Detransition rates in a large national gender identity clinic in the UK

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Background: *Detransition – reverting to birth assigned gender after transition to another gender – may be considered to be a part of people's exploration of their gender; but may also cause regret if irreversible changes have been undertaken. In nationalised healthcare it is therefore important to determine rates of detransition as they are important in ensuring health and wellbeing.*

Methods: *End rates of detransition of patients at The Nottingham Centre for Transgender Health were reviewed. Taking a random sample of patient files (N=303), all were thoroughly investigated for any evidence of detransitioning.*

Results: *Only one case of a detransition was found (0.33 per cent). An additional two cases had noted a history of detransition before coming to the Nottingham Centre for Transgender Health specifically (0.99 per cent).*

Discussion: *This study concludes that the standards of care used within this service therefore appear to be working satisfactorily in relation to detransition. With such a low prevalence, there is no justification in slowing the pathway for other patients in order to prevent detransition as such slowing would likely have a deleterious effect on the mental health of the vast majority.*

Keywords: *Detransition; desist; sex change; gender reassignment; regret; sex reassignment.*

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TRANS PEOPLE are those people who are not content to remain in their birth-assigned gender. Trans people often do very well, but naturally, due to the incongruence between internal identity and external presentation – especially in the presence of prejudice – they are more vulnerable to mental health issues. For instance, trans people are more vulnerable to depression and anxiety, which in turn, may lead to suicide (Clements-Nolle, Marx & Katz, 2006; Bouman et al., 2017; Bouman, Davey, Meyer, Witcomb, & Arcelus, 2016). Consequently, many trans people seek assistance through psychological or medical interventions to aid transition – which in most cases enhances mental health and psychological wellbeing (Coleman et al., 2012; White Hughto & Reisner, 2016).

Within the UK, the interventions funded by the NHS are endocrine therapy, specialised psychological therapies, voice and communication therapies, laser hair removal/electrolysis, genital surgeries, and bilateral mastectomies. Throughout this process, patients are entitled to regular follow-up appointments which continue until assistance is no longer required. During these appointments it is not a clinician's responsibility to judge a patient on their gender, but instead to check for the rare occasions another cause of dysphoria is present; and to establish that treatment supports the process of transition (WPATH, 2011).

Although, exploring one's identity is a natural part of development (Newhook et al., 2018), if people have irreversible physical interventions, which they later decide were not appropriate, regret may result with the associated physical and mental difficulties. The literature investigating detransition (which may simply be a part of a person's process of gender exploration) unfortunately often

confuses it with regret. Indeed, Kuiper and Cohen-Kettenis (1998) clarified 'detransition' temporality and suggested that some people who experience regret will subsequently decide to detransition, but some do not. On the contrary, some people who detransition explain that their choice to detransition was not associated with their internal identity per se, but how the process of transitioning made their dysphoria worse because they became increasingly preoccupied with passing as their established gender (Marchiano, 2017). Similarly, due to the persecution of trans people in some countries, people may detransition to avoid the unfair discrimination they would face. This can be seen on a micro level such as family and peer rejection; (Klein & Golub, 2016), or on a macro level when trans people are subject to anti-trans laws (c.f. Matebeni & Monro, 2018). Social support is often cited as a buffer against transphobia and the associated negative outcomes (Budge, Adelson & Howard, 2013), thus, it may be plausible to assume that some trans people could feel that social support is more important than completing a transition, if people such as spouses and children disagree with their decision (Bischof, Warnaar, Barajas & Dhaliwal, 2011).

We can see therefore, detransition is a complex phenomenon and we may not directly infer that internal identity is incorrect when one does so – thus a holistic approach is of great importance within this area (Reisner, Radix & Deutsch, 2016). Nonetheless, although the literature regarding detransition is scarce, and the matter complex, there is enough evidence to deduce low rates of regret and detransition within the literature discussed below.

Prevalence rates in the Literature

Within the literature searched there were 12 articles obtained where the rate of regret was 0 per cent (Prunas et al., 2016; Lothstein, 1980; Rehman, Lazer, Benet, Schaefer & Melman, 1999; Nelson, Whallett & McGregor, 2009; Cohen-Kettenis & van Goozen 1997; Vujovic, Popovic, Sbutega-Milosevic, Djordjevic & Gooren, 2009; Papadopulos et al., 2017; Ruppin & Pfäfflin, 2015; Johansson, Sundbom, Hojerback & Bodlund, 2010; Ross & Need, 1989; Lobato et al., 2006). Of these articles, the highest number of participants was N=232 (Lawrence, 2003) and the lowest was N=14 (Ross & Need, 1989). Within those papers where the prevalence rate was higher than 0 per cent, the rate varied between 1.83 to 6 per cent (Blanchard, Steiner & Clemmensen, 1989; Dhejne, Oberg, Arver, & Landén, 2014; Kuiper & Cohen-Kettenis, 1998; Bodlund & Kullgren, 1996; Van Kesteren, Gooren & Megens, 1996; Van de Grift, Elaut, Cerwenja, Cohen-Kettenis & Kreukels, 2018; Landen, Wålinder, Hambert & Lundström, 1998; Dhejne et al., 2011; Pfafflin, 1993; Weitze & Osburg, 1996). The highest prevalence in the entirety of the literature was 30 per cent (Lindemalm, Korlin & Uddenberg, 1986); however, we have reported it separately here due to the fact that within that particular study the sample size was only 13 due to a large dropout rate, possibly associated with the length of observation being approximately 12 years. Similarly, a lot of the literature is rather outdated in view of the fact that healthcare has recently become rather more accommodating of gender diversity.

Detransition and regret were defined in the reviewed literature in many and varied ways. For instance, Ross and Need (1989) operationalised detransition through the recording of chronic doubts as well as occasional but significant doubts. Others were more specific, such as Nelson, Whallet and McGregor (2009) who recorded the regret of having a physical procedure – in this case a reduction mammoplasty. This does rather presume that having doubts is problematic, which is a curious stance as any big life decision, be it a new job, a new partner, a new house, will naturally come with some doubts.

In contrast, some papers operationalised detransition within specific actions taken after transition. For instance, Lindemalm et al. (1986) and Dhejne et al. (2011) recorded the number of cases who had taken legislative action to return to their birth-assigned gender. Most articles recorded regret more generally and were based on frequency of feelings, for example, Lawrence (2003, 2006) recorded regret in terms of being 'consistently regretful' or being 'sometimes regretful'. This poses the challenge of uniformity across all data sets. Interestingly, Blanchard et al. (1989) associated sexuality with regret and found that four of the 14 same-gender attracted people regretted their transition in comparison to zero of the 97 participants in the different-gender attracted group; thus suggesting that sexuality may be an important factor associated with regret.

Purpose

A recent article published by Wiepjes et al. (2018) has explored detransition in a large cohort in Amsterdam between 1972 and 2015, and found very little regret in those who had had a gonadectomy – being 0.6 per cent of trans women and 0.3 per cent of trans men. However, although this research uses a robust method including a long follow-up, it may not accurately reflect the process of detransition and may more accurately reflect the regret associated with surgical outcomes. Although it should also be noted that regret is a significant predictor of medical detransition (Marchiano, 2017).

We can see then that the prevalence of regret regarding transition varies; but within robust studies is ubiquitously low. The variation may be because there is variation in treatment protocols across the globe. In England the National Health Service (NHS) clinics use the *Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria* (Royal College of Psychiatrists, 2013); the *Standards of Care for the Health of Transsexual, Transgender and Gender Non-conforming People* (7th edn) (WPATH, 2011); and the *NHS England Service Specifications for Gender Dysphoria Services* (NHS England, 2019), which theoretically should lead to some uniformity across the country.

As there were no detransition studies which covered England, and especially detransition within the National Health Service (NHS), it was decided to undertake an audit of case files in a large National Gender clinic within England to determine the rate of detransition there. This Audit therefore examined detransition within the NHS gender clinic – the Nottingham Centre for Transgender Health. From May 2016 to May 2017 there had been approximately 773 new referrals in an exponential increase which gives some indication as to the size of the service. The service is truly multidisciplinary with psychologists, endocrinologists, speech and language therapists, and psychiatrists all working together in the team.

The baseline for comparison globally was 0 per cent and therefore the incidence at the Nottingham Centre for Transgender Health was expected to be low. Regret is usually underestimated within this cohort due to its ability to manifest itself through many aspects of life including mental health and suicide attempts (Dhejne et al., 2014). Taking this into consideration, the term 'detransition' was operationalised on a social level rather than by feelings alone in order to capture regret which had precipitated action to reverse gender roles. Therefore, the definition that was employed throughout the audit included a documented report (by the clinician or the patient themselves) of a patient having lived in a different gender to their birth-assigned one and then returning to live as their birth- assigned gender. Our hope was to undertake a thorough and holistic assessment of those who have detransitioned in an attempt to identify any underlying factors such as mental health problems, bullying, or lack of social support that may provide an explanation, and so may guide support and treatment protocols at the Nottingham Centre for Transgender Health.

Method

In order to achieve a representative sample a method of randomisation was employed. This method consisted of selecting the first 15 accessible patient files of each letter of the alphabet that corresponded with the first letter of the patient's surname. If there were not 15 patient files available for a letter then the process moved on to the next letter. Although not truly random, an alphabetical approach does not significantly bias the data. Current patients were selected rather than discharged patients, as the data contained is naturally more up-to-date and thus, relevant to current treatment protocols. As this was a clinical audit measured against established treatment protocols, ethical permission was obtained from the relevant department of the Nottinghamshire Healthcare NHS Foundation Trust, which the Nottingham Centre for Transgender Health sits within.

The files were reviewed for any record of the patient detransitioning to at least a social level. This included scanning documents such as letters to/from the patient's general practitioner, patient diaries, clinician formulations, and legal change of name documents. Therefore, as mentioned previously, any account made by the clinician or the patient themselves of reverting to their birth-assigned gender was taken as an account of detransition. Those files with detransition were then screened for any underlying factors such as mental health problems, social support, discrimination, etc.

Results

Out of the 303 files screened, only a single instance of detransition was found. This detransition occurred during 2003 due to lack of support from their spouse, however they went onto re-transition three years later. It should be noted that there was retrospective data of two other people detransitioning, however, they were not under the care of the Nottingham Centre for Transgender Health at that time and so were excluded as their detransition would not directly inform our clinical protocols. Of the two patients who detransitioned before coming to the clinic; the first patient had transitioned three times (detransitioned twice) due to lack of family support; and the second had transitioned and detransitioned once for the same reasons. This gives an overall detransition rate by person of 0.99 per cent and a percentage of people within the current protocols of the Nottingham Centre for Transgender Health within the NHS of 0.33 per cent.

Discussion

These rates of detransition within current NHS treatment protocols at the Nottingham Centre for Transgender Health are reassuringly low. The services, including physical interventions such as hormones and surgeries, do not appear to lead to regret and detransition; at least while people are still being seen at the Nottingham Centre for Transgender Health; and we may infer from this that current protocols are enabling trans people to live in their desired gender.

However, although detransition was low, the factor that was prevalent in all cases was the lack of social support. It would seem that social support may be a protective factor against mental health problems associated with transitioning, and indeed this is reflected in the literature (e.g. Cohen & Wills, 1985). Taking this into consideration, it is important to recognise the benefits of family, relationships, and systemic influences in any incidents of regret or uncertainty, not just in adolescents (Lev, 2013). Indeed, minority stress (the stress of being in a minority and subject to prejudice) is a recognised factor in transgender mental health and we might reasonably assume it too has a part to play in rates of detransition in what is still a largely heterosexual and cisgender-oriented society.

When considering adaptations one could make to the protocols to account for detransition rates, aside from societal change, there is not an obvious intervention (or given the numbers, need). In the same way clinicians are encour-

aged to be cautious about the endorsement of permanent medical interventions; prolonging assessment may also have negative effects. Hypothetically, we could require an extended period of lived experience in order to identify those who may detransition, however, it is a case of risk of detransition versus risk of mental health problems from being untreated. Imposing a long wait to the general population of patients will have negative consequences whereas timely treatment can bring significant benefits. For example, Wilson, Chen, Arayasirikul, Wenzel and Raymond (2014) reported that when trans women utilised trans-related medical care such as hormonal therapy, this significantly reduced estimated odds of suicidal ideation, binge drinking, and non-injection drug use. Using this very low rate of detransition as a justification for extending the assessment period would seem to be unethical to the large majority who benefit from treatment.

Indeed, not only are the procedures currently used effective clinically but, for those of a more brute pragmatic disposition, they are also effective economically. For instance, the cost per suicide in England is £1.7 million (Knapp, McDaid & Parsonage, 2011) and Terada et al. (2011) found that 31.8 per cent of patients with untreated gender dysphoria had attempted to suicide and self-mutilate. Consider then that, Bauer, Scheim, Pyne, Travers and Hammond (2015) noted that access to medical transition contributes (alongside increasing social inclusion and reducing transphobia) to substantial reductions in prevalence of suicide attempts and ideation. Therefore, treatment is not only clearly morally appropriate, but may also be justified economically.

Limitations

Overall, although this study shows a low rate of regret at the Nottingham Centre for Transgender Health, this is only over a short period of time as the patients assessed were still within the service. It would be interesting to evaluate the long-term outcomes within the NHS as others have done elsewhere (Dhejne et al., 2011; Wiepjes, 2018). We say interesting of course, but note that long-term studies of decades duration are not demanded of other established medical interventions. Of course, as with all long-term studies, drop out will be high and is perhaps especially so in this population. Aside from pragmatic concerns such as contact address and other details changing over time, there are trans-specific reasons for loss of follow-up. For example, Carroll (1999) suggested that patients may drop out of follow-up due to not having had to think about transition for many years and understandably not wanting to prolong that period of their life. Similarly, there are also many barriers to research participation within these communities due to lack of trust and worries about being 'outed' (Owen-Smith et al., 2016).

Despite these limitations, a detransition rate of 0.33 per cent reassures us that the current protocols are working well, and that we will strive to evolve them to be even more client-centred; and even more respectful of individual autonomy while retaining excellent clinical safety.

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Audit approval was gained from the appropriate NHS authority.

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