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Gender-Related Medical Experiences of Youth Who Have Detranstioned

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ABSTRACT

People whose gender does not align with their sex assigned at birth can undergo a medical transition process, so their body reflects their gender. However, some people interrupt this process temporarily or permanently, which is often referred to as "detransition." Media coverage of detrans experiences tend to attribute this phenomenon to a lack of medical gatekeeping. However, research has shown detransitions are highly unpredictable. The aim of this article is to examine the medical experiences of youth who have detransitioned during various stages of the process from transition to today. Twenty-five interviews with 15–25-year-old youth who detransitioned were conducted. Thematic analysis led to the development of six themes: facing gatekeeping and invalidation during transition, accessing trans care, lacking adequate support during transition, finding support in detransition, lacking support in detransition, leaving the medical system. Our results question the usefulness of gatekeeping to prevent detransition and shows that it tends to erode the trust relationship between youth and practitioners and stifle gender exploration. Validation, support, information giving as well as exploration without constrain, or expectation of outcome seems to be a more helpful way forward to work with gender diverse youth.

KEYWORDS

Detransition; transition; gender affirming care; trans youth; medical transition; gatekeeping; exploration

Introduction

Gender transitions encompass diverse, non-linear journeys undertaken by people whose "gender identity or expression differs from the socially ascribed gender assigned to them at birth" (Coleman et al., 2022). For young people, these pathways involve multiple dimensions, including social, medical, and legal aspects, which may be pursued simultaneously or independently (Coleman et al., 2022). Within this population, some people choose to interrupt their transition temporarily or permanently, medically, socially or both (Expósito-Campos, 2021; Hildebrand-Chupp, 2020). This process is commonly referred to as "detransition" or "discontinuation of transition."

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This paper examines gender-related medical experiences of people who have undergone a gender transition (social, medical and/or legal) and interrupted it, by discontinuing their medical treatment and/or changing their social presentation for diverse reasons (whether due to a change in identity, or other factors such as social pressures, health concerns, etc.).

Situating the phenomenon of detransition

There is no consensus on the definition of this term nor on the prevalence of the phenomenon because of different understandings of the phenomenon and methodologies used. A systematic review estimates a prevalence ranging between 0% and 29,8% (Expósito-Campos et al., 2023) but some studies look at regrets (Bustos et al., 2021; Kamali et al., 2021; Narayan et al., 2021; Nieder et al., 2021; Tang et al., 2022; Wiepjes et al., 2018) while others look at the discontinuation of treatments (Boyd et al., 2022; Brik et al., 2020; G. Butler et al., 2022; Elkadi et al., 2023; Fornander, 2022; Glintborg et al., 2022; Hall et al., 2021; McCallion et al., 2021; Nieder et al., 2021; Roberts et al., 2022; Wiepjes et al., 2018), and others look at identity shifts (G. Butler et al., 2022; De Castro et al., 2024; Elkadi et al., 2023; Fornander, 2022; Olson et al., 2022; Richards & Doyle, 2019; Roberts et al., 2022). Furthermore, in a study based on people identifying themselves as transgender or non-binary, 13.1% reported an experience of detransition in the past (Turban et al., 2021). These figures invite us to think about a continuum between transition and detransition, as well as the complex, dynamic (Ashley, 2019; Turban et al., 2018) and non-linear (Baril & Silverman, 2022) nature of gender experiences.

Recently, the issue of detransition has assumed a prominent place in public and media discourse which massively relay stories of regrets or error. Millette et al. (2022) talk about a "framing effect" where detransition is almost always presented as a "proof" that transition was a "mistake" or the result of a "wrong diagnosis," leading to regrets. Usually, this type of discourse concludes that more gatekeeping of gender affirming care (GAMC) is needed (Millette et al., 2022; Slothouber, 2020). Gatekeeping is defined as the application of strict eligibility criteria upstream of any engagement in gender-affirming care. It calls on "mental readiness" and is seen as a potentially significant barrier to accessing care for trans people (Verbeek et al., 2022). Detrans people express concerns about certain groups, particularly gender-critical and trans-exclusionary radical feminist factions, who weaponize detransition narratives against trans rights, promoting rigid definitions of gender based on biological sex and opposing gender self-determination (Andersson, 2021; Bassi & LaFleur, 2022; MacKinnon, Gould, et al., 2022; A. P. Pullen Sansfaçon, Gelly, et al., 2024). This already has concrete political impacts in Europe, Canada and the United States where access to GAMC for trans youth is debated and/or

restricted (CBC News, 2024; Goupil, 2024; Laberge, 2024; Weiner, 2024) often calling on the risk of regrets or inability to make informed decisions.

Yet, research has not demonstrated the efficacy of restricting or delaying access to GAMC to prevent detransition. The prevailing scientific consensus acknowledges the limited ability to predict the evolution of a child's gender identity and expression over time, and whether or why detransition occur for some (Coleman et al., 2022, pS77). Many detrans people come to realizations about their identity retrospectively, with some acknowledging that transitioning facilitated self-understanding and reassessment of their needs (MacKinnon, Kia, et al., 2023; A. Pullen Sansfaçon, Gelly, et al., 2023). And while some studies try to identify predictors or associated factors, these have not been empirically tested (Expósito-Campos et al., 2023) or compared with the trans population. Consequently, guidelines like WPATH's SOC8 argue against using detransition as a basis for restricting access to GAMC (Coleman et al., 2022).

Studies on detransition show that these experiences are complex, not solely characterized by regret but often encompassing ambivalent feelings (Expósito-Campos, 2021; Littman, 2021; MacKinnon, Kia, et al., 2022; A. Pullen Sansfaçon, Gelly, et al., 2023). Research into detransition motives reveals a myriad of internal and external factors. Internally, these factors include stagnant mental health, evolving gender conceptions or identity, or health concerns (Littman, 2021; Narayan et al., 2021; Turban et al., 2018, 2021; Vandenbussche, 2021). Externally, discrimination, employment difficulties, relationship challenges, financial burdens related to medical expenses, and familial or societal pressures can also contribute (Littman, 2021; Narayan et al., 2021; Turban et al., 2018, 2021; Vandenbussche, 2021).

The complexity of detransitioning is compounded by the binary gender expectations inherent in traditional transition pathways (Baril & Silverman, 2022; Espineira, 2011; Johnson, 2016). Conforming to normative and binary transness models is often required to access GAMC, reflecting the impact of "transnormativity," "a hegemonic ideology that structures transgender experience, identifications, and narratives into a hierarchy of legitimacy that is dependent upon a binary medical model and its accompanying standards" (Johnson, 2016, p. 471). Detransitioning, retransitioning, and non-binary paths challenge this framework (J. Butler, 2004; MacKinnon, Gould, et al., 2022), disrupting conventional understandings of gender.

Various approaches to gender affirming medical care

Various approaches to medical and psychosocial support for transgender and non-binary youth (TNBY) have emerged over time, sometimes overlapping. Ehrensaft (2017) delineated three primary approaches. Firstly, the "live in your own skin," developed by Drs. Susan Bradley and Ken

Zucker, focuses on helping children accept the gender identity matching their assigned sex at birth through behavioral, environmental, and familial interventions (Ehrensaft, 2017). Secondly, the "watchful waiting model" or the "Dutch approach" (de Vries & Cohen-Kettenis, 2012), developed by Dr. Peggy Cohen-Kettenis provides close psychological support during childhood and adolescence, allowing prepubescent children time for gender contemplation before potential hormone blocker administration after thorough assessment (de Vries & Cohen-Kettenis, 2012). Thirdly, the "gender affirmation model," originating in the United States, emphasizes non-pathologizing assessment of a child's gender status, fostering exploration without predetermined outcomes, addressing psychological co-occurring issues, managing gender-related stress, and cultivating supportive environments involving parents, schools, and families (Ehrensaft, 2017).

Additionally, the informed consent model (ICM) of care has gained traction, advocating for treatment access without mandatory assessment or diagnosis if the individual can provide informed consent. The ICM aims to reduce barriers to accessing GAMC and uphold autonomy, although its application varies from collaborative, patient-led assessment to no assessment at all (Ashley et al., 2021).

Responding to the increased visibility of detransition journeys, another model has emerged: the exploratory approach. Developed by Anastassis Spiliadis in England, this approach acknowledges the uncertainty inherent in trans journeys and underscores the clinician's responsibility in facilitating exploration before undertaking a transition (Spiliadis, 2019). While recognizing the importance of contextual understanding and the dynamic nature of gender for appropriate support (Ashley, 2019; Coleman et al., 2022; Wren, 2019), some critique the exploratory approach's suggestion that exploration should precede transition (Ashley, 2019).

WPATH's Standards of Care have evolved over time, with SOC 7 (available when we conducted our study) recommending one professional assessment before accessing hormonal treatments and "top surgeries" and two assessments for "bottom surgeries" (Coleman et al., 2012). In 2022, SOC 8 relaxed guidelines, emphasizing informed consent while still recommending comprehensive assessment for adolescents and adults in complex cases (Coleman et al., 2022). The legal age to access various interventions varies by country but generally puberty blockers cannot be offered before reaching Tanner stage 2 of puberty (Coleman et al., 2022) and gender affirming hormones may be accessible from 14-year-old. TNB youth generally must wait to be 16 for a mastectomy and 18 for a genital surgery. Given the international scope of our study and the varied transition periods of our participants, they may have encountered diverse practices.

Gender-related medical experiences of detrans people

Research on individuals who have halted their transition is beginning to emerge, shedding light on their experiences within the medical transition process. Some detrans people express feelings of inadequate information or support during their transition decisions (Littman, 2021; Littman et al., 2024; MacKinnon, Gould, et al., 2023; Vandenbussche, 2021). For example, a qualitative study in Canada with detrans adults revealed varied medical journeys, some feeling pressured to prove they are "trans enough" or to undergo hormonal treatment to access desired surgeries (MacKinnon, Gould, et al., 2023), underscoring the challenges posed by transnormativity (Johnson, 2016). While many participants favored an informed consent approach and a majority think medical transition was a good choice at the time, one third expressed regrets due to insufficient information and support for decision-making, highlighting the need for tailored guidance and individualized follow-up (MacKinnon, Gould, et al., 2023). Another study reveals that 66,7% of detrans participants feel they were not adequately informed on the risks when undertaking a transition and 75% feel they lacked information on alternatives (Littman et al., 2024).

Additional research indicates a lack of support during detransition (Haarer, 2022; Littman, 2021; MacKinnon, Gould, et al., 2022; MacKinnon, Kia, et al., 2022; Vandenbussche, 2021). Yet, this population is particularly in need of support, as detransition can lead to isolation (MacKinnon, Gould, et al., 2022) and losing support, particularly in the trans community (Vandenbussche, 2021). The necessity for comprehensive medical care and psychosocial support, including assistance in hormone treatment cessation, reconstruction surgery information, and addressing dysphoria and regrets, is emphasized by study participants (MacKinnon, Kia, et al., 2022; Vandenbussche, 2021). However, the majority report a lack of guidance and support from medical teams (Vandenbussche, 2021).

Detrans individuals, already a minority within a minority, face unique and poorly understood minority stressors (MacKinnon, Gould, et al., 2022), often leading some to avoid medical settings altogether due to shame, distress, pressure endured in case of forced detransition, or accessibility concerns (MacKinnon, Kia, et al., 2022). Littman (2021) found that only 24% of participants had informed their doctor of their detransition. Other people choose to distance themselves from medical environments following negative experiences, including perceived lack of understanding, skills, or expertise from healthcare professionals (Vandenbussche, 2021).

This article seeks to explore the medical journey of youth who have discontinued their transition or detransitioned (YDT), examining their experiences during both transition and detransition phases. We aim to elucidate how YDT perceive medical care throughout these stages. Following an overview of

our methodology, we will introduce our sample and delve into participants' experiences with medical care during both transition and detransition. Through the discussion of our findings, we endeavor to gain insight into the impact of these experiences on detrans youth trajectories and to identify avenues for improved support.

Methodology

This article is based on data obtained from one dimension of a three-pronged pilot research, designed in collaboration with Gender Creative Kids. The project aimed at understanding the discourses on detransition from three perspectives: that of professionals working with trans and non-binary youth, that of media and social media, and that of youth who have discontinued their transition. For the latter, we employed a qualitative methodology based on 25 in-depth individual interviews with youth who have started a transition and later discontinued it. A first wave of interviews was conducted in 2020 with 20 participants. Then a second wave of interviews was conducted in 2022 with eight youth, of which five interviews were kept.[1] Participants were recruited through an advertisement circulated on social media platforms, including TikTok, Instagram, Twitter, and Facebook groups. We contacted private detrans groups and trans and non-binary groups to invite them to share the poster. Some participants also shared the poster on Reddit and Twitter. This snowball effect allowed to reach a lot of detrans persons. Semi-structured interviews were conducted by a non-binary person and lasted from 68 to 135 minutes. Participants had signed a consent form and received a $30 gift card as compensation at the end of the interview. Project has been approved by the boards of ethics[2] of all researchers involved on the project (Université de Montréal, Université du Québec à Montréal, University of Ottawa). The interview grid covered the gender trajectory and transition process, the discontinuation of the transition, the assessment and self-projection, currently and in the future, the present perceptions and opinions on transition, detransition and gender. For the transition and detransition process, we asked participants about their experience with the medical system. We also discussed accessibility of gender affirming care and what aspects of these services should change from their point of view.

Interviews have been transcribed and coded with MAXQDA following the reflective thematic analysis methodology (Braun & Clarke, 2021, 2023; Braun et al., 2019) and drawing on an anti-oppressive, fluid and gender-affirming perspective (Baril & Silverman, 2022; Medico & Pullen-Sansfaçon, 2017). Adopting this perspective in research means that the team is open to hear all trajectories and backgrounds, whatever the gender identity, without judging or favoring any outcome. Analysis was guided by the question "How do youths who detransition or discontinue

a transition talk about and interpret their experience?." Within the scope of this article, we will only focus on six themes emerging from the analysis and related to participants' medical experiences: facing gatekeeping and invalidation, accessing trans care, lacking adequate support, finding support in detransition, lacking support in detransition, avoiding medical caregivers. We have grouped together the themes that relate to the experience of transition and those that relate to the experience of detransition.

Results

Presenting our sample

The sample consisted of 25 participants aged from 16 to 25 years old coming from a variety of geographical backgrounds (US, Canada, France, Belgium/Germany, UK, Finland and Indonesia) and ethnic backgrounds.[3] Among our 25 participants, eight only socially transitioned but did not medically transition, 17 went through a medical transition of which 16 participants took hormonal treatments, and nine had surgery (see Table 1). We included all participants in our analysis because we have discussed medical care with all of them. Moreover, those who did not medically transition sometimes considered this option and/or have had experiences with medical professionals (for example being on waiting lists, meeting a therapist, etc.).

We cannot assert when participants started to identify as trans precisely as they discuss this as a part of their narrative. Hence, some described it as being part of a gradual process while others did not remember the exact moment it happened, or when they started their medical transition. However, we were able to estimate this based on the analysis of their narratives. (see Figure 1).[4] What we notice is that a majority of youth started to question their gender or to identify as trans during puberty (around 12 to 16 year old) with a peak around 12–14 years old. But a majority of youth (13 out of 17) started their medical transition after 18 years old.

Table 1. Medical interventions undergone by participants.

Type of medical interventions undergone	Number of participants
Undergone medical interventions	**17**
Hormone replacement therapy (HRT)	16
Did not start with blockers	14
Started with blockers	2
Surgeries	9
Mastectomy	8
Bottom surgery	2
Facial surgery	1
No medical intervention	**8**
Total	**25**

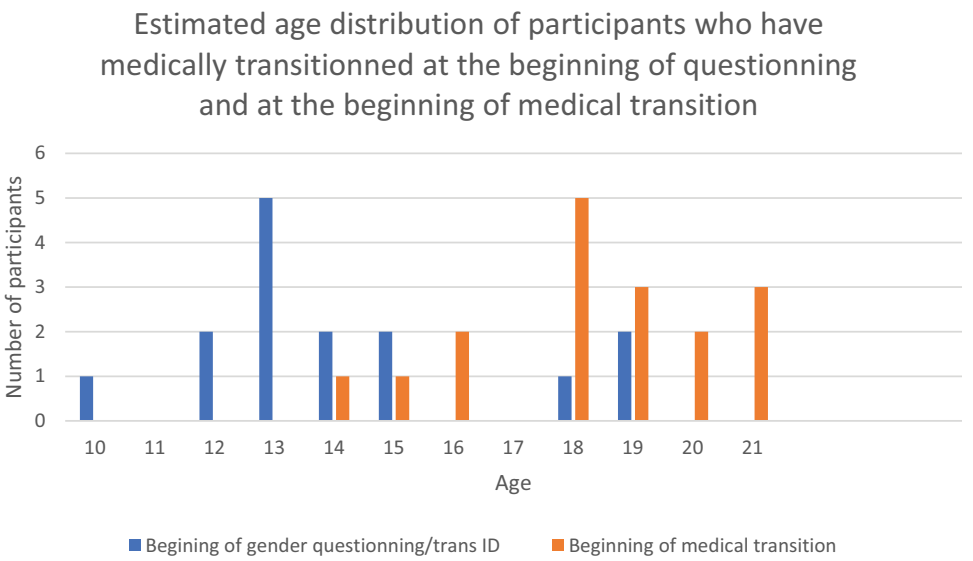

Figure 1. Estimated age distribution of participants who have medically transitioned.

In sum, it appears that the transition was a gradual process for most participants. In most cases, a medical transition was started after years of reflection and gender exploration.

Experiences of transition

When discussing participants' experience of transition, 3 themes emerge: facing gatekeeping and invalidation, accessing trans care and lacking adequate support.

Facing gatekeeping and invalidation

Most participants faced challenges when pursuing a medical gender transition. Some were denied access to GAMC or faced long and tedious processes. For instance, Iris who comes from Canada was initially refused hormonal treatment due to mental health concerns but succeeded to obtain it a year later. Other participants, especially minors without parental support, said that they encountered significant delays and barriers that halted or delayed their transition, like Eleanor who socially transitioned at 14–15 but waited to be 21 to start a medical journey: "I kind of knew that I wasn't going to be able to get hormones as a minor. 'Cause there was literally no way with my mom. So I just socially transitioned."

Therapist approval was sometimes required for surgeries and hormones, with varying delays (generally shorter with private practitioners): "I first, um, found a therapist. Um, because in Germany you have to start with therapy in order to get, um, hormones [. . .] covered by insurance. (Aren, 24, HRT,

surgery). Access depended on country laws, care standards, and personal privileges like age and finances, as illustrated by Addie:

> Like, sometimes in college too, I would stop for a month because I couldn't afford it, um, 'cause you would have to go into the doctor to get refills every now and then, like, I think it's, like, every three months you have to go back to the doctor. And, um, in Tennessee see they stopped funding Planned Parenthood, which means that my appointments went from, like, $60 an appointment to, like, $200 an appointment. And as a college student just working at restaurants, it was not feasible all the time, so I wasn't able to afford it all the time. (Addie, 23, HRT)

Interpersonal challenges were also mentioned. Some participants felt that their care providers invalidated their trans identities, exhibited close-mindedness, transphobia, or oppressive behaviors. Some recounted experiences where their transition was channeled into certain narratives. For example, Sasha highlighted how therapists reinforced gender stereotypes during diagnosis by asking questions like "what kind of toys did you play with?," while Yaël underwent an undesired hysterectomy due to legal marker requirements. Yaël also recalled an experience with an endocrinologist who invalidated their transition because it did not follow a typical trajectory and touched their body which was received as a violation:

> Hospital teams take care of people according to a vision that's very binary, very psychiatric and pathologizing. For them, you really have to fit into boxes. For example, I don't fit into their boxes because I don't want phalloplasty, and so for them, I should never have started my transition and received someone's approval. . . my endocrinologist. . . told me, "But here, there are many people like you who come to us, and we don't really know why they started a transition when they actually don't want surgeries or such. . ." And it was really violent, [. . .] she asked me to undress to see if my hair had grown well, and [. . .] as if seeing my hair wasn't enough, she had to touch my chest to check if I had hair there, and my legs, and I felt very very violated. (Yaël, 23, HRT and surgeries)*[5]

Participants reacted negatively to such situations, feeling anger, trauma, and sometimes seeking independence. Some participants developed strategies to navigate gatekeeping. For instance, Chris accepted deadnaming to avoid conflict, and Sasha conformed to expectations for hormone access after looking online at what questions she would be asked.

> I said "Yeah, I'm okay with [getting more body hair]." But I- I never really was. Even when I was on testosterone I generally always shaved my legs [. . .] I did not like it. I knew at some level, even at that age, that like, there were things that I definitely just said because I knew it was gonna get me what I thought I needed. (Sasha, 21, HRT and surgery)

Two participants who could not access GAMC also evoked the idea of getting hormones on the unregulated/underground market. One of them even had to go out of their way and obtain a PO box address to receive hormones

purchased on internet as their parents were unsupportive of their transition. Finally, when major, some youth decided to turn to trans-affirming structures where they know they would be well received and easily access GAMC.

Accessing trans care

While many participants faced barriers as minors, some of them accessed hormonal treatments quickly when they reached majority through private medical professionals or informed consent clinics (which are only available to adults):

> I was able to finally go to an informed consent clinic on my own, and explain my situation, and that prospect was super thrilling to me [. . .] to be able to take my own gender journey in my own hands was really awesome [. . .] I just had to go into an informed consent clinic and essentially, say, "I'm trans. Like, I've known this for x amount of time. Um. I want hormones," and, like, check off, like, yes on a piece of paper, basically and sign off and then I'm good. (Shane, 21, HRT)

In these clinics, participants report that they generally received hormonal treatment after a single consultation. Informed consent practices varied among professionals. Youth report that practitioners offered explanations, discussed formalities, risks and answered questions allowing them to make decisions but some participants mention these conversations were brief.

Several participants remembered receiving validation and support during their transition journey. Professionals were open-minded, confirming identities through diagnosis or pronoun usage, and promoting access to gender-affirming resources. This validation was positively perceived during transition, fostering a sense of comfort and authenticity. Kit exemplifies how validation enabled honesty: "I didn't have to lie about anything, I didn't have to present myself as suffering more than I was. . . 'Yeah, I'm trans, I don't have any contraindications, please give me the medication'." However, in hindsight, some participants felt professionals assumed their need for medical transition, presented it as the only solution, or seemed too sure about the trans identity, as Aren recalls: "He also told me that, uh, he never ever gave anyone hormones as quickly as me but he was so sure. . . he was so sure with me that he gave them, um, to me very early." Interestingly, participants did not criticize validation itself, but rather the lack of exploration into their transition motivations and needs.

Lacking adequate support

Several participants reported experiencing a lack of support, a lack of exploration, or experience of improper care. Notably, some say that potential regrets were not discussed and that the motivations behind their desire to transition were left unexplored: "I was able to get on testosterone at 14. [. . .] I was never asked like, 'How did you come to even find out what trans even is?' I never got

asked that." (Sasha, 21, HRT and surgery). This absence of exploration experienced by some youth could lead to distress and a feeling of being on their own. Ethan felt they lacked support in their decision process and that the decision's burden fell solely on them: "*It was just a lot of me being thrown to make all decisions myself as a 16 year old.*" Nevertheless, some participants reported having seen professionals who questioned their motivations, wanted to address the underlying problems, discussed doubts and concerns, or used a phased approach. Yet, an overly cautious approach could be frustrating. Some professionals missed the real issue (gender) for which the participant was consulting and did not allow a good care relationship, especially if they did not adopt a validating approach. Some participants also found therapy unhelpful or inadequate, like Sam who mentioned their gender therapist did not provide useful guidance.

Finally, unwanted results (hair loss, etc.), side effects (like mood swings, vaginal atrophy, etc.), or post-surgical complications have been reported. Those were either due to the medication side effects or sometimes due to provider errors or inadequate care.

Overall, access to transitions depended on the country and participant privileges, such as age and financial resources. While many participants received validation, some practitioners still invalidated trans identities or used stereotypical diagnoses. While validation was generally positive, participants often felt their motivations, doubts, and underlying issues weren't adequately explored, resulting in insufficient support. The experience of Yaël, who underwent surgery for legal criteria, highlighted the dangers of imposing specific pathways on trans individuals. This notion was reinforced by some youths lying to providers to meet "trans criteria" for accessing gender-affirming care.

Experiences of detransition

The experience of detransition in a medical setting is less documented by participants. However, we can see three themes emerging from the experiences of medical detransition: participants who received support in their detransition, participants who did not and participants leaving the medical system.

Finding support during detransition

Among youth who medically detransitioned, ten youth told at least one of their care providers about them stopping their transition, among whom three mentioned they wanted to have information to stop their transition safely.

> I actually have an appointment, my general practitioner um next week, where I'm hopefully gonna get like my blood tested because I am like, I want to know what my

> hormone levels are currently. Something I thought maybe the endocrinologist would have wanted to know but didn't see- didn't seem to want to. So (laughs) I was like, I want to know because I want to know what's going on in my body right now. Um, and then I have some other questions because [. . .] most of my information on what I'm going through right now is like coming from other detrans people and what they've gone through. So I've noticed some symptoms that might be from like vaginal atrophy which seems to occur and a lot of detrans women who have done testosterone, um, so it's another reason I'm going to a doctor. (Sasha, 21, HRT and surgery)

Some youth mentioned having notified their care provider by letter, message or e-mail while others set up an appointment or talked directly to their practitioner. However, some participants stopped their treatment before notifying their care provider or where not totally open about their situation (at least not with all of their care providers). Yaël reports having hidden their detransition from the previous doctors but being open to their current gynecologist who is more open minded, and Lea mentions that she lied about the reasons why she wanted to stop testosterone and told she had concerns for their health. Two other participants went to see a counselor or therapist to accompany them in their detransition.

Among those ten participants who stayed in the medical system, a majority report at least a positive experience with their care provider. Notably, they say their care provider remained present for them, accepting, and supportive of their decision. Here, Shane explains how she was positively surprised by her care providers' reactions:

> I wasn't sure how they'd react, or if they would maybe treat me as an experiment then. Um, so I spent a lot of time, like, in fear about that. But once I did open up, um, probably like a year later to, like, my physician, and, um, psychiatrist, and gynecologist about all of this, like, they were all, like, really receptive. Just curious, like, how I decided that, and were like, "Well, ultimately, that's- that's completely okay. Like, as far as we can tell, your health is good, and that's all that matters to us." [I felt] kind of astounded, but like, really, really great, ultimately. (Shane, 21, HRT)

Some professionals also offered options to change the gender marker and name in the files, gave information on detransition, looked for compromises so youth can find a balance between feeling good in terms of gender expression and limiting side effects of stopping a treatment.

> But that's it, he told me to do it gradually and that if I didn't feel well or that if I had too many, like, mental effects that I didn't have or that. . . Or uh, that's it, you know weird effects like if I was too tired or I had mood swings, well to increase it again but I didn't feel any of that because basically I was okay. (Iris, 22, HRT, surgery)*

These positive reactions made youth feel good and encouraged in their decision.

Lacking support during detransition

Some participants who were open about their detransition to their care provider, however, say the latter did not ask questions nor seem to care. A few participants even faced some negative reactions or challenges. Notably, they notice a difficulty from some professionals to adapt to their new reality and identity, as illustrated by Shane:

> [. . .] perhaps the most annoying response I got was from a therapist I was seeing, [. . .] when I told her, like, I- I think I actually, you know, want to detransition completely, and don't really want to have a gender identity anymore, or use pronouns, she was like, "What do you mean? Like, there's so many we can try out. Like there's so many. Like, you just haven't found the right one yet." And I'm like, "I- I understand, like, what you're trying to say, but this is so frustrating. Like, I'm- I'm telling you I need a break, not that I need to go through the glossary or whatever." (Shane, 21, HRT)

A lack of accessibility to detrans care was also expressed by some participants. Iris explains that she was denied access to breast reconstruction because she is detransitioning, and consequently worries about having difficulties accessing voice training too.

> [T]he worst thing is really my voice [. . .] I know there's a place [. . .] that offers [voice training] but I don't know if they'll want to accept someone who, who's detransitioning there. Because I know that. . . my mastectomy, to have a reconstruction, I did some research, but one clinic told me no because they didn't want to do it on a trans person, even though they do it on lots of women who've had mastectomies. I'll have to find someone else, but I'll probably have to go to Montreal for that. (Iris, 22, HRT, surgery)*

Jada and Sasha mention that in the US, breast reconstruction is not covered by insurances, neither is laser hair removal:

> Um, I know, the breast augmentation is not covered by insurance, even though my top surgery was, um, so I'm, I'm paying out of pocket for it. So I'm, um, in terms of like the electrolysis stuff, I'm thinking down the line on that, um, when I have a little more money. (laughs) (Sasha, 21, HRT and surgery)

Those negative experiences, including the reactions from the professionals and the lack of access described, can lead participants to feel frustrated, nervous or invalidated in their new identity or in their decision to stop transitioning.

Avoiding medical care providers

Eight participants mention having hidden or not disclosed their decision to stop the transition to at least one of their care providers or left the medical system, partially or fully, for various reasons. Some worried about their CP's reaction or mentioned discomfort or a feeling of shame for having regrets or having made what they perceive as "a mistake."

> And I couldn't, you know, I couldn't tell the surgeon anything, 'cause what could he do? He thought he was really helping me. So, it was kind of. . . uh, I guess, shameful, that, you

> know, he was like really caring and I just. . . was, just, horrified, that I made a horrible mistake at that time. (Ethan, 24, HRT, surgeries)

Others thought they did not need to tell their CP because it is none of their business and they believe they can detransition without their help.

> Um, I, um, I wasn't worried about going off HRT. Like I wasn't, um, I wasn't like, "Oh, fuck, I need to be medically supervised or whatever." Because you basically don't need to be medically supervised going off of testosterone. [. . .] I've never heard of anyone having problems. (Kit, 24, HRT)

Those results show that opening-up to a care provider about detransitioning can be challenging and not always perceived as essential. Admitting that you have changed your mind can generate a feeling of shame or a fear of the CP's reaction, especially because detransitions are not common. In those circumstances, having a practitioner who is open-minded, validating, and supportive, no matter the outcomes, seems very welcomed by participants in this vulnerable stage. Besides, we observe that some participants disengage with some of their caregivers but maintain a trusting relationship with others who make them feel listened and validated.

Discussion

The study's findings reveal that detrans youth underwent various medical and psychosocial interventions, none of which effectively prevented detransition. Crucially, many felt a lack of adequate support during their journey.

Access to GAMC varied among participants, with some obtaining hormone replacement therapy (HRT) through informed consent clinics upon reaching adulthood, while others faced lengthier processes. Interestingly, only four out of 17 participants initiated a medical transition during adolescence. This contradicts media portrayals of detransition, which emphasize the need for child protectionism (Slothouber, 2020) and gatekeeping (Millette et al., 2022; Slothouber, 2020). These media representations which feed some clinicians' fears of regret or detransition (MacKinnon et al., 2021) contribute to a preventive mind-set, even among researchers. Indeed, some authors advocate for more careful assessments to prevent people from making a transition they'll later regret. For example, Littman (2021) suggests that the switch from approaches using a thorough evaluation to more liberal ones like the affirmative approach and the informed consent model of care may increase the likelihood of detransition. She also stands up for exploratory approaches, which tend to delay access to GAMC in an attempt to prevent detransition (Ashley, 2019; Turban et al., 2018). Criticizing other approach for their lack of research evidence, the exploratory approach has only been proposed as an alternative to other long standing intervention approaches. Moreover, our data shows that delaying access to GAMC can be perceived negatively—

especially without affirming the identity. In fact delaying access to trans-affirming care and waiting for "mental readiness" instead of working simultaneously on both aspects can cause distress and mental health crisis (Verbeek et al., 2022). While only one participant discontinued their transition process after counseling, several initiated a medical transition and later detransitioned despite lengthy assessments. Some participants, lacking parental support and access to GAMC, even considered obtaining or obtained hormones from the black market, reflecting findings from a Canadian study where up to 7% of youth sourced hormones outside of official channels (Taylor et al., 2020).

Additionally, some youth have reported experiencing stereotyping, invalidation, or pressure to undergo surgeries for legal gender changes. These occurrences reflect transnormativity, an ideology shaping transition experiences based on specific norms like the gender binary and continuity (Johnson, 2016). Transnormativity often accompanies gatekeeping, where GAMC is restricted to individuals meeting strict eligibility criteria (Verbeek et al., 2022). Espineira (2011) describes a "therapeutic shield" distinguishing "true trans" eligible for GAMC from "false trans" who are not. In response, our participants sometimes made choices misaligned with their needs (causing later regret), downplayed their gender expression, lied to their practitioner, omitted their doubts or just provided the "right answers" to access GAMC. These findings resonate with research indicating that non-affirming approaches can undermine trust and alter the care relationship, emphasizing the importance of spaces for ambiguity, fluidity, and uncertainty exploration (Bettergarcia & Israel, 2018). Similarly, a study has shown that pre-transition strict assessments can lead trans people to downplay or withhold their mental health concerns from their care provider to access necessary GAMC (MacKinnon et al., 2020). Thus, longer or stricter assessments do not appear to prevent detransition; instead, they may harm the care relationship and impede trans youth from receiving adequate support in decision-making and addressing mental health needs for fear of denial of GAMC access.

However, transnormativity can also manifest subtly, even among trans-affirming caregivers, who may advise medical transition without fully exploring individuals' needs or discussing alternative paths. In this respect, Sadjadi (2020) cautions against the temptation, in a highly polarized political context, to defend a medical-focused approach to transition, urging reflection not only on the potential side effects of puberty blockers but also on their role in normalizing gender. The assumption that changing physical appearance to align with the opposite assigned gender is necessary has been criticized by non-binary people (Murawsky, 2023) but also among detrans people who critique the favoritism toward binary transgender identities in the gender-affirming model (MacKinnon, Gould, et al., 2023). Some of our participants express a desire for alternatives or broader support beyond gender reassignment procedures. Additionally, participants sometimes internalize pressure to

conform to certain gender norms, driven by fear of being outed as trans, personal beliefs, or social media influences (Savard et al., 2022). The term "trans-trenders" within some trans communities further exemplifies transnormativity, dismissing non-binary, fluid, or non-medical transitions as well as detransitions (MacKinnon, Gould, et al., 2022). Such accountability to transnormativity, whether internal or external, also affects non-binary individuals (Murawsky, 2023). These findings underscore the need to facilitate gender exploration and expression without favoring any particular identity (Coleman et al., 2022, p.S50). They also emphasize the importance of deconstructing transnormativity, even within gender-affirming environments.

The lack of support during the exploration of motivations for transitioning and potential co-occurring mental health issues is significant and reflects previous findings (Littman et al., 2024; MacKinnon, Gould, et al., 2023; MacKinnon, Kia, et al., 2023; Vandenbussche, 2021). Balancing the need for exploration while maintaining the care relationship and validating the experiences of gender non-conforming youth poses challenges. Ashley (2019) addresses this dilemma by advocating for an ethic of gender exploration, rejecting approaches that prioritize prediction and future regrets. They argue that exploration operates alongside transition, recognizing gender's dynamic nature and the impact of decisions on gender perception and future possibilities. For example, going through puberty is as much irreversible as taking a hormonal treatment. From this perspective, supporting exploration is not about assessing gender authenticity or permanency but instead entails providing space, tools to explore gender without preferable outcome, and acknowledging that decisions need not be permanent (Ashley, 2019). It means questioning biases when thinking of trans or detrans bodies as "monstrous" (Ashley, 2019) and tackling transnormativity. Care providers can facilitate exploration by guiding youth through an examination of their different options, needs, motivations, expectations, body image, gender norms, doubts, and other factors affecting well-being without restricting access to GAMC. Such an approach would reinforce informed consent—which, according to our participants, has not always been practiced equally—as long as it is neither forced nor used as an assessment of "mental readiness" (Verbeek et al., 2022) but instead promotes autonomy. Like MacKinnon et al. we think that "centering autonomy and bolstering informed consent in gender care may limit decisional regret" (2023, p. 17).

To facilitate an exploration of gender without external pressure or fear of gatekeeping, we propose the development of a self-assessment tool, such as an online course or interactive PDF. This tool would enable teenagers and young adults to reflect on their experiences and needs before or alongside engaging with a care provider to further discuss their thoughts and concerns. Similar tools have been implemented in Quebec to aid healthcare providers in supporting youth's decisions regarding GAMC, including interactive guides for

hormonotherapy and a decision tree for fertility preservation (accessible at https://transitionner.info/). Building upon these initiatives, a collective effort could be made to develop a tool, possibly through a Delphi process, for systematic use by professionals working with transgender and non-binary individuals. This tool would prompt individuals seeking GAMC to reflect on their motivations, needs, and potential doubts, present a range of medical and non-medical options for addressing dysphoria or seeking gender euphoria, and outline potential outcomes, risks, and benefits.

In our exploration of detrans experiences, participants' distrust of the medical system is evident, reflecting findings from previous research indicating detransitioning without informing healthcare providers (Littman, 2021) or disengaging from medical care despite increased needs (MacKinnon, Kia, et al., 2022). Similarly, participants in our study, akin to those in MacKinnon's study (2022), express feelings of shame and fear of judgment from their practitioners. Some believed they could cease hormonal treatments without medical supervision. Some of those who openly detransitioned encountered challenges such as a lack of response, difficulty accessing detransition care, or reluctance from practitioners to accommodate their new identity, highlighting inadequate detransition support (MacKinnon, Kia, et al., 2022). Nonetheless, some participants reported positive interactions with caregivers who remained present, accepting, and supportive, providing information and options to address their changing needs. In a vulnerable period for detrans youth, having an open-minded, validating, and supportive caregiver was integral to feeling understood and supported in their decision-making process.

Conclusion

These observations underscore the importance for care providers to maintain neutrality regarding gender outcomes and allow youth to freely explore their identity, embodiment goals, and needs. This includes offering validation and options for individuals who may stop identifying with a gender, transition toward cis or non-binary identities, or continue identifying as trans. Options may encompass access to re-affirming interventions, alternative approaches to dysphoria management *if desired*, and psychosocial support, given the challenges of detransition and the potential need to address lingering mental health issues. It is crucial to view detransition as a valid choice, *not a mistake* (MacKinnon, Kia, et al., 2022). Aligning with other authors, we advocate for a shift from a preventive to a supportive approach toward detransition (C. Butler & Hutchinson, 2020; Expósito-Campos, 2021; Hildebrand-Chupp, 2020; MacKinnon, Kia, et al., 2022). A preventive stance can exacerbate shame and disengagement among a vulnerable population (Expósito-Campos, 2021; Hildebrand-Chupp, 2020; MacKinnon, Kia, et al.,

2022) fostering transnormativity and gatekeeping that may not effectively prevent regrets but can perpetuate detransphobia (Hildebrand-Chupp, 2020; MacKinnon, Gould, et al., 2022). Future research should prioritize reconciling exploration and autonomy through robust informed consent processes (MacKinnon, Gould, et al., 2023) and better understanding the needs of detransitioning individuals as they navigate their detransition journey.

Notes

1. Three interviews had to be removed from the data set following throughout team assessment which concluded in fraudulent participation. After removing these three interviews, our sample is composed of 25 participants. For more information, see A. P. Pullen Sansfaçon, Gravel, et al. (2024).
2. Certificate number CERSC-2020-076-P(1).
3. During the first wave of interviews, we did not ask about the ethnicity, but some participants spontaneously discussed it. However, we asked that question during the second wave. We estimate that around a quarter of participants are BIPOC.
4. This graphic presents an imperfect estimation of age of gender questioning and medical transition based on participants' stories.
5. Quotations with an asterisk have been freely translated from French.

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