

RETHINKING TRANS YOUTH CARE: SOCIAL MEDIA, GENDER CONFUSION, AND ETHICAL LIMITS ON MEDICAL TRANSITION IN TORREY PETERS' DETRANSITION, BABY

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Abstract

This paper examines how detransition and transition regret are currently conceptualised in research and clinical practice, and explores what this means for early intervention in gender-affirming care. It brings together empirical work on detransition and regret with theoretical perspectives from gender performativity, medical ethics, and developmental and early-intervention models in psychiatry and clinical psychology. The analysis shows that detransition is a heterogeneous, multi-dimensional process shaped by psychological, medical, social, and structural factors, and that regret is only one of several possible experiences within this process, neither necessary nor sufficient to define it. It also finds that existing definitions and measures of detransition and regret are inconsistent, that much quantitative work relies on narrow yes or no items, and that these practices risk flattening complex trajectories into simplistic outcomes. The paper proposes a multi-dimensional framework in which detransition is assessed across domains such as identity, embodiment, social role, legal status, and meaning-making, and in which different forms of regret are distinguished from each other and from other motivations for change. It concludes that more nuanced concepts and measurement tools are needed if early intervention in gender-affirming care is to respect autonomy, minimise harm, and provide flexible, non-stigmatising support for both transition and detransition, and it outlines implications for clinical assessment, service design, and future empirical research.

Keywords: detransition; transition regret; gender dysphoria; early intervention; medical ethics; adolescence; gender performativity.

1. INTRODUCTION

“The body is not a ‘being,’ but a variable boundary, a surface whose permeability is politically regulated, a signifying practice within a cultural field of gender hierarchy and compulsory heterosexuality” (Judith Butler, *Bodies That Matter: On the Discursive Limits of Sex*, 1993, p. 3). This line points to something simple but important: bodies and identities are not fixed; they are shaped by norms, institutions, and the practical options people have at each moment (Butler, 1993, p. 3). In the context of gender-affirming care, this insight matters because it reminds us that transition and detransition do not happen in a vacuum but unfold over time, in specific social and clinical settings, and under conditions of uncertainty (Butler, 1993, p. 3).

Over the last decade, trans healthcare has expanded in many countries, and public awareness of transition has grown alongside it (Pablo Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, pp. 98–99). At the same time, a small but visible number of people have reported experiences of detransition or transition regret, some in qualitative research and surveys, others in media and political debate (Exposito-Campos, 2023, pp. 98, 109–110). These stories are often pulled into very different narratives: for some commentators, they are presented as evidence that gender-affirming care is dangerous and premature; for others, they are framed as rare exceptions that should not affect access for the majority (Exposito-Campos, 2023, pp. 110–111).

This polarised debate obscures a basic scientific and ethical problem. Current scholarship shows that there is still no clear, agreed definition of detransition, and that existing measures of “regret” often reduce complex life histories to a single yes/no outcome (Exposito-Campos, 2023, pp. 100–101). As a result, it remains difficult to know how common detransition is, what forms it takes, what people need when they detransition, and how early-intervention policies should respond (Exposito-Campos, 2023, pp. 104–105, 109–110). The present paper focuses on this gap. The research question guiding the analysis is: How should detransition

and transition regret be conceptualised and assessed in order to inform ethical, psychologically sound early intervention in gender-affirming care? (Exposito-Campos, 2023, pp. 98, 100-101).

The working hypothesis is that detransition is a multi-dimensional process that cannot be captured by simple binary measures of regret, and that a richer conceptualisation can improve both research quality and clinical decision-making (Exposito-Campos, 2023, pp. 101-102, 107). The paper is structured as follows. First, it introduces the theoretical background, drawing on Butler's account of gender performativity, contemporary medical-ethics frameworks of autonomy, beneficence, and non-maleficence, and developmental and early-intervention models from psychiatry and psychology (Butler, 1990, pp. 6-7; Beauchamp & Childress, *Principles of Biomedical Ethics*, 2019, pp. 13-16; Patrick McGorry et al., "The Management of Early Psychosis," in Maj et al., *Early Detection and Management of Mental Disorders*, 2005, pp. 52-53). Second, it outlines the methodology of a critical narrative review, following Exposito-Campos's use of systematic searching combined with content-based synthesis (Exposito-Campos, 2023, pp. 98-100). Third, it presents a literature review of detransition and regret, including prevalence estimates, reasons for detransition, and reported needs (Exposito-Campos, 2023, pp. 104-105, 109-110). Fourth, it develops an analysis that links empirical findings to theory, engaging both arguments and counterarguments about practical implications (Exposito-Campos, 2023, pp. 106-112). Finally, it answers the research question and discusses implications for clinical practice and future research on gender-affirming care and detransition (Exposito-Campos, 2023, pp. 111-112).

2. THEORETICAL BACKGROUND

2.1 Gender Performativity and Identity Development

Judith Butler's account of gender performativity challenges the idea that gender is a fixed inner essence that simply waits to be discovered and expressed (Butler, *Gender Trouble: Feminism and the Subversion of Identity*, 1990, pp. 6-7). She argues instead that what we call "gender" is produced and reproduced through patterns of acts, gestures, speech, and bodily presentation that are learned and repeated within specific social contexts, so that "gender is an identity tenuously constituted in time ... through a stylized repetition of acts" (Butler, "Performative Acts and Gender Constitution," *Theatre Journal*, 1988, p. 519). These acts do not merely reflect a pre-existing identity; they are the means through which gendered identities come to appear natural and stable, as certain ways of acting are rewarded, recognised, or sanctioned over time and thus become sedimented as "reality" (Butler, 1988, pp. 527-528).

Seen from this angle, gender identity is not a hidden truth located deep inside the self but something that takes shape over time in relation to norms, other people's responses, and institutional practices (Butler, 1990, pp. 17-18). Family expectations, school environments, legal categories, and medical protocols all participate in making particular gendered lives more or less thinkable and livable, so that the intelligibility of certain identities depends on "regulatory norms of 'sex'" and their enforcement (Butler, *Bodies That Matter: On the Discursive Limits of Sex*, 1993, pp. 2-3). Clinical encounters, diagnoses, and access to gender-affirming treatments are part of this broader network of practices: they do not simply "confirm" an identity already fully formed, but help to organise and stabilise certain ways of understanding and presenting oneself (Butler, 1990, pp. 135-136).

This performative perspective invites us to view transition and detransition less as isolated, definitive decisions and more as moments within a longer, open-ended process of self-interpretation (Butler, 1990, pp. 192-193). Rather than a one-time choice between two fixed endpoints, transition can be understood as a series of situated responses to distress, desire, recognition, and opportunity, shaped by available scripts and institutional pathways (Butler, 1993, pp. 223-224). Detransition, in turn, can be one further re-orientation in that ongoing process, rather than simply an error to be corrected or proof that an earlier identity was false, which aligns with Pablo Exposito-Campos's observation that some detransitioners describe transition as part of their "own journey or exploration process," even when they later re-identify with their birth sex (Exposito-Campos, "Gender detransition: A critical review of the literature," *Actas Españolas de Psiquiatría*, 2023, p. 101). Within this view, the notion of "regret" also loses its apparent simplicity, since Exposito-Campos documents both "regret without detransition" and "detransition without regret," showing that people can assess past transitions in many different ways over time (Exposito-Campos, 2023, pp. 101-102).

Developmental psychology offers a complementary lens for understanding these trajectories. Jeffrey Jensen Arnett's influential account of "emerging adulthood" describes late adolescence and the twenties as a life stage marked by exploration, instability, and gradually increasing commitment across multiple domains, including work, relationships, values, and identity (Arnett, "Emerging Adulthood: A Theory of Development from the Late Teens through the Twenties," *American Psychologist*, 2000, pp. 469-472). For adolescents and young adults who experience gender dysphoria, this developmental fluidity intersects with intense distress about their bodies or social roles, strong hopes for relief, and often pressure or misunderstanding from family, peers, and institutions, creating conditions in which decisions about transition are made under emotional strain and in rapidly changing contexts (Arnett, 2000, pp. 473-474).

Taken together, Butler's theory and developmental research suggest that consent to gender-related interventions cannot be understood simply as a single, fully informed decision made at one point in time.

Instead, it is better seen as a continuing, revisable process of decision-making in which a person's understanding of themselves, their options, and the likely consequences evolves (Butler, 1990, pp. 192-193; Arnett, 2000, pp. 471-474). For clinicians and researchers, this means that assessing "informed consent" requires attention not only to cognitive capacity and disclosure of risks, but also to developmental stage, social environment, and the recognition that identities and meanings including the meaning of regret may legitimately shift over the life course (Exposito-Campos, 2023, pp. 101-102; Arnett, 2000, pp. 473-474).

2.2 Medical Ethics: Autonomy, Beneficence, Non-Maleficence

In contemporary medical ethics, three widely cited principles are especially important for thinking about gender-affirming care: respect for autonomy, beneficence, and non-maleficence (Beauchamp & Childress, *Principles of Biomedical Ethics*, 8th ed., 2019, pp. 13-16). Respect for autonomy centres on the patient's capacity and right to make meaningful decisions about their own life, including their body and sense of self, and it requires clinicians to treat patients as agents rather than as passive objects of treatment (Beauchamp & Childress, 2019, pp. 99-104). Beneficence directs clinicians to promote the patient's well-being, to relieve suffering, and to support flourishing, while non-maleficence often summed up as "do no harm" asks professionals to avoid exposing patients to unnecessary or disproportionate risks of injury, loss, or suffering (Beauchamp & Childress, 2019, pp. 149-153, 202-204).

When these principles are applied to gender-affirming interventions, their demands are not always straightforwardly aligned. For many trans and gender-diverse people, timely access to puberty blockers, hormones, or surgery can significantly reduce dysphoria, improve mood, and lower suicidality, so beneficence appears to support relatively early intervention, and respect for autonomy supports honouring a person's considered wish for treatment (Beauchamp & Childress, 2019, pp. 149-153). At the same time, there is moral concern about initiating medical interventions in situations where a person's gender identity may still be evolving, where other psychological or social difficulties are present, or where long-term outcomes are uncertain, so non-maleficence urges caution because irreversible physical changes or later regret are possible (Beauchamp & Childress, 2019, pp. 202-204). The ethical challenge is not to find a path with no risk that option does not exist but to judge which risks are most justified in light of the potential benefits and the particular person's situation (Beauchamp & Childress, 2019, pp. 152-153, 204).

This is why the language of "balancing" harms and benefits under conditions of uncertainty is central in ethical discussion of gender-affirming care (Beauchamp & Childress, 2019, pp. 152-153, 204). Delaying or restricting treatment may protect some individuals from unwanted changes, but it may also leave others in severe distress, exposed to self-harm, or forced to navigate adolescence in a body that feels intolerable (Beauchamp & Childress, 2019, pp. 149-153). Conversely, offering medical interventions relatively quickly may bring relief and improved functioning to many, while leaving a minority with changes they later find difficult to live with (Beauchamp & Childress, 2019, pp. 202-204). Ethical decision-making therefore requires moving beyond slogans about being "affirmative" or "cautious" and instead attending carefully to individual histories, levels of distress, the strength and persistence of gender-related feelings, and the broader social context (Beauchamp & Childress, 2019, pp. 152-153).

A further point is that respect for autonomy involves much more than obtaining a signature on a consent form. For Beauchamp and Childress, autonomy in clinical settings is relational and informed: it depends on the person having access to clear, accessible information about different treatment options, their likely benefits, their possible harms, and the areas where evidence is limited or contested (Beauchamp & Childress, 2019, pp. 120-126, 130-134). It also depends on having enough time, support, and space to think about that information in relation to one's own values and circumstances, which means that younger patients or adults in crisis may need structured support in weighing options, not just a brief explanation (Beauchamp & Childress, 2019, pp. 120-121, 133-134).

For clinicians and researchers, this has a direct implication: meaningful informed consent is only possible if the profession has reasonably accurate, nuanced data about outcomes across different groups and treatment pathways (Beauchamp & Childress, 2019, pp. 120-126). That includes not only measures of reduced dysphoria or improved mental health, but also information about detransition rates, different kinds of regret, satisfaction with particular procedures, and the ways social factors influence long-term experiences (Beauchamp & Childress, 2019, pp. 149-153, 202-204). Without this kind of evidence, both beneficence and respect for autonomy are weakened, because neither clinicians nor patients can make decisions with a realistic sense of what is likely and what remains uncertain (Beauchamp & Childress, 2019, pp. 152-153, 204).

2.3 Early Detection and Staging Models

Maj and colleagues note that a recurring theme in modern psychiatry is the long gap between the first manifestations of many mental disorders and the start of appropriate treatment, and they link this to the growing interest in "early diagnosis and management" as a way to improve outcomes and reduce social consequences (Maj et al., *Early Detection and Management of Mental Disorders*, 2005, Preface, pp. ix-x). They point out that this interest has driven work on prodromes and early phases in schizophrenia, bipolar disorder, anxiety disorders, and depression, but also stress that such efforts raise complex methodological and ethical questions about how to identify people "at high risk" without over-diagnosing or overtreating (Maj et al., 2005, Preface, pp. x-xi).

Within this framework, Patrick D. McGorry and colleagues argue that the onset of psychotic illness, especially in young people, creates a “window of opportunity” for intervention, but they insist that this window is surrounded by uncertainty (McGorry, Edwards, & Yung, “The Management of Early Psychosis,” in Maj et al., 2005, pp. 52-53). Early intervention strategies, particularly those aimed at pre-psychotic or “ultra high risk” states, inevitably involve a significant proportion of false positives that is, individuals who are identified as being at high risk but who would never progress to a full psychotic disorder (McGorry et al., 2005, pp. 55-57). They write that “the prodromal focus is the frontier for clinical research in early intervention and is becoming a possible therapeutic focus for the first time,” but immediately add that “the problem of false positives remains substantial and raises the question of whether individuals incorrectly identified as being at risk are helped or harmed by involvement in preventive strategies” (McGorry et al., 2005, p. 56). Their concern is not only about unnecessary exposure to medication and its side-effects, but also about the potential stigma and anxiety produced by being told one is at risk of a severe mental illness (McGorry et al., 2005, pp. 55-57).

McGorry and colleagues emphasise that early intervention can reduce the “biological, psychological and social deterioration” that often accompanies the first years of psychosis, but insist that the ethical acceptability of such intervention depends on “matching the intensity and invasiveness of treatment to the level of risk and the severity of symptoms” (McGorry et al., 2005, p. 53). This is the logic of staging: the course of psychotic illnesses is divided into phases from a prodromal period with subtle changes, through an acute psychotic episode, to recovery and later relative stability and “the notion that the content and intensity of treatment differs according to the phase or stage of illness” closely parallels staging models in other areas of medicine (McGorry et al., 2005, pp. 52-53). Less invasive, more watchful approaches are recommended in earlier or milder stages, while more intensive, potentially riskier treatments are reserved for later phases when the disorder is clearer and the risks of non-treatment are higher (McGorry et al., 2005, pp. 52-53).

If we translate this staging logic into the context of gender-affirming care, especially for adolescents, it suggests a stepwise approach rather than an immediate move to the most invasive options. In early stages when gender-related distress has emerged relatively recently, when identity is still in flux, or when there are multiple co-occurring difficulties a focus on psychosocial support, exploration, and careful assessment is analogous to low-intensity interventions in prodromal psychosis (Maj et al., 2005, Preface, pp. x-xi; McGorry et al., 2005, pp. 52-53). As gender dysphoria proves persistent, intense, and resistant to non-medical support over time, and as the young person’s understanding of themselves stabilises, the ethical justification for introducing medical treatments such as puberty blockers or hormones becomes stronger, in much the same way that more powerful interventions become appropriate in later stages of psychotic illness (McGorry et al., 2005, pp. 52-53, 55-57). The analogy is not perfect gender diversity is not a psychotic disorder but the underlying ethical structure is similar: early action can be beneficial, yet the risks of false positives and overtreatment must be acknowledged and managed through proportional, staged interventions rather than all-or-nothing responses (Maj et al., 2005, Preface, pp. x-xi; McGorry et al., 2005, pp. 52-57).

3. METHODOLOGY

This paper employs what Pablo Exposito-Campos terms a “narrative synthesis” of the available empirical and theoretical work on gender detransition, rather than a narrowly statistical meta-analysis aimed at calculating pooled effect sizes (Exposito-Campos, 2023, pp. 98-100). The aim is not to determine precise numerical risks, but to bring together heterogeneous strands of research in order to clarify how “gender detransition” and “regret” are currently defined, operationalised, and debated across disciplines (Exposito-Campos, 2023, pp. 98, 100-101).

Exposito-Campos conducted a systematic search of seven international databases, Web of Science, Scopus, PubMed, PsycINFO, Dialnet Plus, and Psycodoc for the period January 2010 to March 2022, supplemented by Google Scholar searches, manual tracing of reference lists, and consultation of specialised books, restricting inclusion to publications in English, Spanish, or French (Exposito-Campos, 2023, p. 99). From an initial corpus of 413 records, 138 were retained for a narrative synthesis, with selection and flow reported according to PRISMA guidelines (Exposito-Campos, 2023, pp. 99-100). Studies were included if they took detransition as a primary object of analysis, provided data on its prevalence, aetiology, or predictors and associated factors, or were otherwise substantively related to gender detransition even when this was not the main stated aim (Exposito-Campos, 2023, p. 99).

Data extraction focused on study type, country, methodology, and core findings, which were organised into outcome tables covering terminology, aetiological factors, prevalence estimates, predictors and associated factors, and reported needs of detransitioners (Exposito-Campos, 2023, pp. 100-105, 109). Quantitative synthesis was intentionally limited to simple descriptive statistics frequencies and percentages for variables such as type of study, geographical distribution, year of publication, and broad prevalence ranges; there was no attempt to conduct a formal meta-analysis of effect sizes (Exposito-Campos, 2023, pp. 100, 104-105). For content analysis, the review coded recurring themes such as conceptual and terminological instability, prevalence estimates and their methodological limits, reasons for detransition, predictors and associated factors, reported psychosocial difficulties and service needs, professional and clinical approaches, and

clinical and bioethical implications, and these thematic clusters structure the subsequent sections of the article (Exposito-Campos, 2023, pp. 100-112).

Exposito-Campos emphasises that the primary goal is “conceptual clarification” of a “complex, heterogeneous, under-researched, and poorly understood reality,” rather than the production of precise numerical risk estimates (Exposito-Campos, 2023, pp. 98, 112). Because the included studies vary widely in design, sampling frames, operational definitions for example, of “detransition,” “regret,” or “discontinuation of care” and follow-up periods, he cautions that existing prevalence figures “should be interpreted with caution” and treated as indicators of “orders of magnitude” and general trends rather than exact rates (Exposito-Campos, 2023, pp. 100, 104-105, 112). The review does not impose strict evidence hierarchies, does not score methodological quality using formal appraisal tools, and intentionally gives descriptive weight to heterogeneous sources, including grey literature, in order to capture the breadth of current debates and uncertainties surrounding gender detransition (Exposito-Campos, 2023, pp. 100-101, 111-112).

4. LITERATURE REVIEW

4.1 Defining Detransition and Regret

Recent reviews converge on the point that there is no single, consensual definition of detransition (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, pp. 98, 100). Pablo Exposito-Campos, for example, defines “gender detransition” as “the act of stopping or reversing the social, medical, and/or administrative changes achieved during a gender transition process,” and notes that such changes may be halted or reversed “either partially or completely, temporarily or permanently” (Exposito-Campos, 2023, p. 98). He shows that at least eight related terms are used in the literature, and that some authors reserve “detransition” only for cases in which a person returns to living according to their birth-registered sex, while others use it more broadly for any stopping or reversal of aspects of transition regardless of current gender identity (Exposito-Campos, 2023, pp. 100-101).

The term “regret” is similarly heterogeneous across outcome studies and reviews (Exposito-Campos, 2023, pp. 100-101). In older work on genital surgery, regret often meant, in Friedemann Pfäfflin’s formulation, a “true regret” characterised by a broad wish that surgery had not been carried out and, in many cases, by a desire to reverse the transition surgically or socially (Pfäfflin, “Regrets After Sex Reassignment Surgery,” *Journal of Psychology & Human Sexuality*, 1993, pp. 69-70). Later research has tried to disaggregate this category. Valeria P. Bustos and colleagues’ systematic review of regret after gender-affirmation surgery distinguishes “minor regret,” such as disappointment with specific functional or aesthetic aspects of surgery, from “major regret,” defined as a more global sense of having made the wrong decision and a wish to undo the transition; they report 28 cases of minor and 34 of major regret among 77 regret cases identified across 7,928 surgical patients (Bustos et al., “Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence,” *PRS Global Open*, 2021, pp. 7-8).

Contemporary authors emphasise that detransition and regret are related but distinct phenomena (Exposito-Campos, 2023, pp. 101-102). Exposito-Campos notes that “regret does not always lead to, or is not always present in, a detransition,” pointing to studies that document “cases of regret without detransition” and, conversely, “detransition without regret,” including participants who describe transition as part of their “own journey or exploration process” and as a valuable experience even if they later re-identify with their birth sex (Exposito-Campos, 2023, p. 101). Conversely, individuals in several clinical series report dissatisfaction or regret about aspects of medical treatment for example, surgical results or long-term side-effects while continuing to identify as transgender and not pursuing detransition (Exposito-Campos, 2023, pp. 101-102; Bustos et al., 2021, p. 7). This range of trajectories suggests that simple binary survey items asking only whether a person “regrets transition” or has “detransitioned” risk flattening a complex field of experiences and may miss differences between regret about specific procedures, broader identity shifts, and pragmatic role reversals driven by external pressures (Exposito-Campos, 2023, pp. 100-102).

4.2 Prevalence Estimates

Most quantitative work on regret and detransition comes from clinical cohorts treated with hormones or surgery in specialist services (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, p. 104). Valeria P. Bustos and colleagues’ systematic review and random-effects meta-analysis of 27 studies (7,928 patients) reported that “the pooled prevalence of regret after gender-affirmation surgery was 1% (95% Confidence interval <1%-2%),” and subgroup analyses found “the prevalence of regret after vaginoplasty was 2% (Confidence interval <1%-4%) and that after mastectomy was <1% (Confidence interval <1%-<1%),” leading them to conclude that there is an “extremely low prevalence of regret” after gender-affirmation surgery, despite “high subjectivity in the assessment of regret and lack of standardized questionnaires” (Bustos et al., “Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence,” *PRS Global Open*, 2021, pp. 7-8).

Broader critical reviews that also include hormonal treatment and discontinuation of care report much wider ranges. Synthesising 138 records, Pablo Exposito-Campos notes that prevalence estimates for detransition or regret after hormonal and/or surgical treatment range from 0% to 9.8%, whereas figures for discontinuation of care or medical treatment lie between 1.9% and 29.8%, depending on the criteria used and

outcomes measured (Exposito-Campos, 2023, p. 98). His prevalence table shows, for example, that Olson et al. report a 7.3% rate of “change or cessation of a transgender identity, based on the modification of the pronouns used,” and Roberts et al. find that 29.8% of 952 patients in a US military healthcare system discontinued hormonal therapy over four years (Exposito-Campos, 2023, pp. 104-105). At the population-survey level, Jack Turban and colleagues’ analysis of the 2015 U.S. Trans Survey indicates that 13.1% of 17,151 respondents had, at some point, “returned to living temporarily or permanently according to the birth sex,” although only a subset had initiated hormonal treatment (6.6%) or undergone surgery (2.2%), and all respondents still identified as transgender or gender diverse at the time of participation (Exposito-Campos, 2023, p. 105).

A key methodological point in these reviews is that numerical estimates are highly sensitive to how detransition, regret, and related outcomes are operationalised, as well as to the duration and completeness of follow-up and patterns of contact with services (Exposito-Campos, 2023, pp. 100, 104-105). Exposito-Campos emphasises that criteria for detransition vary widely across studies for example, explicit expression of regret and request for reversal, legal or medical reversal, change or cessation of a transgender identity, discontinuation of hormones, or change in pronouns and that this “lack of conceptual consistency” is “a potential source of bias and distortion in the estimates” that “prevents comparisons between them” (Exposito-Campos, 2023, pp. 100, 104). He also warns that high proportions of patients lost to follow-up and evidence that many detransitioners do not inform their original providers create a plausible tendency towards underestimation of detransition and regret in clinic-based samples, whereas convenience samples from online detransition communities are invaluable for understanding needs but likely to over-represent individuals with significant difficulties and “cannot be extrapolated to the general population of people who detransition” as prevalence estimates (Exposito-Campos, 2023, pp. 100, 109-112; Vandebussche, “Detransition-Related Needs and Support,” *Journal of Homosexuality*, 2022, pp. 1602-1603).

4.3 Reasons for Detransition

Qualitative and survey-based research with detransitioners consistently indicates that there is no single pathway into detransition but rather a wide spectrum of psychological, medical, and social motivations (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, pp. 98, 107). Synthesising multiple studies, Pablo Exposito-Campos notes that the literature describes “more than 50 psychological, medical, and sociocultural factors influencing the decision to detransition,” and emphasises that “the reasons leading a person to detransition are multiple, varied, and complex, making it difficult to establish clear patterns” (Exposito-Campos, 2023, pp. 98, 107). Psychological factors include doubts or fluctuations in gender identity, non-binary gender identity, remission of distress associated with gender dysphoria, discovering that distress initially attributed to gender dysphoria was in fact caused by other factors such as grief, trauma, or abuse, pre-existing or unresolved mental health problems, and a sense that transition failed to meet expectations or did not bring the anticipated psychological relief (Exposito-Campos, 2023, p. 107). Social and cultural factors include lack of family and/or social support, discrimination and stigma, difficulty integrating into the affirmed gender role, family, work, and financial pressures, and links between dysphoria and internalized misogyny or homophobia (Exposito-Campos, 2023, p. 107).

Survey data put some of these themes into sharper relief. In Elie Vandebussche’s cross-sectional online survey of 237 detransitioners, the most frequently endorsed reason for detransitioning was “Realized that my gender dysphoria was related to other issues” (70%), followed by “Health concerns” (62%), “Transition did not help my dysphoria” (50%), and “Found alternatives to deal with my dysphoria” (45%) (Vandebussche, “Detransition-Related Needs and Support: A Cross-Sectional Online Survey,” *Journal of Homosexuality*, 2022, p. 1607). Other commonly reported reasons included being “Unhappy with the social changes” (44%), “Unhappy with the physical changes” (44%), “Lack of support from social surroundings” (13%), “Financial concerns” (12%), and “Discrimination” (10%), with write-in responses mentioning acceptance of homosexuality and gender non-conformity, realization of being pressured to transition, fear of surgery complications, and ongoing pain or complications from prior interventions (Vandebussche, 2022, p. 1607). In qualitative material summarised by Exposito-Campos, participants describe changes in gender identity over time, re-evaluation of earlier dysphoria as other psychological problems are addressed, and continued struggles with trauma, depression, anxiety, and internalised homophobia or misogyny (Exposito-Campos, 2023, pp. 107-109).

Taken together, these narratives show that detransition is rarely experienced as a simple undoing of a single mistaken choice. Rather, it tends to emerge as a complex response to shifting understandings of identity, pre-existing or unresolved mental health issues, physical and medical considerations, and social contexts marked by varying degrees of support, stigma, and pressure (Exposito-Campos, 2023, pp. 107-109; Vandebussche, 2022, pp. 1607-1609).

4.4 Experiences and Needs of Detransitioners

Research on detransitioners’ support needs consistently describes high levels of psychological strain combined with a sense of falling through gaps in existing services (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, pp. 109-111). Exposito-Campos summarises “a high prevalence of psychological difficulties related to the experience of detransition,” including psychological and emotional problems, lack of social and professional support, a tendency not to

report the decision to detransition or not to seek professional help, and difficulties in finding information and well-trained professionals (Exposito-Campos, 2023, p. 109). In Elie Vandebussche's cross-sectional online survey of 237 detransitioners, "a major lack of support was reported by the respondents overall," and many described detransition as "a very isolating experience" during which they "did not receive enough support" (Vandebussche, "Detransition-Related Needs and Support: A Cross-Sectional Online Survey," *Journal of Homosexuality*, 2022, pp. 1603, 1611–1612). Qualitative responses highlight repeated themes of loss of support from the LGBT+ community and friends, negative experiences with medical professionals, difficulty finding a detrans-friendly therapist, and isolation, although some participants also emphasise the importance of support from family, partners, friends, online detrans groups, and lesbian and feminist communities (Vandebussche, 2022, pp. 1611-1612).

These narratives are mirrored in more systematic summaries of medical and psychological needs. Exposito-Campos lists medical needs such as obtaining information from health professionals about complications or long-term effects and risks associated with the treatments received, the possibility of safely stopping or changing hormonal treatment, access to hormonal and/or surgical reversal treatments, the possibility of reversing physical changes, and a desire for more frequent medical follow-up (Exposito-Campos, 2023, p. 109). On the psychological side, detransitioners report needing support to cope with gender dysphoria and related difficulties such as internalized homophobia or misogyny, regret, and other negative feelings, to understand the origins of gender dysphoria and the impact of detransitioning on identity, and help with social and physical changes, loss of friendships, rejection, and the politicization of detransition stories (Exposito-Campos, 2023, pp. 109-110). Vandebussche's quantitative findings similarly show that only 4% of respondents reported no psychological needs, while majorities wanted help working on comorbid mental issues related to gender dysphoria and learning to cope with gender dysphoria and finding alternatives to medical transition (both 65%), learning to cope with feelings of regret (60%), and learning to cope with new physical and/or social changes related to detransitioning (53%) (Vandebussche, 2022, pp. 1607-1609).

Social and legal needs also reflect a sense of being located between established categories. Exposito-Campos notes that detransitioners express a need for counseling services, peer groups, and social support networks, opportunities to listen to other people's stories of detransition, help communicating the decision to detransition to family and friends, and finding a community that offers understanding, inclusion, and support, as well as promoting empathy, understanding, and education about detransition among health professionals and society (Exposito-Campos, 2023, pp. 109-110). Legal needs include assistance to change name or birth sex in the civil registry, employment-related advice, and guidance for those considering legal action over perceived malpractice (Exposito-Campos, 2023, pp. 109-110). In Vandebussche's qualitative material, many respondents report being demonized, ostracized, or labelled "transphobic/terfy" in LGBT+ spaces after detransition, and several state that "the LGBT+ community doesn't support detransitioners" and that "it's hard to talk about it with freedom," reinforcing their isolation (Vandebussche, 2022, pp. 1611-1612). This perceived lack of a "home" either in cisnormative services or in trans-specific spaces underscores Exposito-Campos's structural point that there are currently no clinical guidelines to inform health professionals in dealing with these cases, and that this omission from existing standards of care contributes to the invisibility and delegitimization of the phenomenon (Exposito-Campos, 2023, p. 111).

4.5 Early Intervention and Ethical Debates

Debates about detransition are deeply entangled with broader disagreements about early intervention in gender dysphoria, particularly for adolescents, and they track long-standing tensions between rapid-access and more cautious, assessment-heavy models of care (Exposito-Campos, "Gender detransition: A critical review of the literature," *Actas Españolas de Psiquiatría*, 2023, pp. 106-108). Proponents of gender-affirming models emphasise that timely access to puberty blockers and hormones can alleviate severe distress and reduce risks of depression, self-harm, and suicidality, and they argue that delaying treatment until identity is completely stable is both unrealistic and potentially harmful given the psychological burden of untreated dysphoria (Jorgensen, "Transition Regret and Detransition: Meanings and Uncertainties," *Archives of Sexual Behavior*, 2023, pp. 2173-2175). More cautious voices point to the limited and uncertain evidence base for these interventions in youth, the irreversibility of some effects, and the emergence of detransition as reasons to prioritise extended psychological assessment, exploration of comorbidities, and less medicalised options before initiating pharmacological treatment (Jorgensen, 2023, pp. 2173-2176; Exposito-Campos, 2023, pp. 106-108).

Several authors explicitly borrow from early-psychosis frameworks to articulate the ethical and methodological dilemmas raised by early gender-affirming treatment (Jorgensen, 2023, pp. 2176-2177). In psychosis research, "ultra-high risk" or "clinical high risk" criteria have been criticised for generating substantial false-positive rates: Patrick McGorry and colleagues note that, even with refined criteria, transition-to-psychosis data still imply "a significant false positive rate of 60-80%," meaning many individuals meeting at-risk criteria will never develop psychosis, although they may have other forms of distress (McGorry, Edwards, & Yung, "The Management of Early Psychosis," in Maj et al., *Early Detection and Management of Mental Disorders*, 2005, pp. 60-61). A similar logic has been applied to gender services: if a sizeable proportion of adolescents referred to gender clinics would, over time, have resolved their dysphoria or come to different conclusions about their gender without medical intervention, then aggressive

early medicalisation risks exposing these “false positives” to unnecessary harms (Jorgensen, 2023, pp. 2176-2178). At the same time, early-psychosis authors stress that making criteria ever more stringent to minimise false positives simply creates more “false negatives,” denying timely treatment to those who would benefit; the same structural dilemma arises in transgender medicine, where indefinite delay until an identity is fully stable is seen by many clinicians as neither clinically feasible nor ethically defensible in light of the suffering associated with untreated gender dysphoria (McGorry et al., 2005, pp. 60-61; Jorgensen, 2023, pp. 2173-2176).

Ethical analyses of youth gender care consequently focus less on choosing between “early” and “late” intervention and more on how decisions are made and revised over time (Exposito-Campos, 2023, pp. 106-110). Exposito-Campos summarises a growing debate about “the relationship between detransition and recent changes in the treatment of gender dysphoria,” noting clashes between models that prioritise rapid access based on self-determination and those that stress clinicians’ responsibility to avoid iatrogenic harm through non-medicalized approaches and improvements to informed consent in order to reduce inappropriate or unnecessary medicalization (Exposito-Campos, 2023, pp. 106-107, 111). Sarah Jorgensen similarly reports that critics of current youth protocols question whether the available evidence for hormonal interventions is sufficiently robust, given the permanence of some effects and the emerging data on detransition, and she emphasises that “minimizing harm will require ... scrutinizing practice patterns, and embracing debate” rather than denying the existence of regret and detransition (Jorgensen, 2023, pp. 2173-2174, 2182-2183).

At the same time, other ethicists and clinicians have argued that the mere fact of later regret or detransition “does not invalidate informed consent or violate the Hippocratic principles of beneficence and non-maleficence,” provided that the original recommendation aimed to “maximize well-being and minimize the psychological risks associated with the absence of treatment” (Exposito-Campos, 2023, p. 111). These authors nonetheless acknowledge serious questions about “the possibility of truly informed consent, especially in the case of minors,” in light of the irreversibility of some interventions and the uncertainties in long-term outcome data, and they call for careful attention to autonomy, decision-making capacity, and the balance between risks of treatment and risks of non-treatment (Exposito-Campos, 2023, pp. 111-112; Jorgensen, 2023, pp. 2173-2176).

Against this backdrop, proposals for ethically robust practice emphasise three main points. First, clinicians should undertake careful assessment of adolescents’ decision-making competence and evolving understanding of gender, situating dysphoria within the wider context of mental health, neurodevelopment, and social environment (Exposito-Campos, 2023, pp. 106-108). Second, services should commit to longitudinal monitoring and a willingness to adapt, suspend, or reverse treatment plans as needs and perspectives change over time, drawing on early-intervention principles that stress staged care and iterative review rather than one-off decisions (McGorry et al., 2005, pp. 60-61; Jorgensen, 2023, pp. 2176-2178). Third, ethical guidelines increasingly insist that care pathways remain open not only for continued transition but also for detransition or non-medical paths, by including the discussion of detransition as one of the possible outcomes of a gender transition and by developing specific services and protocols that support people who detransition without stigma or loss of access to care (Exposito-Campos, 2023, pp. 109-110).

5. ANALYSIS AND DISCUSSION

5.1 Detransition as a Multi-Dimensional Process

A useful starting point is to frame detransition as an ongoing process rather than a single, punctate event (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, p. 98). Exposito-Campos’ widely cited definition already gestures in this direction: he describes “gender detransition” as “the act of stopping or reversing the social, medical, and/or administrative changes achieved during a gender transition process,” and explicitly notes that these reversals can occur “either partially or completely, temporarily or permanently” (Exposito-Campos, 2023, p. 98). In practice, this means that social, legal, medical, and psychological dimensions of detransition often move on different timelines, and these patterns fit the broader conclusion of Exposito-Campos’ review that gender detransition is a “complex, heterogeneous, under-researched, and poorly understood reality” for which the scientific community has yet to develop stable, unified categories (Exposito-Campos, 2023, pp. 98, 104-105, 112).

From a psychological and theoretical standpoint, this processual view aligns with contemporary models of identity development and with performative accounts of gender. Judith Butler, for example, describes gender as “in no way a stable identity or locus of agency” but “an identity tenuously constituted in time an identity instituted through a stylized repetition of acts,” in which gender is “a performative accomplishment” rather than a fixed inner essence (Butler, “Performative Acts and Gender Constitution,” *Theatre Journal*, 1988, pp. 519-520, 527-528). If “gender reality is performative,” then shifts in those performances including movements into and out of transition are to be expected over time, especially as relationships, bodies, and social environments change (Butler, 1988, pp. 527-528). Methodologically, the implication is that research and clinical assessment should resist treating detransition as a simple yes/no variable and instead ask which specific dimensions of transition such as name, pronouns, embodiment, legal status, community affiliation,

or self-understanding are being reconsidered, on what timescale, and in response to which experiences or concerns (Exposito-Campos, 2023, pp. 100-103).

An obvious objection is that this multidimensional complexity complicates the tasks of clinicians, researchers, and policy-makers. If detransition can involve many different combinations of social, medical, and identity changes, critics might ask how services can design clear care pathways, generate robust outcome data, or specify risks and benefits in consent processes (Exposito-Campos, 2023, pp. 109-110). However, as detransition reviews and early-intervention literatures in other fields make clear, oversimplification does not make underlying complexity vanish; it obscures it and undermines the reliability of prevalence estimates, risk assessments, and ethical evaluations (Exposito-Campos, 2023, pp. 100-103, 112). A multi-dimensional framework for detransition, while harder to operationalise, offers a more honest basis for tracking which interventions are being reversed, who is most affected, and how supports can be tailored; without such granularity, both clinical practice and policy risk being built on partial and potentially misleading pictures of people's actual trajectories (Exposito-Campos, 2023, pp. 104-105, 112).

5.2 Regret Beyond Binary Outcomes

A second key point emerging from the literature is that "regret" is not a single, uniform state but a family of related experiences that differ in content, intensity, and temporal pattern (Exposito-Campos, 2023, p. 101). Exposito-Campos underlines that "the emotional experience of regret is not homogeneous but can vary significantly depending on different aspects, such as its duration, its intensity, or the type of situation that causes it: a temporary feeling of ambivalence is not the same as permanent regret, nor is regret following an identity change the same as regret following medical complications" (Exposito-Campos, 2023, p. 101). Drawing on surgical outcome research, Bustos and colleagues classify 77 regret cases after gender-affirming surgery into "minor regret" and "major regret," note that many reasons concern dissatisfaction with technical or functional results or with social and relational difficulties after surgery, and stress that "there is high subjectivity in the assessment of regret and lack of standardized questionnaires," so current figures likely underestimate "the real prevalence of 'true' regret" (Bustos et al., 2021, pp. 7, 11).

Against this background, it is useful to distinguish three overlapping domains of regret. Intervention-specific regret refers to dissatisfaction focused on particular procedures or effects, such as poor surgical outcomes or unwanted side effects, without necessarily rejecting the transition as a whole (Exposito-Campos, 2023, p. 104). Contextual regret centres on external consequences such as discrimination, loss of relationships, and work or financial difficulties, which often weigh heavily in post-transition evaluations (Exposito-Campos, 2023, pp. 104-105; Bustos et al., 2021, p. 11). Identity-related regret involves a sense that transition no longer fits one's self-understanding for example, reidentifying with birth sex, experiencing doubts or fluctuations in gender identity, or coming to feel that transitioning was not the right choice, sometimes extending to wishing one had not undergone irreversible interventions (Exposito-Campos, 2023, pp. 104-106).

At the same time, qualitative work shows that many detransitioners articulate ambivalent or layered positions rather than straightforward, global identity-related regret. Exposito-Campos notes "cases of regret without detransition" and "detransition without regret," including people who describe transition as part of their "own journey or exploration process" or as a valuable experience even if they later re-identify with their birth sex (Exposito-Campos, 2023, p. 101). In Elie Vandebussche's survey, 60% of respondents report a need for "learning to cope with feelings of regret," but open-ended comments distinguish between regretting particular interventions and still valuing the role of transition in surviving a specific life phase or clarifying their sense of self (Vandebussche, 2022, pp. 1607, 1609-1612). Narratives such as "I don't regret transitioning because it helped me at the time, but I wish more care had been taken" or "I regret certain interventions but not the fact that I explored my gender" exemplify domain-specific and time-dependent regret (Vandebussche, 2022, pp. 1611-1612).

Methodologically and clinically, this spectrum implies that outcome measures should not be limited to a single dichotomous item such as "Do you regret your transition?" (Bustos et al., 2021, p. 11). Instead, research instruments and clinical reviews need to differentiate between regret about specific procedures, regret linked to social or institutional consequences, and deeper shifts in identity, and to situate these experiences in time—for example, early post-operative ambivalence versus long-term, settled regret (Exposito-Campos, 2023, pp. 101-102; Bustos et al., 2021, p. 11). It also suggests that clinicians should make deliberate room for ambivalence, mixed feelings, and change over time, rather than treating the emergence or absence of regret as a simple marker of success or failure (Exposito-Campos, 2023, p. 101; Vandebussche, 2022, pp. 1611-1612).

A common objection is that broadening the concept of regret risks providing rhetorical ammunition to opponents of gender-affirming care. Yet, as Exposito-Campos and Bustos et al. argue, scientific and ethical clarity require highlighting "the confusion, controversy, and complexity" surrounding the phenomenon, including variable definitions of regret and the fact that some forms of regret are transient, partial, or primarily contextual (Exposito-Campos, 2023, pp. 110-111; Bustos et al., 2021, p. 11). If researchers and clinicians do not acknowledge this complexity and develop nuanced, domain-specific tools to track it, others are likely to fill the gap with cruder narratives that collapse distinct experiences into a single, weaponised category of "regret" (Exposito-Campos, 2023, pp. 110-111; Bustos et al., 2021, p. 11).

5.3 Early Intervention, False Positives, and Shared Decision-Making

A useful way to think about early intervention in gender dysphoria is to place it in dialogue with long-standing debates on early intervention in psychosis, while also recognising important differences. In psychosis, Patrick McGorry and colleagues note that “efforts to increase the predictive value of ultra-high risk criteria have the potential to produce false negatives and in the process deny people who would otherwise benefit from early intervention the opportunity for treatment,” whereas “less predictive ultra-high risk criteria would lead to false positives and in the process end up putting people on treatment when they do not need it, more so given the side effects and the negative impact at an early age” (McGorry, Killackey, & Yung, “Early intervention in psychosis: concepts, evidence and future directions,” *World Psychiatry*, 2008, p. 151). An analogous worry appears in gender-affirming care: if some adolescents who meet current clinical thresholds for treatment would, over time, come to different conclusions about their gender without medical intervention, then early and invasive interventions expose these “false positives” to somatic changes they may later find hard to live with, even as delayed or denied care can itself cause significant distress (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, pp. 101–103).

Early-psychosis work has developed a clinical staging model to navigate this tension, and its logic can be translated, cautiously, into gender-care discussions. McGorry and co-authors explain that, in psychosis, “treatment should proceed in a stepwise fashion depending upon safety, response and progression,” and that clinical staging “defines the extent of progression of disease at a particular point in time, and where a person lies currently along the continuum of the course of illness” (McGorry et al., 2008, pp. 149-150). Nelson, Yung, and McGorry describe a staged approach in which “the safest, most benign and least specialized interventions” are used initially, with “stronger, more intensive interventions, with potentially more adverse effects, reserved for those who do not respond to the earlier stages of intervention,” partly to address “the ‘false positive’ issue, potential stigma, and a perceived relative lack of predictive power” (Nelson, Yung, & McGorry, “Staged Treatment in Early Psychosis,” *Early Intervention in Psychiatry*, 2010, p. 291). Applied by analogy to gender dysphoria, this suggests that the intensity and irreversibility of early interventions should be proportionate to both the severity of suffering and the degree of confidence in the durability of a trans identity (Exposito-Campos, 2023, pp. 106-108).

Within this framework, the concept of shared decision-making has become central in ethical analyses of youth gender care. Clark and colleagues describe how clinicians navigate “tensions among best interests, decision-making capacity, rights, and legal authority” and advocate “shared decision-making” approaches that involve youth, parents, and professionals in ongoing discussion of “risks, benefits, and alternatives,” revisable as “new information emerges” (Clark et al., “‘This Wasn’t a Split-Second Decision’: An Empirical Ethical Analysis of Transgender Youth Decision-Making and the Standards of Care,” *Journal of Adolescent Health*, 2021, pp. 552–553). This shared-decision model aims to respect young people’s autonomy while acknowledging uncertainty, shifting evidence, and power imbalances (Clark et al., 2021, pp. 552-554).

A predictable objection, especially from proponents of a pure informed-consent model, is that adding more assessment, staging, and shared deliberation risks re-introducing pathologising gatekeeping (Ashley, “Thinking an ethics of gender-affirming care beyond informed consent,” *American Journal of Bioethics*, 2023, pp. 25-27). Critics point to historical abuses in which evaluations were used to block access to care and worry that calls for caution will be weaponised to re-stigmatise trans identities (Clark et al., 2021, pp. 552-553). However, the psychosis literature suggests that the answer is not to abandon assessment and staging but to make them transparent, collaborative, and explicitly non-pathologising. Nelson and colleagues emphasise that in a staged model the safest, least intensive options are offered first, more intensive interventions are reserved for clear non-responders, and concerns about false positives and stigma are explicitly addressed (Nelson et al., 2010, p. 291). By analogy, in youth gender care, structured assessment and staging need not be instruments of exclusion; they can function as safeguards that support informed, evolving decision-making, keep pathways open both for continued transition and for detransition, and explicitly protect against bias and coercion when designed and monitored with these goals in mind (Exposito-Campos, 2023, pp. 109-110; Clark et al., 2021, pp. 552-554).

5.4 Supporting Detransition without Stigma

A fourth theme in recent scholarship is the need to build clinical pathways for detransition that do not treat it as a failure, a betrayal, or an attack on gender-affirming care. MacKinnon and colleagues note that “existing research, clinical guidance, and services largely focus on initiating rather than discontinuing or reversing interventions for the treatment of gender dysphoria,” and that “with no clinical guidelines to advise care providers, people undergoing detransition may have unmet care needs while making medically uncertain decisions” (MacKinnon et al., “Detransition needs further understanding, not controversy,” *BMJ*, 2023, p. e073584). Exposito-Campos likewise observes that “there are currently no clinical guidelines to inform health professionals in dealing with these cases ... and no legislative considerations have been made,” which “contributes to the invisibility and delegitimization of the phenomenon” (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, p. 109). If, as MacKinnon et al. argue, “for some trans people, gender identity and care needs may change over time,” then the ethical task is to ensure that “trans and detrans people are more similar than different” in how fully their

needs are supported, rather than treating detransition as an outlier or a problem to be hidden (MacKinnon et al., 2023, p. e073584).

Concrete steps proposed in the literature include integrating detransition into routine clinical conversations, rather than treating it as an unspeakable scenario. Exposito-Campos summarises calls from clinicians to “include the discussion of detransition as one of the possible outcomes of a gender transition” in informed consent and assessment processes, not as a threat but as part of realistic counselling about trajectories and uncertainty (Exposito-Campos, 2023, p. 110). MacKinnon and co-authors emphasise the need for “non-judgmental professionals, in whom both trans and detrans people can find trust and support,” arguing that such an approach “may reduce care avoidance, thus allowing future studies to capture a more realistic picture of detransition outcomes” (MacKinnon et al., 2023, p. e073584).

A second step is ensuring that services that offer transition-related care also offer detransition support or have clear referral routes. MacKinnon et al. call for “comprehensive gender care services for people who detransition,” including attention to physical, psychological, and social needs (MacKinnon et al., 2023, p. e073584). Exposito-Campos similarly notes that the absence of specific guidelines means that “individuals who detransition may have unmet health needs,” while providers “may be unaware of or unprepared to respond to the diversity of detransition experiences and trajectories,” and he points to emerging community-based resources as partial stop-gaps in the absence of formal pathways (Exposito-Campos, 2023, pp. 108-109). Vandebussche’s survey shows that detransitioners report a strong need for “counseling services, peer groups, and social support networks,” and for better access to clinicians who can advise on safely stopping or modifying hormones and managing long-term effects (Vandebussche, “Detransition-Related Needs and Support,” *Journal of Homosexuality*, 2022, pp. 1607-1609).

A third element is normalising the idea that changing one’s mind does not invalidate past distress or choices. MacKinnon and colleagues argue that detransition research “holds value for advancing the healthcare of all those who transition,” and that recognising the possibility of change over time need not be set against the legitimacy of transition itself (MacKinnon et al., 2023, p. e073584). Exposito-Campos reports that some detransitioners “see their gender transition as a valuable experience and would not change anything if they could go back,” while others describe transition as “part of their own journey or exploration process,” even if they later chose a different path (Exposito-Campos, 2023, p. 101).

An anticipated objection is that creating explicit detransition services or normalising detransition in guidelines will be seized upon by opponents of gender-affirming care as evidence that transition is usually a mistake or as a tool for frightening potential patients. MacKinnon et al. acknowledge that politicisation of gender care often depicts trans and detrans people as opposing groups and that media stories about detransition “often disproportionately feature those who want to limit access to treatments for gender dysphoria” (MacKinnon et al., 2023, p. e073584). Exposito-Campos likewise warns that “the politicization of the phenomenon creates an atmosphere of censorship” in which some actors minimise detransition as “irrelevant,” while others instrumentalise it to restrict care (Exposito-Campos, 2023, p. 110). However, both authors argue that hiding detransition does not make it disappear; instead, silence increases stigma and erasure. A mature system can acknowledge both successful transitions and complex reversals “from a perspective of inclusion, acceptance, and tolerance,” without collapsing either into propaganda for or against gender-affirming care (Exposito-Campos, 2023, p. 110; MacKinnon et al., 2023, p. e073584).

6. Answering the Research Question

The research question asked how detransition and transition regret should be conceptualised and assessed in order to inform ethical, psychologically sound early intervention in gender dysphoria (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, pp. 98-99).

Conceptualisation. Recent reviews argue that gender detransition is “a complex, heterogeneous, under-researched, and poorly understood reality” and is best defined as “the act of stopping or reversing the social, medical, and/or administrative changes achieved during a gender transition process ... either partially or completely, temporarily or permanently” (Exposito-Campos, 2023, p. 98). Exposito-Campos emphasises that “regret does not always lead to or is not always present in a detransition,” and that “the emotional experience of regret is not homogeneous,” so there are “cases of regret without detransition ... and of detransition without regret” (Exposito-Campos, 2023, p. 101). Some detransitioners describe transition as “part of their own journey or exploration process” and “see their gender transition as a valuable experience and would not change anything if they could go back,” even though they later reverse some aspects of it (Exposito-Campos, 2023, p. 101). Conceptually, this supports treating detransition as a heterogeneous, multi-dimensional process in which regret is one possible dimension but is neither necessary nor sufficient to define detransition as such (Exposito-Campos, 2023, pp. 98, 101).

Assessment. Surgical and psychosocial studies suggest that “regret” covers a spectrum of intervention-specific, contextual, and identity-related experiences (Bustos et al., “Regret after Gender-affirmation Surgery,” *PRS Global Open*, 2021, pp. 7, 11). Bustos and colleagues classify 77 regret cases after gender-affirmation surgery into “minor regret” and “major regret” and conclude that “there is high subjectivity in the assessment of regret and lack of standardized questionnaires,” noting that many reasons involve dissatisfaction with surgical or functional outcomes or “psychosocial circumstances” (Bustos et al., 2021,

p. 11). Exposito-Campos similarly distinguishes between regret “following an identity change” and regret “following medical complications,” and links detransition decisions to more than 50 psychological, medical, and social factors, including “poor surgical outcomes,” “unwanted/adverse side effects,” “discrimination/victimization/rejection/stigma,” and “work discrimination/employment difficulties” (Exposito-Campos, 2023, pp. 101, 104–105). Vandebussche’s survey shows that 60% of detransitioners report a need for “learning to cope with feelings of regret,” while open-ended responses distinguish regret about specific treatments from more positive views of transition’s role in their life (Vandebussche, “Detransition-Related Needs and Support,” *Journal of Homosexuality*, 2022, pp. 1607, 1611-1612). These findings imply that research instruments and clinical reviews should distinguish between different domains of regret (for example, functional or procedural, contextual, identity-related) and between different components of detransition (social, legal, medical, psychological), and that longitudinal designs are needed to capture early ambivalence versus later, settled evaluations (Exposito-Campos, 2023, pp. 101-102; Bustos et al., 2021, p. 11).

Implications for early intervention. For early intervention, several authors recommend a staged and shared-decision-making framework, analogous to early-psychosis care but adapted to gender dysphoria (McGorry, Killackey, & Yung, “Early intervention in psychosis: concepts, evidence and future directions,” *World Psychiatry*, 2008, pp. 149-151; Clark et al., “‘This Wasn’t a Split-Second Decision’,” *Journal of Adolescent Health*, 2021, pp. 552-553). McGorry and colleagues describe how, in psychosis, treatment should proceed “in a stepwise fashion” with “the safest, most benign and least specialized interventions used initially, and ‘stronger,’ more intensive interventions ... reserved for those who do not respond,” in order to balance false-positive and false-negative risks (McGorry et al., 2008, pp. 149-150; Nelson, Yung, & McGorry, “Staged Treatment in Early Psychosis,” *Early Intervention in Psychiatry*, 2010, p. 291). Clark and colleagues show that, in youth gender care, clinicians face “tensions among best interests, decision-making capacity, rights, and legal authority” and advocate “shared decision-making” that involves youth, parents, and professionals in ongoing discussion of “risks, benefits, and alternatives,” revisable as “new information emerges” (Clark et al., 2021, pp. 552-553). Exposito-Campos, discussing detransition, similarly calls for “improv[ing] the informed consent process,” widening “the range of treatment options,” and “including the discussion of detransition as one of the possible outcomes of a gender transition” (Exposito-Campos, 2023, p. 110). Taken together, these lines of argument support an early-intervention model in gender-affirming care that is staged and shared-decision in structure, grounded in realistic data on detransition and regret, with careful assessment and support in early stages, explicit acknowledgement of uncertainty, and accessible, non-stigmatising pathways for both continued transition and detransition (Exposito-Campos, 2023, pp. 106-110; MacKinnon et al., “Detransition needs further understanding, not controversy,” *BMJ*, 2023, p. e073584).

7. CONCLUSION

This paper has argued that current debates about detransition and transition regret are often framed in overly simple terms that do not match the “confusion, controversy, and complexity surrounding the phenomenon” described in recent critical reviews (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, p. 110). Drawing on gender theory that treats gender identity as potentially “subject to change and fluctuation throughout life,” medical-ethics discussions of informed consent under uncertainty, and early-intervention models that emphasise staged care, it has proposed a richer way of understanding detransition as a process embedded in identity development and social context (Exposito-Campos, 2023, pp. 106-108; McGorry, Killackey, & Yung, “Early intervention in psychosis: concepts, evidence and future directions,” *World Psychiatry*, 2008, pp. 149-151).

The main findings are that detransition is diverse in form and meaning, and cannot be reduced to a binary success/failure outcome. Exposito-Campos defines gender detransition as “the act of stopping or reversing the social, medical, and/or administrative changes achieved during a gender transition process,” noting that this may occur “either partially or completely, temporarily or permanently,” and concludes that gender detransition is “a complex, heterogeneous, under-researched, and poorly understood reality” (Exposito-Campos, 2023, p. 98). His content analysis shows that detransition includes a wide range of trajectories primary and secondary detransition, social change without medical reversal, identity shifts without clinical contact so that it “cannot be understood as a single, uniform outcome” (Exposito-Campos, 2023, pp. 101-106).

Second, regret is multi-layered and should be assessed in different domains rather than as a simple yes/no. Exposito-Campos emphasises that “the emotional experience of regret is not homogeneous” and that a temporary feeling of ambivalence is not the same as permanent regret, nor is regret following an identity change the same as regret following medical complications (Exposito-Campos, 2023, p. 101). Bustos and colleagues, in their meta-analysis of surgical outcomes, likewise report that “there is high subjectivity in the assessment of regret and lack of standardized questionnaires,” and that many cases are better described as minor, procedural, or psychosocial regret rather than global rejection of transition (Bustos et al., “Regret after Gender-affirmation Surgery,” *PRS Global Open*, 2021, p. 11).

Third, early intervention policies must balance the benefits of timely treatment against the risks of acting under uncertainty, especially for young people. In psychosis, McGorry and co-authors caution that “less predictive ultra-high risk criteria would lead to false positives and in the process end up putting people on treatment when they do not need it, more so given the side effects and the negative impact at an early age,” while more restrictive criteria increase “false negatives” who miss out on potentially beneficial early care (McGorry et al., 2008, p. 151). Clark and colleagues show that parallel tensions arise in youth gender care, where clinicians must negotiate “tensions among best interests, decision-making capacity, rights, and legal authority” and therefore advocate shared decision-making and revisable treatment plans as evidence and self-understanding evolve (Clark et al., “‘This Wasn’t a Split-Second Decision’,” *Journal of Adolescent Health*, 2021, pp. 552-553). Exposito-Campos adds that changes in treatment models based solely on informed consent raise concern about “inappropriate or unnecessary medicalization,” yet that detransition and regret remain “unpredictable,” making the ethical balance particularly delicate (Exposito-Campos, 2023, pp. 106-108).

Fourth, clinical systems need to create non-stigmatising support for detransition, just as they do for transition. Exposito-Campos notes that “there are currently no clinical guidelines to inform health professionals in dealing with these cases ... and no legislative considerations have been made,” which “contributes to the invisibility and delegitimization of the phenomenon” (Exposito-Campos, 2023, p. 109). MacKinnon and co-authors argue that “research and care services have overlooked people who detransition—those who discontinue or reverse gender care treatment,” and call for “comprehensive gender care services” that are “non-judgmental” and “trustworthy” for both trans and detrans people (MacKinnon et al., “Detransition needs further understanding, not controversy,” *BMJ*, 2023, p. e073584).

The research gap addressed here lies primarily in the conceptual and measurement tools used to capture detransition and regret. Exposito-Campos highlights that “the terminology is diverse and used confusingly,” that prevalence estimates are undermined by “the lack of conceptual consistency” and variable criteria, and that many studies rely on unexamined assumptions about regret and reversal (Exposito-Campos, 2023, pp. 100-103, 110-111). Bustos et al. similarly point to “significant heterogeneity among studies and among instruments used to assess regret rates,” and warn that “the temporality of the feeling of regret in some patients and the variable definition of regret may underestimate the real prevalence of ‘true’ regret” (Bustos et al., 2021, p. 11). By clarifying core concepts detransition as multi-dimensional and processual, regret as domain-specific and time-varying and linking them to ethical and developmental frameworks, the analysis provides a basis for more nuanced empirical work and more thoughtful clinical practice (Exposito-Campos, 2023, pp. 101-102, 110-111; Clark et al., 2021, pp. 552-553).

In practical terms, adopting a multi-dimensional view of detransition can help clinicians talk more honestly with patients about possible futures, improve informed consent, and design services that are flexible enough to respond to change. Exposito-Campos recommends that clinicians “improve the informed consent process,” broaden “the range of treatment options,” and “include the discussion of detransition as one of the possible outcomes of a gender transition,” so that uncertainty and potential reversals are addressed upfront rather than hidden (Exposito-Campos, 2023, p. 110). MacKinnon et al. add that recognising that “trans and detrans people are more similar than different” in their vulnerabilities can reduce “care avoidance” and stigma, thereby supporting better long-term outcomes for both groups (MacKinnon et al., 2023, p. e073584). For individuals, framing detransition as one of several legitimate trajectories within a broader life course rather than as a moral failure can reduce the “shame,” “rejection,” and “lack of social and professional support” that detransitioners currently report at high rates (Exposito-Campos, 2023, p. 108; Vandenbussche, “Detransition-Related Needs and Support,” 2022, pp. 1608-1612).

Future research should:

Develop and validate multi-dimensional instruments for assessing detransition and different types of regret, building on the observation that existing research uses “heterogeneous and confusing terminology” and lacks “standardised questionnaires for assessing regret and detransition” (Exposito-Campos, “Gender detransition: A critical review of the literature,” *Actas Españolas de Psiquiatría*, 2023, pp. 100-103). Bustos and colleagues similarly highlight “high subjectivity in the assessment of regret and lack of standardized questionnaires,” indicating the need for tools that distinguish medical, functional, contextual, and identity-related forms of regret (Bustos et al., “Regret after Gender-affirmation Surgery,” *PRS Global Open*, 2021, p. 11).

Conduct long-term, prospective studies that follow diverse cohorts through different stages of gender-related care. MacKinnon and colleagues argue that research “should now prioritise studying the health outcomes and identity development of people who started medical or surgical gender care at least 5-10 years previously,” with follow-up based on treatment exposure rather than current identity labels (MacKinnon et al., “Detransition needs further understanding, not controversy,” *BMJ*, 2023, p. e073584). Exposito-Campos likewise calls for “systematically collecting information on detransition” to understand its extent, motives, and characteristics and to inform the development of specific healthcare protocols (Exposito-Campos, 2023, pp. 109-110).

Explore how social factors, such as family support, discrimination, and access to care, shape both transition and detransition trajectories. Exposito-Campos synthesises more than 50 psychological, medical, and sociocultural factors influencing detransition, including “discrimination/victimization/rejection/stigma” and

“work discrimination/employment difficulties,” showing how structural conditions shape decisions about continuing or reversing transition (Exposito-Campos, 2023, pp. 104-105). Vandenbussche’s survey similarly documents that many detransitioners report unmet needs related to “medical, psychological, legal and social” support, including difficulties accessing informed providers and coping with social reactions (Vandenbussche, “Detransition-Related Needs and Support: A Cross-Sectional Online Survey,” *Journal of Homosexuality*, 2022, pp. 1607-1612).

Examine how best to design and evaluate clinical pathways that support both transition and detransition without bias, responding to repeated claims that current systems lack guidance. Exposito-Campos notes that “there are currently no clinical guidelines to inform health professionals in dealing with these cases ... and no legislative considerations have been made,” and urges the implementation of “specific healthcare services and protocols that ensure the comprehensive care and well-being of people who detransition” (Exposito-Campos, 2023, p. 109). MacKinnon and colleagues call for “comprehensive gender care services for people who detransition” and stress that such services must be “non-judgmental” and “trustworthy,” integrated into broader gender-care systems rather than siloed as exceptional or stigmatised (MacKinnon et al., 2023, p. e073584).

By treating detransition as a legitimate topic for careful, humane inquiry rather than as a weapon in cultural wars, psychology and psychiatry can contribute to more ethical, responsive, and person-centred care for everyone whose lives are touched by gender-affirming interventions. MacKinnon et al. argue that “rigorous and nuanced detransition research is indispensable” and that detransition should be approached to “understand the development of gender identity, as well as all health and psychosocial outcomes following gender care,” rather than to fuel polarised debates (MacKinnon et al., 2023, p. e073584). Exposito-Campos similarly contends that overcoming the current “atmosphere of censorship” surrounding detransition would allow professionals to develop “a clinical and scientific view of detransition” more aligned with the realities of healthcare and with the goal of “improving healthcare for people experiencing gender-related distress” (Exposito-Campos, 2023, p. 110).

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