Review fails to provide concrete evidence for this, relying instead on vague anecdotal claims. Additionally, the Cass Review raises concerns based on a similarly vague, unreferenced claim that “people experiencing regret may be hesitant to engage with the gender services that supported them through their initial transition.”^{13(p43)} The Cass Review thus recommends reviewing the services available to people who re-identify, to ensure they are fully supported. While it could be that people who re-identify do not return to their treating doctors, publicly provided services like those in the UK (and Australia) are already in the position for active case management to ensure that those who do not return to clinics for any reason are followed up.

The Cass Review overly focuses on the presence of additional health-related factors such as mental illness, neurodiversity, and past trauma in people who “detransition,” noting that the availability of audits containing such data “would be informative for clinicians assessing young people with a view to starting masculinising/feminising hormones.”^{13(p189)} This implies that such factors make people less able to make decisions about their needs, and require additional clinical oversight. Furthermore, the Cass Review emphasises internal reasons for “detransition” such as people’s mental health not improving, dysphoria being caused by trauma or abuse, and homophobia or difficulty accepting their sexuality as a reason for transition and subsequent “detransition.” Based on the discredited “desistence literature” discussed earlier, the Cass Review claims that “the current evidence base suggests that children who present with gender incongruence at a young age are most likely to desist before puberty, although for a small number the incongruence will persist.”^{13(p41)}

In response to the Cass Review

As discussed, Australian-specific research shows that for a paediatric clinic, rates of re-identification sat at 5.3%, or 1% of young people who had begun to medically transition.⁴ In Australia, people who disclose to healthcare providers re-identification and/or a desire to cease medical treatment receive follow-up care and ongoing mental health support that they may need.⁴

Many statements about “detransition” in the Cass Review are vaguely evidenced and rely on anecdotal evidence from clinicians. When designing and delivering policy and guidelines on gender-affirming healthcare, the practical expertise of clinicians who provide such care is invaluable. However, concerns have been raised about the Cass Review’s engagement with clinicians working in trans healthcare.^{3,14} The input of healthcare workers of varying backgrounds was sought, including from those who were not even clinicians.³ When surveyed, a substantial number of them stated their understanding of the topic came from public discourse and the media.³ A worrying 32% strongly agreed or agreed with the statement “there is no such thing as a trans child.”^{3,14} As a number of clinical experts have pointed out, “a guideline that solicits opinions from those who will not acknowledge the condition for which care is being sought should not be used.”^{3(p11)}

When the Cass Review does draw on research about “detransition,” it repeats findings from the poorly designed research discussed above. The Cass Review does briefly mention that those studies have faced criticism, but then claims later, more scientifically sound, research has echoed those earlier findings. However, the later research that the Cass Review draws on has, in fact, been heavily criticised for the same issues.⁵ For example, they included participants who would have never met criteria for a formal gender dysphoria diagnosis, and one study recruited participants from a clinic that, at the time, sought to “lower the odds” that patients would grow up to be trans.⁵ Therefore, statements in the Cass Review about the evidence suggesting that “children who present with gender incongruence at a young age are most likely to desist before puberty”^{13(p41)} are misleading. In actuality, methodologically sound research on young people’s identity over time shows that pre-pubertal children who express trans identities continue to do so in adolescence, while also emphasising that exploring gender fluidity throughout the course of one’s life is not problematic or abnormal.¹ Such statements belittle young people’s agency, implying they are not able to know their own identity and needs.

In discussing the research and reasons for “detransition,” the Cass Review fails to consider external pressures and wider social contexts such as internalised transphobia, a lack of social acceptance and support, experiences of transphobia and discrimination, family non-support, and “conversion” practices as potential factors. These have all been noted in the research as important factors which can contribute to a person re-identifying with their birth-registered sex.¹⁵⁻¹⁸ In one study on people’s reasons for re-identification, 82.5% of people who re-identified with their birth-registered sex reported at least one external driving factor; the most common were pressures from family and societal stigma.¹⁷ The types of internal factors that are emphasised in the Cass Review were much less common.¹⁷ In emphasising these internal factors, the Cass Review perpetuates harmful and incorrect myths that being trans is “caused” by things such as trauma, and not an innate aspect of human diversity. This primes readers for recommendations that suggest treating other issues—such as poor mental health—before providing access to gender-affirming healthcare will reduce re-identification rates and potentially reduce dysphoria and the need for gender-affirming healthcare.⁶ However, there is no evidence for this approach.⁶ In Australia, any additional mental health needs are identified in collaboration between specialist gender clinics and community-based specialist mental health services to ensure ongoing management and treatment of these needs alongside gender-affirming healthcare; gender-affirming care should not be withheld on this basis. This is in line with international best practice.¹⁹

Finally, the Cass Review repeatedly raises the potential of people to regret aspects of their medical transition as a cause for concern. Regret and re-identification are not synonymous; those who re-identify may not feel any regret, and in the rare instances when people do regret aspects of their transition, it does not automatically mean they re-identify with their birth-registered sex.^{1,3} The rates of regret for aspects of gender-affirming care—such as surgery—are very low; approximately 1%.²⁰ In contrast, regret rates following non-gender-affirming plastic surgery are much higher; reaching 47.1% for breast reconstruction.²¹ Regret for all forms of gender-affirming healthcare are very low, whereas rates of patient satisfaction are high.¹⁹

Conclusions

- Re-identification with birth-registered sex is uncommon; approximately 5% of adolescents who seek specialist gender-affirming healthcare ever re-identify, and 1% of people who begin medical treatments (e.g., puberty suppression and hormone therapy) ever re-identify.
- Concerns about re-identification should not overshadow existing clinical care frameworks.
- The phenomenon of re-identification is prone to misinformation and sensationalism. Current high-quality research shows rates of re-identification remain low.
- The Cass Review ignored its own evidence in favour of unsubstantiated speculation from healthcare workers who a large proportion of did not provide gender-affirming healthcare, nor “believe” that trans people exist.

Intended use of information

While we make every effort to make sure the information in this resource is accurate and informative, the information does not take the place of professional medical advice.

Do not use our information as a substitute for the advice of a health professional.

If you are an individual seeking medical or health information for yourself or for someone else, you should obtain advice relevant to your particular circumstances from a health professional.

More information and support

For clinicians, please contact AusPATH for resources and support. www.auspath.org.au

For families and young people, please contact Transcend Australia for resources and support. www.transcend.org.au

This resource and associated evidence briefs and fact sheets can be downloaded from www.transcend.org.au/resources/evidence

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