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More than 'canaries in the gender coal mine': A transfeminist approach to research on detransition

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Abstract

Detransition is tied to three related but distinct concepts – the act of detransitioning, the 'detransitioner' identity, and the negative transition experience – which I refer to collectively using the umbrella term 'detrans'. Detrans research is inevitably political and value-laden, but different methodologies and research questions lend themselves to divergent goals. Drawing on work in the feminist philosophy of science and transfeminist scholarship, I draw a conceptual distinction between research aligned with the goals of 'preventing detrans' vs. 'supporting detrans'. Existing research has constructed detransition as a negative clinical outcome to be *prevented* because it has been focused on the causes of detrans and the detrans rate. Research associated with the goal of *supporting* detrans is defined by its focus on the experience and process of detrans itself. Research on preventing detrans constructs detrans as a divisive issue of zero-sum clinical risk, and it is not oriented toward helping people who detransition or who have a negative transition experience. Research on supporting detrans, in contrast, constructs detrans as an issue of inclusion and can be used to improve the medical and mental health care that detrans people receive. I argue that there is an urgent need for qualitative sociological research involving detrans people. I conclude with some broad guidelines for researchers studying detrans.

‘What detransitioned Women actually want:

1. Study into the safest way to stop T[estosterone].
2. Clothes that fit.
3. People believing the first answer when we get asked about pronouns…
4. Better peer support networks…
5. The Trans community to be a safe place…
6. Universal Health Care. Free therapy. Free surgery. Free recovery. Free meds. Free ambulances. Free and accessible and for everybody.
7. Student Loan Forgiveness’ (Freack, 2019)

‘Donating because free speech and biological sex matters. Detransitioners are the canary in the gender coal mine – we must listen to them.’ (anonymous comment left on Caspian, 2019)

The epigraphs above express two very different approaches to research on detransition and detransition communities. The first is a blog post written by a detransitioned woman laying out her own tentative wish list. It is accompanied by the following note: ‘notice how NONE of this is more gatekeeping’ (ie, restricting access to medical transition). Her desire for research on detransition is part of a broader agenda focused on providing material and social support to detransitioned women. The second epigraph is a note attached to an anonymous donation to James Caspian, a master’s student at Bath Spa University whose thesis project studying detransition was blocked by the university’s ethics review board.[1] By positioning detransitioners as the ‘canary in the gender coal mine’, the donor implies that the testimonies of detransitioners are valuable insofar as they signal a broader risk within the entire system of transition-related care, or perhaps within society as a whole. In the former approach, detransition research is important because it will help detransitioners; in the latter approach, detransition research is important because it documents a broader set of harms that must be prevented.

In this essay, I explicate the distinction between these two goals, preventing vs. supporting detransition, in order to think through the possible futures of research on detransition. I begin by distinguishing between ‘detransition’ as an act, ‘detransitioner’ as an identity, and the ‘negative transition experience’. Drawing on feminist philosophy of science and transfeminist scholarship, I argue that research on detransition is inevitably value-laden and political, and I sketch out what a transfeminist approach to detransition research might look like. I then review some of the relevant literature, including both clinical scholarship on transition regret and lay research on the online detransitioned women’s community carried out by detransitioned women themselves. In the second half of the paper, I elaborate on the conceptual distinction between research on preventing detransition and research on supporting detransition, outlining the values, methodologies, and consequences associated with each type. I conclude by providing some specific recommendations for future research on detransition, emphasising the importance of qualitative sociological research as well as other methodological approaches that focus on the experience and process of detransition itself in order to generate findings that might be used to help people who detransition.

Conceptualising detransition

Detransition can be broken down into three related but meaningfully distinct concepts: *detransitioning*, *detransitioner*, and *negative transition experience*. The first refers to an observable act or process, the second refers to a specific identity or label that assigns a particular meaning to detransitioning, and the third refers to a subjective experience that can be associated with detransitioning. *Detransition* is, in one sense, a descriptive verb that refers to the act of returning in some way to a pre-transition state. Detransition can have both medical and social components. Medically, someone who is detransitioning may stop taking hormones, or they may begin taking different hormones that are meant to return their hormone levels to a pre-transition state and prevent further change or reverse certain changes to secondary sexual characteristics. It may also involve surgical reversal. Socially, someone who is detransitioning may return to using the pronouns and/or name they used before transitioning, and they might change their gender presentation. Alternatively, someone who is detransitioning might keep their post-transition name, gender presentation, and/or pronouns. Just as transition is an individual process that varies considerably, there are many ways to go through a process of detransition. The term *retransition* is sometimes used to refer to the act or process of transitioning again after having detransitioned at some previous point.

Detransitioner or *detransitioned woman/man* are terms used to refer to a specific way of understanding the experience of detransition, as an identity and community who share this identity. Because these are identities, any definition involves pinning down a set of loosely shared meanings that exist in a particular space and time. 'Detransitioned women' are women who identify as 'detransitioned', which generally means that they were a) designated female at birth, b) identified as transgender men, non-binary, genderqueer, and/or transmasculine at some later point, and c) subsequently stopped identifying as transgender and came to identify as detransitioned women. Some use the term ‘detransitioned female’ because they do not ‘identify’ as women; rather, they ‘accept’ or ‘embrace’ themselves, or at least their bodies, as female (see Hailey, 2017; Stella, 2016). In contrast, while a transgender woman might choose to detransition temporarily by stopping hormones for a limited period of time (see Kanner, 2018), she would almost certainly not refer to herself as a ‘detransitioned woman,’ even if she is technically a ‘woman who has detransitioned’. That is a result of the distinction between detransition as act and detransition as identity; becoming a detransitioner involves a fundamental shift in one’s subjective understanding of oneself, an understanding that is constructed within these communities. Knowing a person’s medical history would give no insight into whether that person had detransitioned in this sense, because it refers to a specific way of making meaning out of the experience of detransition.

Some detransitioners draw a distinction between being ‘detransitioned’ and being ‘reidentified’. The former can refer to someone who medically transitioned and then medically detransitioned, while the latter can refer to someone who may only have socially transitioned, or who only ever identified as transgender but did not change their name, pronouns, or presentation. As a result, sometimes the term ‘detransitioned/reidentified’ is used to include both groups, but the term ‘detransitioned’ is also sometimes used as an umbrella term (see Hailey, 2017; Stella, 2016). The terms ‘desister’ or ‘desisted’ overlap with the term ‘reidentified’, in that they are sometimes used within detransition communities to refer to people who identified as transgender as some point as children or adolescents and then stopped. However, the term ‘desister’ comes from clinical research (eg, Steensma et al., 2013), and it is relatively uncommon as a term of self-identification.

Rather than using the most conceptually precise terminology that strictly maintains this act/identity distinction (ie, using the phrase ‘medically detransitioned detransitioner’ to refer to the intersection of detransition as act and detransition as identity), in this piece I use the term ‘detransitioner’ to refer to someone who both a) transitioned and detransitioned medically and b) identifies as a detransitioner or detransitioned man/woman/male/female. I recognise that the term detransitioner is not always used in this way, and that its meaning continues to be hashed out by these communities. To refer to the broader category of individuals who are or have been in the process of detransition, whether they adopt a detransitioner identity or not, I use the (admittedly awkward) phrase ‘people who have detransitioned’. For example, the category ‘people who have medically detransitioned' could include someone who has stopped taking hormones a) because of medical complications, b) because they only desired the longer-lasting effects from being on hormones for a few months, c) because they want to become pregnant, d) because they decided binary transition was not for them and now identify as non-binary, e) because they now identify as a detransitioner, f) because of a temporary lack of access to transition-related care, and so on.

I use the broad term *negative transition experience* (NTE) to capture a range of negative subjective evaluations of one's own transition or some aspect of it. The term NTE does not refer to the experiences of some third party. Though research on NTEs has often used narrower terms, like 'regret' and 'dissatisfaction' (see Dhejne et al., 2014; Lawrence, 2003), it seems likely that many NTEs that do not fit within these concepts. For example, a number of detransitioners have described grief as a crucial aspect of their detransition experience (eg, crashchaoscats, 2016). NTEs can be associated with a variety of aspects of transition: physical, psychological, economic, and social (see Callahan, 2018). NTEs can shift over time, emerging, subsiding, or changing form. The decision to detransition is not defined by any particular subjective experience. Thus, no one concept, including 'regret', should be the *a priori* term used to describe transition. It is imperative for researchers to recognise that negative transition experiences are not synonymous with the act of detransition or with identifying as a detransitioner (see Stella, 2016).

Though distinguishing between these three concepts (detransitioning, detransitioner, and negative transition experience) is incredibly important, my main argument here applies to research involving all three. Rather than continuously restating all three concepts, I use the term '*detrans*' to refer to this constellation of concepts. While I have generally tried to avoid using existing terms in ways that stray too far from their common usage, I am using the term 'detrans' in an idiosyncratic, analytic way for the sake of concision. Nevertheless, I believe that the distinction between these aspects of detrans is crucial. Researchers must be very precise, both conceptually and methodologically, regarding which of these concepts they are studying.

Theoretical background

There is no value-neutral, apolitical way to study detrans. Different forms of detrans research are each entangled with different goals, in a way that is constitutive of knowledge production more broadly and cannot be simply reduced to bias. Researchers have a limited amount of time and resources to spend pursuing grants and carrying out research; constructing a research question necessarily involves deciding not to study others. Within institutional constraints, researchers make value-laden decisions about what topics they should study, what problems are most important, and what questions are most likely to yield compelling findings (Elliott, 2017). Because the existing body of detrans research is quite small, the importance of these decisions is magnified. Moreover, value-laden decisions made now can influence which questions researchers pursue in the future. Furthermore, the particular design of any given study provides empirical support for a limited set of interventions. Taken collectively, these decisions about what questions to ask (and how) constrain, at least to some extent, the types of interventions that can become seen as effective or necessary in the future. Even if these constraining effects diminish in the long-term as a wider range of possible approaches are explored, these decisions can have substantial impacts in the near-term. Feminist philosophers of science have gone even further, arguing that the practical goals of a body of research are deeply embedded in the way that research is conceived, carried out, and evaluated (Douglas, 2000; Longino, 2013). In the words of Helen Longino, ‘Research cannot be separated from conceptions of what we want the resulting knowledge for’ (2013, p. 143).

Emi Koyama’s transfeminist manifesto provides a valuable starting point for imagining a transfeminist approach to detrans research. She writes, ‘[E]ach individual has the right to define her or his own identities and to expect society to respect them’ (Koyama, 2003, p. 245). This principle of gender self-determination has important methodological implications for studying detrans. Determining the past and present identity of a person who has detransitioned requires asking them. Therefore, we cannot and should not attempt to deny that detransitioners a) ever identified as transgender in the first place or b) truly stopped identifying as transgender (or a gender different from their assignment at birth). Koyama’s second principle states, ‘[W]e hold that we have the sole right to make decisions regarding our own bodies, and that no political, medical, or religious authority shall violate the integrity of our bodies against our will or impede our decisions regarding what we do with them’ (Koyama, 2003, p. 245). In the context of detrans research, this principle urges researchers to be sceptical of research that seeks to justify external constraints on decisions about transition *or* detransition. Instead, this principle implies that detrans research should be oriented toward enabling a wider range of options.

I also draw on Finn Enke’s analysis of the term ‘cis’ to insist that we allow detransitioners to exist in the irreconcilable gap between our concepts of trans and cis. Enke writes, ‘Despite their binary opposition, cis and trans are not functionally equivalent or parallel figures' (2012, p. 76). Detransitioners build community in the asymmetrical gap between these nonparallel figures. Unless we violate the principle of gender self-determination and ascribe some kind of false consciousness to them, detransitioned women and men are clearly not transgender. Describing them as cisgender is misleading, because it erases their history and experiences with transition and detransition. They often continue to deal with gender dysphoria (Stella, 2016), and many continue to experience what Heath Fogg Davis (2017) would describe as 'sex-identity discrimination'. By constructing a shared set of understandings about their experiences which overlaps with but is distinct from that of many trans communities, detransitioners refuse to 'preserve the stasis of cis as non-trans' (Enke, 2012, p. 74).

Cameron Awkward-Rich's (2017) essay, 'Trans, Feminism: *Or,* Reading like a Depressed Transsexual,' suggests one way of imagining the relationship between transfeminism and detransition communities. He asks:

> [W]hat might our expectations for trans/feminist thought oriented to social justice be if we took pain—in this case the psychic pain produced in the encounter between competing theories of gender that seem aimed at each other's annihilation—as a given, not necessarily loaded with moral weight? (Awkward-Rich, 2017, p. 836)

He imagines the figure of the 'depressed transsexual' encountering conflicts between 'trans' and 'feminism'. He writes, 'The depressed transsexual, then, might assess this situation and determine that the problem is not so much that (some) feminists would like him gone. Rather, the problem is that he is here, and now we all have to figure out how to live with that' (Awkward-Rich, 2017, p. 832). I want to apply this same approach: detransitioners are here, and now we all have to figure out how to live with that.

The detransition literature

To date, very little research has been done on detransition. Existing research has almost exclusively studied questions related to the rate of detransition or NTEs. That research has generally centred around the constructs of 'surgical regret' and 'desistance', but these constructs do not neatly map onto the conceptual framework I have put forth. For example, some studies on 'surgical regret' have measured the rate of what I call negative transition experiences (ie, 'regret' of a specific surgical procedure), while other studies on 'surgical regret' have measured the rate of medical detransition (ie, 'regret' of medical transition altogether). Overall, this body of research suggests that the rate of medical detransition after gender-affirming surgery is low (eg, Dhejne et al., 2014), and medical detransition is basically non-existent in desistance research. However, there is almost no research on the rate of detransition or NTEs among those who are taking hormones and have not undergone surgery. Similarly, the only research currently available on the online communities of detransitioners is from informal community surveys carried out internally. In general, existing research on detransition has primarily studied detrans as a negative clinical outcome to be avoided.

Transition regret

Most people who want to describe the detransition rate cite research on the rate of medical detransition after gender-affirming surgery (or 'surgical regret'). The most complete study available used Swedish government data regarding applications for gender-affirming surgery and 'regret applications' for a medical reversal of its effects (Dhejne et al., 2014). These applications were intertwined with the bureaucratic process for changing one's legal sex, and all costs were covered by national health insurance. Out of the 681 successful applicants for surgery in Sweden over the past 50 years, only 15 (2.2%) submitted regret applications. By accessing the complete records of applications to the Swedish government, Dhejne et al. provided a more complete picture than other studies that focused on a single clinic. The rate of regret applications among people who underwent gender-affirming surgery between 2001 and 2010 was only 0.3%. However, among those who did submit a regret application, the median length of time between surgery and regret application was about 8 years. Therefore, if half of the people who submitted a regret application did so 8 or more years after surgery, and the data on regret applications from the 2001-2010 cohort were collected in 2013 or 2014, this more recent 0.3% rate may be an artefact. Nevertheless, if one excludes the people who underwent surgery between 2001 and 2010, there were still only 14 regret applications out of 321 surgery applications (4.4%). Most studies of surgical regret have found rates below 5% (e.g., Hess et al., 2014; Krege et al., 2001; Lawrence, 2003; Nelson et al., 2009; Smith et al., 2005).

The existing body of research on surgical regret is limited in several ways. First, the research does not address the rate of transition regret for those who do not access surgery, or negative experiences with non-surgical aspects of transition. Second, the rigid clinical protocol and other features of the system for providing transition-related care in these European countries may not generalise to some other countries, like the United States. Third, it is possible that some people detransitioned without applying for a medical and legal reversal. While it seems likely that those who submitted ‘regret applications’ did detransition and stop identifying as transgender, it is still only a proxy for the act of detransition or for a shift in identity, and these statistics do not capture the particular motivations for detransition.

One study has assessed ‘known cases of regret’ after accessing hormones through informed consent clinics (Deutsch, 2012). Deutsch surveyed health professionals at 12 informed consent clinics in the United States that collectively treated 1,944 patients and searched academic, legal, and news databases for any cases involving a malpractice lawsuit regarding the provision of hormones. The sites surveyed reported seventeen known cases of ‘regret’, with only three instances ‘leading to reversal of gender transition’, for a ‘prevalence’ of 0.1% (Deutsch, 2012, p. 141). She summarises these results as having ‘revealed a low regret rate and an absence of any malpractice claims relating to regret’ (Deutsch, 2012, p. 146).

Insofar as this study is an attempt to ‘reveal’ the ‘regret rate’, it is significantly flawed. Anecdotally, many detransitioners who have NTEs report that they did not confront their previous doctors; they simply stopped showing up at the clinic they previously received services from (eg, crashchaoscats, 2018). In fact, when a well-funded socially conservative legal organisation began approaching detransitioners looking for potential plaintiffs for lawsuits against professionals providing transition-related care, prominent members of the detransitioned women’s community circulated a statement online urging other members not to get involved (Callahan et al., 2017). Thus, any methodological design that relies on adding up all the complaints lodged or lawsuits filed is profoundly limited. Treating the prevalence of lawsuits as an empirically valid indicator of the rate of NTEs might even *encourage* those who experience NTEs to file lawsuits against medical and mental health professionals involved in providing transition-related care. Some people who have an NTE might, upon learning about research using this measure, come to view filing a lawsuit as the best way to make themselves heard.

Desistance

While surgical regret research has been used to suggest the detransition rate is low, desistance research has been used to imply that the detransition rate is much higher than generally recognised. Longitudinal research involving gender non-conforming and/or gender dysphoric children and adolescents suggests that most ‘desist’, ie, come to identify with the gender they were designated at birth (eg, Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008). A number of scholars have criticised this research (eg, Temple Newhook et al., 2018;

Vincent, 2018b), and it does have a number of serious methodological limitations. Rather than wade into the complex debate over desistance research, however, I simply want to note that these studies do not report an overlap between desistance and medical detransition. There certainly are detransitioners who, if they had been enrolled in one of these longitudinal studies as a teenager, would have eventually been classified as a desister who also medically detransitioned (see, eg, McCann, 2017). Absence of evidence is not evidence of absence, but the available desistance research does not provide evidence for a substantial overlap between desistance and medical transition *per se*. More generally, my discussion here deals with the possibilities for research involving adults, not children or adolescents.[2]

Internal surveys of the online communities

Despite lacking formal research training, detransitioned women have carried out two online surveys of their communities to address the dearth of such research (Hailey, 2017; Stella, 2016). Summaries of these survey results have been posted online, including responses to the open-ended survey questions, but these data have not been formally published in any academic journal. Cari Stella's 2016 survey recruited 203 participants from Tumblr and private detransitioner Facebook groups. Participants included 'anyone female/AFAB who formerly self-described as transgender', including 'women who transitioned, whether socially and/or medically, and have subsequently detransitioned, as well as individuals who still identify as nonbinary or genderfluid, but have desisted from medical or social transition'. The average age at which participants decided to 'come out as trans and/or start transitioning' was 17, and the average age at which participants decided to 'stop' was 21. 12% of participants experienced only 'social dysphoria', 14% experienced only 'physical sex dysphoria', and 74% experienced both. When asked, 'How has stopping transition impacted your dysphoria?', 11% said it was 'completely gone', 64.5% said that it was better, 17% said it was the same, and 7.5% said it was worse. Participants were asked, 'What led you to stop your transition?', given 14 options, and told to check all options that applied. 59% of participants reported they 'found alternative ways to cope with dysphoria' and 63% selected 'political/ideological concerns'. These were the two most frequently selected options by around thirty percentage points. When participants were asked, 'Do you believe you were given adequate counselling and accurate information about transition?', 68% said no, 26% said 'somewhat', and 6% said yes. More broadly, 61% of participants had negative feelings 'toward transition in general', 8% had positive feelings, 17%

had neutral feelings, and 14% had mixed feelings or were not sure. Stella's survey did not ask participants whether they had medically transitioned. More broadly, the design of the survey's questions does limit the interpretation of some of the findings; the lack of questions about medical transition, as well as the 'double-barrelled' question that merged coming out and beginning transition, make it impossible to tell what percentage of these participants are 'detransitioners' vs. 'reidentified'.

Hailey's 2017 survey focuses primarily on co-morbid mental health conditions. She recruited 211 detransitioned females through social media, defined as 'any natal females who had in some way desisted from transition or trans identity'. Hailey states that 22% had taken testosterone or hormone blockers, and 8% had undergone surgery. She asked participants what mental illnesses they had been diagnosed with, if any, following up with an open-ended question: 'Do you feel that any of the conditions listed above contributed to your trans identification and/or transition? If so, how?' She reports that a number of participants did draw connections between their gender dysphoria and their experiences with a range of mental health conditions and provides examples from the open-ended responses for each condition.

Though these are informal surveys, they do suggest a few key features of these communities. The two most common reasons cited for detransition were that participants 'found alternative ways to cope with dysphoria' and 'political/ideological concerns'. This suggests that within detransitioned women's communities, detransition is both a strategy for managing dysphoric symptoms and a political act. Although many participants reported that detransition reduced their feelings of gender dysphoria, most participants continued to report some amount of gender dysphoria. One survey suggested that most participants from these communities did not medically transition. Overall, this literature review shows that detrans has been studied almost exclusively as a clinical outcome, and, outside of community surveys, not as an experience or process worthy of investigating itself.

Preventing detrans, supporting detrans

To think through the possibilities for research involving detrans people, I draw a conceptual distinction between research centred around two potential goals: preventing detrans and supporting detrans. Each type is characterised by an interrelated set of research questions, prototypical methodologies, embedded value judgments, and range of interventions. Research with the goal of preventing detrans involves studying what generalisable factors cause or predict detrans; research with the goal of supporting detrans involves studying the experience and process of detrans itself. As a result, there is an asymmetry between the two types: research on preventing detrans facilitates only interventions designed to reduce the detrans rate, while research on supporting detrans enables a wide range of interventions to help people during or after detrans in various ways. The values entailed by each type of research also reflect this distinction. Research on preventing detrans is entangled with negative value judgments about detrans (‘Detrans is harmful in and of itself’, ‘Detrans is a clinical failure’, ‘Detrans is an outcome to be avoided’), while research on supporting detrans entails positive value judgments about detrans (‘Detrans is a viable option’, ‘Post-detrans life can be liveable’, ‘Detrans experiences are important in and of themselves’). My argument is not that every researcher engaged in each of these types of research necessarily has these goals and value judgments; rather, this conceptual distinction is a way to describe how the research itself is, in a deeper sense, intertwined with certain goals and values.

Before delving into the methodologies and potential consequences associated with these two types of research, I want to address some potential objections to this conceptual distinction. First, isn’t there some ‘neutral ground’ between these two options where we simply try to ‘understand detrans’? Studying detrans will, in some way or another, inevitably affect the world. Even the most detached sociological study of detrans experiences will increase awareness of detransition as an option and as an experience, and therefore support detrans in an indirect way. Therefore, even this kind of study isn’t truly ‘neutral’, because it will change the world.

Second, why should we group together research on the causes of detransition *per se* with research on the causes of NTEs? I categorise both of them under ‘preventing detrans’ because they share methodological features and implicit value judgments and enable similar types of interventions. Research on preventing detrans will generally not help people who have already detransitioned, who already identify as detransitioners, or who already have had NTEs. Conversely, research on supporting detrans will be of limited usefulness in making the causal claims needed to justify interventions focused on reducing the ‘detrans rate’ (eg, restricting access to transition-related care).

Finally, are these two types even meaningfully distinct? One can frame this question methodologically: is it possible to investigate the causes of detrans by studying detrans experiences? This question raises complex issues regarding causal inference in qualitative sociological research. For example, imagine a qualitative interviewer carries out a study of the way that detrans people make meaning about their experiences through narratives. Some sociologists would argue that such data can only generate hypotheses for future research into the causes of detrans; others would argue that this data could provide explanations regarding 'local causality' in those specific cases (see Maxwell, 2004, 2013). Alternatively, some sociologists might reject the goal of developing generalisable causal theories using qualitative methods entirely. But even researchers who argue that qualitative research can be used to make causal claims acknowledge the limited utility of qualitative methods for providing straightforwardly generalisable answers to 'variance questions' about correlations (eg, Maxwell, 2004, 2013). More broadly, it is possible to imagine a study that combines methodological designs associated with both goals, or that exists in some middle ground between them, but these possibilities do not negate the usefulness of the preventing/supporting distinction.

Methodologies

Rather than provide an in-depth analysis of different methodologies, my goal here is to sketch out a range of possible research designs for studying detrans and their associated methodological issues. In general, research on preventing detrans attends to the range of causes that lead to one outcome; in contrast, research on supporting detrans has a shared starting point, but it can go in many directions. Because of the difficulties with detrans research carried out in clinical contexts, I argue that a sociological approach is, in some ways, more feasible and useful. However, both clinical and sociological approaches are represented within each type of detrans research.

The prototypical methodological approach for clinical research on preventing detrans is the observational longitudinal study. A sample of trans participants are recruited from clinics that provide transition-related care. When a participant enters the study, researchers gather data on the factors that they hypothesise cause or predict detrans: demographics, psychological variables, environmental factors, etc. In prospective studies, participants are followed for many years and periodically surveyed or interviewed. In retrospective studies, researchers rely on official records (medical, legal, etc.) to gather data about participants' trajectories. Participants classified as detrans are compared to the rest of the cohort. The end result is a set of evidence that supports claims about which people who access transition-related care are most likely to become detrans, however defined. Such evidence could clearly be used to argue for changing clinical protocols, especially attempts to restrict access to transition-related care in order to lower the detrans rate. Alternatively, this methodological design could be used to test other hypotheses about what predicts detrans (eg, internalised cissexism, job discrimination), which might enable a different form of surveillance and intervention into the lives of people who access transition-related care.

Studying the causes of detrans using an observational longitudinal design creates three sets of problems: getting enough data, getting meaningful data, and collecting data in a clinical context.[3] The research reviewed above suggests that medical detransition after gender-affirming surgery happens years later and is quite rare (<5%), which causes statistical problems that can only be fully mitigated by increasing the size of the study. Accumulating a sample of people with NTEs who have detransitioned through a prospective longitudinal study is likely difficult because of participant drop out. Anecdotally, some detransitioners have reported feeling betrayed by, or at least suspicious of, the medical and mental health professionals that they previously sought services from, choosing to stop showing up for appointments instead of confronting those professionals (eg, crashchaoscats, 2018). Therefore, the key participants might be the ones least likely to be available for follow-up. Retrospective designs using medical records can make it easier to collect data regarding a larger sample over a long period of time, but this design cannot capture the fundamentally subjective dimensions of detrans because it relies on medical detransition as an indicator of NTEs or identity shifts. Furthermore, even if the rate of medical detransition is higher among participants who are taking hormones and have not undergone surgery, the motivations for stopping hormone replacement therapy vary widely (see ‘conceptualising detransition’). Therefore, clinical researchers must ask participants about their decision in order to gain meaningful information about such an outcome. Finally, there are ethical issues involved with recruiting research participants in contexts that provide transition-related care, especially longitudinal research that seeks to recruit participants as they are starting their medical transition, because potential participants may feel implicitly pressured to consent to a study in order to access care (Adams et al., 2017).

A prototypical methodological approach for research on supporting detrans would be the in-depth qualitative interview, which can shed light on detrans peoples’ experiences and the way they navigate their lives. A study of people who have detransitioned could investigate the diverse range of meanings associated with detransition. A study involving detransitioners or people with NTEs could delve into their narratives, the kinds of struggles they have encountered when interacting with medical/mental health systems, their experiences of gender dysphoria, the ways they have found to manage that dysphoria, their experiences with detransition communities, and so on. Other useful qualitative designs include focus groups, qualitative diary research, and ethnography. Detransitioners have discussed their experiences extensively on social media (see Callahan, 2018), but qualitative research with detransition communities provides a way for researchers to, with participants' informed consent, systematically bring these experiences into the academic literature. Researchers could also use qualitative methods to learn more about the experiences of people who detransition and then retransition. Regardless, sociological research using qualitative methods is not only more feasible than the aforementioned longitudinal quantitative designs, but can provide practically useful research in a much shorter time frame.

Because research on supporting detrans starts with detrans people's lives, rather than attempting to reduce the number of detrans people in the world, it encompasses a wider range of clinical and sociological methodologies. A mental health researcher could gather information from online detransition communities about alternative strategies for reducing gender dysphoria in order to design and test the efficacy of a novel psychotherapeutic approach to gender dysphoria among detrans people. A sociologist could use discourse analysis to study how detrans people interact with representations of detrans on social media and in journalistic media coverage. A medical researcher could closely study the timeline of physical effects of medical detransition, both the near-term direct effects and the long-term health effects. These are just a few examples, but they point to the myriad possibilities that are enabled when we shift away from a narrow focus on measuring the 'detrans rate' and investigating the causes of detrans.

Consequences

The future of detrans research will have consequences for both the types of interventions that are enabled and the broader sociopolitical dynamics within and between trans communities, detransition communities, researchers, anti-trans political groups, and so on. Research on preventing detrans will almost certainly be used to argue for restricting access to transition-related care or for other interventions designed to reduce the likelihood of detrans. If, for example, millions of dollars were poured into years of research on the causes of NTEs, we *might*, twenty years from now, generate enough evidence to construct controversial interventions to reduce the rate of NTEs. These interventions, in turn, might take many years to have the intended effect, if ever. If they involve creating additional barriers for trans people to access healthcare, the harm done could vastly outweigh whatever marginal effect they might have on preventing detrans. All the time and money spent on such research would have done absolutely nothing to help detrans people in the meantime. Alternatively, researchers who believe strongly in the goal of preventing detransition might respond to the methodological difficulties of such an approach by producing poor quality research. For example, they might elide the distinction between different kinds of detransition in order to inflate sample sizes.

Research on supporting detrans could enable a variety of interventions designed to help detrans people. Currently, there is no clinical protocol for detransition, and there is no explicit place for detransition within the present model of gender-affirming care (Turban & Keuroghlian, 2018). Sociological research on supporting detrans would provide a valuable starting point for creating such a clinical protocol, with clear guidelines for medical and mental health professionals about how to provide competent, supportive care for detrans people. Research could also provide the basis for other therapeutic options for detrans people who continue to experience gender dysphoria (eg, psychotherapy tailored to the needs of detrans people).

To put it differently, research on preventing detrans constructs detrans as a matter of risk, whereas research on supporting detrans constructs detrans as a matter of inclusion. In the former, detrans is an issue of zero-sum clinical risk that pits detrans and trans communities against each other: the risk of NTEs vs. the risk of harm from strategies to prevent NTEs. In the latter, detrans is an issue of clinical inclusion, a subpopulation with their own particular medical and mental health needs. Both types of research increase awareness of detrans, but in very different ways: as a problem to be mitigated vs. as a set of experiences to be included.

Neither type of research is uncontroversial, nor will either type of research lead to a stable political equilibrium. Research on preventing detrans will almost certainly be weaponised against trans communities and/or detrans communities, exacerbating tensions between these communities for decades to come. Research on supporting detrans will almost certainly increase the perception that detrans is a viable option, accelerating the construction of identities related to detransition and heightening the salience of detrans communities. This might, ironically, increase the number of people who identify as detransitioners, and they could push for research on the causes of detrans. Considering the stigmatising and invalidating historical associations with psychotherapeutic approaches to gender dysphoria (see, eg, Byne et al., 2012, p. 778; Meyerowitz, 2004), research on such interventions involving detrans people might be seen as dangerous or pathologising. But providing evidence that detrans people can live happy, satisfying lives, and designing interventions toward that end, actually undermines anti-trans rhetoric that uses the stories of detransitioners to claim that transitioning ruins lives. Certainly, the sociopolitical consequences of research into effective, non-medical interventions for managing gender dysphoria could be incredibly volatile, even if the only participants in such research were detransitioners. Regardless, research on supporting detrans is more likely to legitimise a pluralistic approach to detrans issues, whereas research on preventing detrans is more likely to legitimise a polarising zero-sum dynamic.

Recommendations

The conceptual framework I have put forward has clear implications for how future detrans research should be conducted. Broadly, it is crucial that researchers are thoughtful and precise about what aspect of detrans they are studying, the relationship between their construct and their methodology, and the way their object of study is communicated to potential participants. Depending on the context, detrans might be defined in a purely medical way, eg, as referring merely to the process of stopping hormone replacement therapy for any reason, or it might be defined in a purely subjective way, as referring to a particular identity label. Similarly, although using respectful terminology is important, a set of terms that is affirming to participants from transgender communities could be off-putting to participants from detransition communities, and vice versa. Some guidelines for research involving transgender participants do also apply to detrans research (Adams et al., 2017; Vincent, 2018a); after all, some detrans research involves recruiting both detransitioned and transgender participants! The best way to navigate these complexities is to be transparent (Vincent, 2018a) and to elicit feedback from potential participants before, during, and after the process of designing and carrying out a study (Adams et al., 2017).

In particular, I believe qualitative interview-based sociological research involving participants from online detransition communities is feasible and urgently needed, regardless of whether the rate of detransition is increasing or decreasing. There is no need to use rhetoric about a ‘rising epidemic’ or ‘contagion’ in order to argue for the importance of studying detransitioners because their experiences are valuable in and of themselves. My impression is that detransition communities are eager to be involved with respectful research, including studies of the diverse range of experiences and narratives within detransition communities across gender, sexual orientation, class, and race. As seen in the first epigraph, detransitioners have also expressed interest in medical research that could be used to refine clinical protocols for stopping hormone replacement therapy, which would benefit trans people who medically detransition for any reason as well. Regardless, researchers must not use qualitative research involving detransitioners to make tenuous, generalised claims about the causes of detransition more broadly; there are plenty of other valuable insights that such evidence can actually provide.

I began this piece by applying the distinction between preventing and supporting detrans to two quotes that imagine, in divergent ways, what it would mean to 'listen to detransitioners'. Although I did not delve into the complex discourses around detransition, I suspect the preventing/supporting distinction is conceptually useful outside of the context of detrans research. Yet some important ideas are excluded from this duality. For example, the call for broader economic justice made in the first epigraph shows how the political concerns of detransitioners can transcend detrans-specific issues. Similarly, the alignment between the goal of supporting detrans and the idea of clinical inclusion downplays the deeply ideological meaning of detransition for some detransitioners (see Stella, 2016). Nevertheless, the conceptual framework I have presented here highlights the importance of considering detransitioners as more than canaries, as more than ill-fated indicators of some broader risk to be prevented. Respecting the struggles of people who detransition, who identify as detransitioners, and who have negative transition experiences necessitates considering their experiences as real, distinct, and worthy of study in their own right.

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[1] A sufficiently detailed account of this messy conflict is too convoluted to recount here. My attempts to obtain independent verification of important details by contacting Caspian for access to his study materials have been unsuccessful.

[2] As the age of the respondents in the internal online surveys of the detransitioned women's community suggest, drawing a sharp distinction between these two sets of possibilities undoubtedly oversimplifies the issues involved.

[3] Researchers could also use a cross-sectional design to study the clinical or social determinants of detrans. For example, a researcher could recruit samples of trans and detrans participants from online communities, using an online survey to test hypotheses about how certain variables correlate with detrans. Such a study is much more feasible than longitudinal research, but from the perspective of most quantitative researchers, it is considered significantly weaker causal evidence.