

# Psychology of Sexual Orientation and Gender Diversity

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# Do Gender Assessments Prevent Regret in Transgender Healthcare? A Narrative Review

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Gender assessments are traditionally required before accessing gender-affirming interventions such as hormone therapy and transition-related surgeries. Gender assessments are presented as a way of preventing regret experienced by some people who reidentify with the gender they were assigned at birth after medically transitioning. This article reviews the theoretical and empirical foundations of commonly used methods and predictors for assessing trans patients' gender identity and/or dysphoria as a condition of eligibility for gender-affirming interventions. We find that the DSM-5 diagnosis, taking gender history, standardized questionnaires, and regret correlates rely on stereotyping, arbitrary, and unproven considerations and, as a result, do not offer reliable ways of predicting future regret over-and-above self-reported gender identity and embodiment goals. This finding is corroborated by empirical data suggesting that individuals who circumvent gender assessments or pursue care under an informed consent model do not present heightened rates of regret. The article concludes that there is no evidence that gender assessments can reliably predict or prevent regret better than self-reported gender identity and embodiment goals. This conclusion provides additional support for informed consent models of care, which deemphasize gender assessments in favor of supporting patient decision making.

### **Public Significance Statement**

Transgender people who want gender-affirming medical care often have to go through a psychological assessment to confirm whether they are “really” trans. These assessments are meant to prevent regret later on. This article looks at the science and concludes that there is no theoretical or empirical support for the belief that assessments of gender help prevent regret better than leaving the decision up to the patient. Clinicians should consider adopting informed consent models of care, which move away from gender assessments and focus on helping patients make the best possible decisions for themselves.

*Keywords:* transgender, gender dysphoria, assessment, detransition, regret

Mandatory gender assessments prior to accessing gender-affirming medical care are often presented as a compromise between the competing interests of transgender individuals and of detransitioners who later regret initiating hormone therapy or undergoing transition-related surgeries (MacKinnon et al., 2021). On the one hand, facilitating access to gender-affirming interventions alleviates the ongoing distress of people who desire them. Gender assessments as a prerequisite to accessing gender-affirming

care have been described as dehumanizing, unjust, and a barrier to care (Ashley, 2019a; MacKinnon et al., 2020). On the other hand, a minority of people who pursue gender-affirming care later detransition and regret the changes brought on by the interventions. Assessing the person's gender identity and/or gender dysphoria, according to the compromise position, would mitigate the risk of regret while ensuring continued access to gender-affirming care.

The compromise position is predicated on the assumption that gender assessments can reliably distinguish between trans people who will be benefited by gender-affirming care and detransitioners who would regret the interventions. Gender assessments as a requirement for gender-affirming interventions are based on clinical opinion and theoretical arguments rather than empirical evidence (Bouman et al., 2014; Cavanaugh et al., 2016; Coleman et al., 2012; Safer & Tangpricha, 2019; shuster, 2016; see also Marrow, 2023). The theoretical and empirical soundness of these assumptions has not been comprehensively examined in the scholarly literature. In this narrative review, we explore whether gender assessments prevent regret associated with gender-affirming interventions. Based on our review of the

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available evidence, we conclude that there is no compelling evidence that gender assessments can reliably predict regret. The conclusion provides further support for informed consent models of care, which deemphasize or abandon gender assessments and focus on supporting trans individuals' informed decision making around gender-affirming interventions (Ashley et al., 2021).

The article is structured as follows. First, we clarify our terminology and distinguish between retransition, detransition, and different forms of regret. Second, we survey whether various assessment methods can reliably predict regret. And third, we explore whether outcomes data suggest that gender assessments are effective at preventing regret.

### Concepts and Terminology

To evaluate the effectiveness of gender assessments, it is necessary to first determine what outcomes these assessments should ethically seek to minimize. Some clinicians have historically sought to minimize the likelihood of someone continuing to identify as trans and/or accessing gender-affirming interventions because of a belief that being trans is inherently undesirable (Ashley, 2022b). However, these approaches are tantamount to conversion practices and are no longer considered ethical (Ashley, 2022b; Coleman et al., 2012; Madrigal-Borloz, 2020).

Ceasing hormone therapy or seeking to reverse a gender-affirming surgery are not in-and-of-themselves undesirable outcomes. Some individuals discontinue hormone therapy because they have reached their embodiment goals or desire to embody their gender without being on hormone therapy permanently (MacKinnon, Gould, et al., 2023). Some individuals stop hormone therapy temporarily for social reasons, medical reasons, or because of other goals like wanting to conceive a child (cárdenas, 2016; Falck et al., 2021). Some individuals cease hormone therapy because of medical contraindications. Some individuals pursue hormone therapy while desiring only some of the changes it brings and discontinue the intervention upon realizing that undesired changes are occurring more rapidly than desired changes. And yet others may discontinue hormone therapy because trying it helped them realize that their embodiment goals do not include hormone therapy (Turban et al., 2018; Turban & Keuroghlian, 2018). While reversing surgery is more likely to be a concerning outcome, it would not be in every case. For instance, the individual seeking surgical reversal may be grateful for the previous surgery but have experienced an evolution in their embodiment goals and prefer having had surgery followed by surgical reversal to not having had surgery at all. In the absence of regret, none of these scenarios are inherently undesirable.

Transitioning back to one's gender assigned at birth is not inherently undesirable either, which we call retransition for the purpose of this article.<sup>1</sup> Retransition often occurs for external reasons unrelated to a person's gender identity such as family pressure, social stigma, and experiences of discrimination (Turban et al., 2021). As many as 13.1% of trans adults have retransitioned at some point in their life; of those, over 87.1% retransitioned for reasons other than fluctuations or doubts about their gender identity and desires (Turban et al., 2021). These retransitions are often temporary and reflect a wide diversity of transition trajectories. The process of retransition does not imply that the initial transition was undesirable. Decisional regret that emanates from discrimination and stigma are not properly attributable to gender-affirming care and do not militate against its access. Holding

otherwise risks blaming trans communities for the marginalization they experience and may reinforce stigma toward them.

Retransition is sometimes motivated by a shift in gender identity such a reidentifying with one's gender assigned at birth, which is often termed detransition. While detransition is often presented as an inherently undesirable outcome, many people who detransition express neutral or positive feelings toward their initial transition (MacKinnon, Gould, et al., 2023). In a composite case study, Jack Turban and Alex Keuroghlian described a young adult who had discontinued testosterone and "did not regret her social affirmation or any physical changes that occurred during this process," instead identifying hormone therapy as "an important part of her identity formation" and expressing gratefulness "that her psychotherapist carefully facilitated her process of introspection through her transition period" (Turban & Keuroghlian, 2018). Changes brought on by hormone therapy or surgery are not always inconsistent with detransitioners' embodiment goals, as bodily desires do not always align with dominant expectations. Many detransitioners are gender nonconforming (MacKinnon, Kia, et al., 2022). The scholarly literature includes multiple examples of detransitioners expressing neutral or positive feelings toward social and/or medical transition (Brik et al., 2020; Durwood et al., 2022; MacKinnon, Kia, et al., 2022; Turban & Keuroghlian, 2018; Turban et al., 2018). Detransitioners' feelings toward their initial transition are not static and may shift from negative to neutral or positive feelings over time, associating negative feelings that they previously expressed with their social environment (Leveille, 2022; Schevers, 2021a, 2021b). It is not known what proportion of detransitioners experience regret or other negative feelings about transitioning. In the absence of such feelings, however, detransition is not an undesirable outcome.

The confluence of detransition and regret is undesirable. It is reasonable to assume that a detransitioner who regrets receiving gender-affirming care would have been better off not receiving it. For the purposes of this article, we assume that assessments are valuable to the extent that they minimize regretful detransition, all other things being equal. Two qualifications are in order, however. Regret is a proxy rather than an end point, and not all regret counts.

First, regret serves as a proxy for the fact that a person would have been better off not transitioning. However, it is not wholly reliable in this respect. Retrospective judgment is subject to various cognitive distortions such as confirmation bias, present bias, outcome bias, and hindsight bias. For some, not transitioning may prevent the psychological development that leads to detransition and regret. Perhaps, the person would be displeased with their gendered situation regardless of whether they transition. Perhaps, the person would have experienced ever greater regret and distress had they not transitioned. Perhaps, transitioning improved the person's lifelong psychoemotional well-being and life satisfaction, despite eventual or transient regret. Nevertheless, short of a time machine, regret is a helpful and adequate proxy for whether a person would have been better off not transitioning.

Second, regret is a complex experience and not all regret is a source of serious ethical concern (McQueen, 2017; Narayan et al., 2021). Regret may involve countervailing positive sentiments and

<sup>1</sup> Retransition is sometimes used to refer to the process of resuming social and/or medical transition after detransitioning (MacKinnon, Gould, et al., 2023). The heterogeneity of language around detransition reflects ongoing terminological evolution across different groups and settings.

attitudes, whether simultaneously or successively. For instance, a person may say that part of them regrets transitioning but part of them is grateful for it. Or the person could be satisfied with having transitioned most of the time yet see regret rear its head from time to time. These forms of partial and occasional regret are part and parcel of the human experience and are neither grave nor consistent enough to guide clinical practices. Regret may also pertain to something other than the decision to pursue a gender-affirming intervention, such as timing, choice of surgeon or technique, technological advancement, availability of support, surgical complications, recovery, or degree of preparation. When we speak of regret as something to be prevented in this paper, we refer to all-things-considered, consistent regret at having received a gender-affirming intervention. This is a form of blanket regret that is stable over time and does not involve significant countervailing emotions.

Despite the ethical nuances and limitations of notions such as detransition and regret, regretful detransition is typically an undesirable outcome that should be prevented if reasonably possible. In the remainder of the article, we use the terminology of regret to refer to this kind of blanket regret experienced by detransitioners unless otherwise indicated.

### Gender Assessment Methods

Clinicians use varied means of assessing gender identity and/or gender dysphoria, and no method has been identified by the literature as a gold standard. This section surveys four different approaches for assessing gender and predicting regret: (a) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) diagnosis, (b) gender history, (c) standardized questionnaires, and (d) regret correlates. Clinical practice often draws on multiple of these approaches simultaneously. The boundaries between these methods can be fuzzy but the division into four approaches is nevertheless useful for structuring the present analysis.

From a conceptual and theoretical standpoint, it does not appear that any of the four methods can accurately predict or prevent detransition or regret. The methods rely on a host of considerations that are unreliable, irrelevant, and stereotyping, considerations that are addressed during the informed consent process, and considerations that are functionally equivalent to self-reported gender. Based on a careful review of the four methods, we find no support for the claim that gender assessments prevent detransition or regret better than self-reported gender identity and embodiment goals of those who seek out gender-affirming care. In the words of Sandy Stone (2013, p. 227):

Professionally speaking, a test or a differential diagnosis was needed for [being trans] that did not depend on anything as simple and subjective as feeling that one was in the wrong body. The test needed to be objective, clinically appropriate, and repeatable. But even after considerable research, no simple and unambiguous test for gender dysphoria [...] could be developed.

### DSM-5 Diagnosis

Gender assessment commonly involves a diagnosis of gender dysphoria under the fifth version of the DSM. Insurance providers in the United States often require the diagnosis as a condition of coverage, and many clinicians mistakenly believe that it is required by the *Standards of Care, Version 7* of the World Professional Association for Transgender Health (WPATH; Ashley, 2021; Coleman et al., 2012).

Adults and adolescents can be diagnosed with gender dysphoria if they demonstrate a marked incongruence between their gender identity and gender assigned at birth for at least 6 months, which leads to significant distress or functional impairment (American Psychiatric Association, 2013). The incongruence can be established by satisfying two out of six criteria: (a) marked incongruence between gender identity and current bodily sexual characteristics, (b) strong desire to be rid of current bodily sexual characteristics because of said marked incongruence, (c) a strong desire for the bodily sexual characteristics of “the other” gender, (d) a strong desire to be of another gender, (e) a strong desire to be treated as another gender, and (f) a strong conviction of having the typical feelings and reactions of another gender.

The criteria can be simplified to having bodily gender dysphoria (a, b), wanting gender-affirming care (c), self-reported gender (d, e), and belief that one is psychologically typical for one’s gender (f). Because only two criteria are required for a diagnosis, it is possible for someone to be diagnosed with gender dysphoria without bodily gender dysphoria or wanting gender-affirming interventions, such as by fulfilling criteria (e) and (f). Someone who wants gender-affirming interventions but only experiences gender euphoria or creative transfiguration,<sup>2</sup> however, may be denied a diagnosis because they do not meet the requirement of significant distress or functional impairment (Askevis-Leherpeux et al., 2019; Beischel et al., 2022; Jacobsen & Devor, 2022; Shook et al., 2022). Pursuing gender-affirming care because of gender euphoria or creative transfiguration has not been shown to be associated with detransition or regret. Gender nonconforming trans people are also less likely to meet the threshold for a diagnosis because of the reliance on gender stereotypes in criterion (f). The childhood diagnosis relies even more heavily on gender stereotypes, with five of the eight criteria reflecting gender norms and stereotypes. Six of the eight criteria must be fulfilled to receive a diagnosis.

The diagnosis of gender dysphoria in adolescents and adults is not tailored to gender-affirming interventions and does not distinguish between desires or feelings based on the body part they pertain to. Someone could secure a gender dysphoria diagnosis based on breast-related distress and subsequently use the diagnosis to access genital surgery. While it is implausible that the person would pursue genital surgery absent other gender-related reasons like gender euphoria or creative transfiguration, the scenario highlights how the DSM-5 diagnosis is ultimately reliant on patients’ self-knowledge and tendency to make decisions in their best interests.

Each of the criteria for a diagnosis depends on self-report, raising questions about whether they can predict or prevent regret any better than self-reported gender identity or embodiment goals. With the exception of criterion (f), which is predicated on gender norms and stereotyping, all criteria can be summarized as self-reported gender identity, gender dysphoria, or desire for gender-affirming interventions. To the extent that gender assessments aim at predicting regret better than informed consent models, which center patient’s self-reported desires and needs, a diagnosis under the DSM-5 does not appear to offer a reliable way of gatekeeping gender-affirming interventions.

<sup>2</sup> Creative transfiguration refers to sentiments grounded in aesthetic sentiment and self-making: “Foregrounding creativity and aspirational aesthetics, creative transfiguration sees the body as a gendered art piece that can be made ours through transition-related interventions” (Ashley, 2019a, p. 481).

Outside the United States and Canada, the eleventh revision of the *International Classification of Diseases* (ICD-11) offers an alternative diagnostic scheme to the DSM-5 (World Health Organisation, 2018). Its analogous diagnosis uses language that is reminiscent of the DSM-5:

Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to "transition" in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. [...] Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

The ICD-11 does not reproduce the DSM-5's emphasis on distress or functional impairment (Askevis-Leherpeux et al., 2019; Robles et al., 2022). Its diagnosis is more narrowly tailored to gender identity, and frames gender-affirming interventions as a consequence rather than cause of being trans. The qualification that the incongruence must be "marked and persistent" does not appear to be based on empirical evidence. While avoiding many of the flaws associated with the DSM-5, the ICD-11 diagnosis can also be reduced to self-reported gender identity, and is thus unlikely to fare better at predicting or preventing regret than informed consent models. We are not aware of studies examining the reliability of either the ICD-11 or DSM-5 at predicting regret.

## Gender History

Another common form of gender assessment involves ascertaining the history and development of the person's gender identity and/or gender dysphoria. Taking gender history is sometimes part of establishing persistent and well-documented gender dysphoria or gender incongruence, which is required under the standards set by WPATH (Coleman et al., 2012; see also 2022).

Historically, trans people who began to experience gender dysphoria at a very young age were thought to have a better prognosis when accessing gender-affirming care. Youths who began displaying transness or gender dysphoria before puberty were thought more likely to be heterosexual and benefit from gender-affirming care. By contrast, those whose transness or gender dysphoria did not become evident until later were thought to be more likely queer, drawn by fetishistic motives, assigned male at birth, and less likely to benefit from gender-affirming care (Lawrence, 2003). Classification based on age is closely linked to classification based on sexual orientation, and was often used to evaluate who is "truly" trans. Under the early typology proposed by Benjamin (1966), "true" transsexuality was limited to individuals who were predominantly or solely attracted to men and emerged in early childhood. Despite purporting to establish a descriptive typology, those who did not conform to his "true" transsexual subtype were denied vaginoplasty and often hormone therapy as well. The requirement seemed motivated by a desire to ensure that patients would not attract negative public attention, which could adversely impact clinicians (Marrow, 2023). Remnants of Benjamin's undeniably outdated work remain in contemporary practices.

Age is not a reliable predictor of regret. According to one study, recalled childhood femininity is a very poor predictor of surgical regret, accounting for less than 3.6% of the variance in occasional regret (Lawrence, 2003; see also Landén et al., 1998).<sup>3</sup> Regret is far rarer

than we would assume if late-onset gender dysphoria was a reliable predictor of regret. Around 40% of trans adults began feeling different from the gender they were assigned at birth at or after 11 years old, and 19% began feeling different at or after 16 years old (James et al., 2016, p. 45). Yet serious regret following gender-affirming interventions is reported by fewer than 1% of people (Bustos et al., 2021). Exploring the history and development of gender dysphoric feelings is therefore of limited usefulness.

Taking gender history may also involve assessing the person's gender expression based on an implicit belief that someone who is genuinely trans would want to conform to social norms associated with their gender identity. Anecdotally, many transfeminine individuals have reported being denied or experiencing delays in accessing hormone therapy for wearing jeans and T-shirts instead of dresses, for having a name deemed insufficiently feminine, or for being comfortable with facial hair, among other things. These considerations are rooted in gender stereotypes, holding trans individuals to unreasonable and binary standards of masculinity and femininity that do not account for the existence of gender nonconforming trans people. The relevance of gender expression to gender-affirming care is assumed rather than established, and no known study demonstrates elevated rates of regret among gender-nonconforming trans people.

## Standardized Questionnaires

Standardized questionnaires are often used to evaluate gender identity and/or gender dysphoria at large gender identity clinics with significant research activity. Although commonly used in clinical work, these questionnaires are not tailored for establishing readiness or eligibility for gender-affirming care (St. Amand & Fitzgerald, 2017). The dual clinical and research purpose of questionnaires poses ethical issues, as it fosters the risk of therapeutic misconception (Kimmelman, 2007) and sheds doubt as to the quality of consent to research since patients often fear that refusing would jeopardize their access to care (Adams et al., 2017; Pearce, 2018b).

The two leading questionnaires in the literature are the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIGDQ-AA), which features 27 binary questions, and the Utrecht Gender Dysphoria Scale (UGDS), which features 12 questions scored on a 5-point Likert-type scale (Deogracias et al., 2007; Schneider et al., 2016). While the questionnaires are reasonably specific and sensitive, their validity was evaluated based on how well they tracked diagnoses made under the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR). Their reliability at predicting detransition or regret is therefore limited by the reliability of DSM diagnoses. Moreover, the questionnaires were not validated against the more recent DSM-5, which is substantially narrower than the DSM-IV and DSM-IV-TR diagnoses.

The GIGDQ-AA and UGDS are conceptually flawed on multiple accounts. First, they are rooted in a binary and transnormative understanding of gender, and do not adequately account for the experiences of nonbinary people or people whose gender embodiment goals do not conform to dominant expectations (Bradford & Syed, 2019; Hastings et al., 2021). While there have been attempts to adapt standardized questionnaires for nonbinary people, the adapted versions continue to

<sup>3</sup> The study does not disclose the percentage of variance explained by age; however, the factor that accounted for the largest percentage of variance only accounted for 3.6%, placing an upper boundary on the number.



rely on totalizing references to the norms, roles, and physical characteristics associated with the person's gender assigned at birth (e.g., Hoq et al., 2023; McGuire et al., 2020). Nonbinary people remain likely to score lower even if their desires, needs, and goals for a specific intervention are the same, such as if they only experience dysphoria toward some physical characteristics but not others, undermining the questionnaires' usefulness in assessing eligibility for gender-affirming interventions. Second, they overly emphasize gender dysphoria to the exclusion of other motivations for pursuing gender-affirming care such as gender euphoria or creative transfiguration. Third, the questionnaires indiscriminately merge feelings toward all primary and secondary sexual characteristics despite the fact that the person may only wish to alter some of them (Hastings et al., 2021). Fourth, they include factors that are irrelevant to gender identity or gender embodiment goals, such as gender expression and feelings toward gender roles and stereotypes. Gender non-conformity and resistance to gender roles and stereotypes are common among cisgender people, and trans people often entertain a complex and nuanced relationship to them that cannot be adequately captured by a binary or Likert-type scale. A recent study found that only 52.5%–54% of trans people reported that the GIGDQ-AA and UGDS accurately reflected their experience, highlighting the scales' unreliability (Galupo & Pulice-Farrow, 2020).

We have strong reasons to doubt that standardized questionnaires can reliably predict regret among people who seek gender-affirming care. At best, the questions they include merely ask whether the person is transgender or experiences gender dysphoria in different ways. At worst, their questions fall prey to irrelevance and stereotyping. Existing questionnaires are not supported by outcome data or rigorous conceptual and theoretical reasoning.

### Regret Correlates

From an evidence-based perspective, a propitious approach to care could be to formulate an assessment method based on studies that seek to identify factors predictive of regret. Our survey of such studies, however, does not reveal any factor whose association with regret is sufficiently strong to reliably guide clinical decisions. While some associations are statistically significant, studies primarily involved occasional regret or retransition rather than blanket regret and none of the associations were strong enough to justify withholding care in any particular case.

A study by Lawrence (2003) sought to identify preoperative factors that could be used to predict regret following genital surgery. None of the participants in the study reported consistent regret, and those who reported occasional regret identified disappointment with physical or functional outcomes or familial or social problems as the sources of occasional regret. Because the study is predicated on occasional regret, it is of limited relevance for this review. The reliability of the study is further limited because of poor statistical reporting, recruiting from the patients from a single surgeon, and low 31.9% response rate. However, it offers an illustration of the clinical unreliability of factors revealed by these studies as predictors of regret, even when the association is statistically significant. Of the 21 preoperative factors that the study tested for correlation with occasional regret, only two were statistically significant: age at which the person first wished to “change sex” and recalled childhood femininity. Others' probable opinion on childhood femininity was not statistically significant. The correlation between age, recalled childhood femininity, and occasional regret was weak, despite being statistically significant. Recalled childhood femininity, the

strongest predictor of occasional regret, only accounted for 3.6% of the variance—a percentage that is far too low to use as a discriminant in assessments. The Spearman's  $\rho$  for recalled childhood femininity was .19, which reflects a negligible to weak relationship that could not be visually identified on a scatter plot (Leclezio et al., 2015; Schober et al., 2018).

A study by Landén et al. (1998) also leads to similar conclusions. Like the Lawrence study, it did not study predictors of blanket regret. Instead, it studied applications to revert legal gender marker changes between 1972 and 1992 in Sweden, a form of retransition. The authors retained two predictors of retransition, namely poor family support and not falling under the “core” type of transness. Individuals were classified under the “core” type based on (Landén et al., 1998, p. 285):

an aversion to biological sex characteristics; effeminate behaviour as a child; lack of sexual arousal when crossdressing; being sexually attracted to the same biological sex; and no fluctuation in gender dysphoria symptoms.

Grouping individuals based on these two factors, rates of retransition reported by the authors ranged from 0.4% among those who were supported by their family and fell under the “core” group to 15.8% among those who lacked family support and fell outside the “core” group. Poor family support was a substantially stronger predictor of retransition, being associated with a 4.1% higher retransition rate (4.5% versus 0.4%) among those in the “core” group and a 14.1% higher retransition rate (15.8% versus 1.7%) among those who fell outside the “core” group. This would tend to align with more recent studies associating retransition with external factors. Given that retransition does not imply regret or reidentification with one's gender assigned at birth, blanket regret was likely much lower than these numbers.

Given that family support is in large part determined by stigma, it would arguably be unethical to withhold gender-affirming interventions because of it. If we set aside poor family support, withholding care to those outside the “core” group would reduce retransition rates by less than 1.3% (1.7% versus 0.4%) at the cost of denying care to the 98.3% who fall outside the “core” group and would not retransition. Yet even assuming a retransition rate of 15.8%, withholding care would be unethical, as it involves denying care to the 84.2% of individuals who would not retransition for the benefit of the 11.3% prevented retransitions (15.8% versus 4.5%), and a much lower percentage of blanket regret prevented, compared to the “core” group with poor family support. The number of people who would be unnecessarily denied care is over seven times higher than the number of retransitions that would be prevented by withholding care to those who lack family support and fall outside the “core” group. All other things being equal, denying care to a large majority for the benefit of a small minority is unethical. Delaying access to gender-affirming interventions for those who are at elevated risk of regret would not be an appropriate alternative to withholding care, as the average time to regret appears to be around a decade (Wiepjes et al., 2018; see also Littman, 2021).<sup>4</sup> Unless additional predictors of regret can be identified, studied factors cannot reliably predict regret.

<sup>4</sup> While it would be replied that detransitioners experience regret for a longer period than such decade-long delay, such argument does not account for the difference between regret and retransition, magnitude of regret, variations in regret over time, large variance in time-to-regret, and the possibility and impact of medical retransition.

A wide range of other factors are claimed to predict regret or psychosocial outcomes of gender-affirming care in the literature. These factors are often rooted in stereotype or prejudice and are not supported by empirical evidence. For instance, Assalian et al. (1999) list psychotic reactions, intellectual disability, unstable personality, drug addiction, criminality, lack of financial autonomy, lack of family support, distance from the clinic, “adequacy” of physical appearance for the target gender role, military service, past and present “heterosexual” experiences based on gender assigned at birth, hypersexuality or strong libido, and older age. Despite claiming that the factors negatively impact prognosis, the authors offer no theoretical or empirical support for their claims. The list offered is a peculiar mixture of stereotyping, unfounded, and frankly puzzling factors.<sup>5</sup> Other frequently posited predictors of regret include sexual trauma, internalized homophobia and/or misogyny, co-occurring mental illness, and neurodiversity. However, no study demonstrates a high rate of regret among those who exhibit these traits nor offers insight into how to distinguish the subset who would experience regret from within these groups. While some studies suggest a high prevalence of some of these traits among people who regret transitioning (Littman, 2021; Vandebussche, 2022), they are also common among those who do not express regret (Gehring & Knudson, 2005; Hanna et al., 2019). Anecdotal reports of correlation may merely reflect the high prevalence of sexual trauma, internalized homophobia and/or misogyny, mental illness, and neurodiversity in trans communities.

Based on the available evidence, regret correlates do not offer a reliable way of predicting regret. Predictors highlighted in the literature are weakly correlated and relate to retransition or occasional regret rather than blanket regret. From a conceptual and theoretical standpoint, we do not have reasons to believe that gender assessments involving DSM-5 diagnoses, gender history, standardized questionnaires, or regret correlates can predict or prevent regret associated with gender-affirming interventions.

### Empirical Data

In this section, we review empirical data pertaining to the effectiveness of gender assessments in preventing regret. In line with the conceptual and theoretical analysis of the preceding section, we found no evidence that gender assessments prevent regret in clinical practice.

Gender assessments are not centered or used by every clinician. Many clinicians use informed consent models, offering gender-affirming interventions based primarily or solely on the person’s informed decision (Ashley et al., 2021). Informed consent models have been used by some clinics since the early 1980s and were promoted in a 1993 standards of care as an alternative to the WPATH standards of care (Deutsch, 2012; Frye, 1993; Karasic, 2000). Informed consent models have grown in prominence in the last few decades and generated significant scholarly literature (Ashley et al., 2021; Blasdel et al., 2018; Deutsch, 2012; Hale, 2007; Schulz, 2018). The rates of retransition or regret reported at informed consent clinics fall within the range reported by clinics that require lengthy gender assessments (Blasdel et al., 2018; Deutsch, 2012; cf. Brik et al., 2020; Bustos et al., 2021; Dhejne et al., 2014; Landén et al., 1998). While regret and retransition are likely underreported, no evidence suggests that underreporting would be higher at clinics using an informed consent model. Despite over 30 years of use, informed consent models do not appear to be associated with

negative outcomes—suggesting that gender assessments do not substantially prevent regret. Future studies should report blanket regret and appropriately distinguish retransition, detransition, and different types of regret.

In a 2012 study, Madeline Deutsch reported known regret and medical malpractice suits at 12 clinics in the United States that used an informed consent model of gender-affirming care (Deutsch, 2012). The clinics had been following an informed consent model for an average of 6.96 years, with a range of 0.5–32 years. The clinics, which provided hormone therapy to 1,944 patients, reported 17 cases of regret (0.87%), of which three led to retransition (0.15%). No lawsuit was reported in any clinic. The study does not specify whether the reported number involves partial, occasional, or blanket regret. Although informed consent models lie on a continuum and the clinics ranged in their approach to gender assessments, reported regret and retransition were not meaningfully associated with the length of the intake process, the number of providers involved, or the type of providers involved in accessing gender-affirming interventions. Indeed, the clinic that reported the highest rate of regret had a medium-length intake process involving both mental health and medical providers. Ten of the 17 known cases of regret were reported by that clinic, which served 150 of the 1,944 total patients. Clinics that reported no time spent with a mental health provider during the intake process reported one case of regret per 148 patients, whereas clinics that reported some time spent with a mental health provider reported one case of regret per 104 patients. The study belies the claim that gender assessments meaningfully reduce the likelihood of regret.

Studies of compliance with the assessment process offer further evidence of the ineffectiveness of gender assessments at preventing regret. A retrospective cohort study by Pimenoff and Pfäfflin (2011) of 32 individuals who underwent genital surgery directly undermines the view that gender assessments prevent regret. Participants in the study were on average 5 years postgenital surgery, and 8.5 years postlegal gender marker change. The study found that participants who received gender-affirming care without psychiatric approval or who deliberately misled the psychiatrist during gender assessment experienced no significant negative outcomes compared to those who complied with the gender assessment process. The vocational, social, and psychological adjustment of participants improved after treatment regardless of compliance with the assessment process, but those who defied the assessment process achieved their embodiment goals far more quickly. Despite the study’s small sample, the fact that circumventing gender assessments did not correlate with poorer outcomes casts doubt on the value of gender assessments.

These observations are consistent with the perspective of some detransitioners. A recent qualitative study of a heterogeneous sample of people who shifted or reversed their gender transition found that many participants endorsed informed consent models of care, were critical of the binary and linear nature of gender assessments, and at times expressed displeasure at the long wait times and barriers to transition put in place to prevent regret (MacKinnon, Gould, et al.,

<sup>5</sup> Researcher Marrow (2023) explains that many of those factors were originally developed out of a desire to turn a small number of trans patients into “normal,” “productive” members of mainstream society that wouldn’t be identifiable as trans, after attempts at curing or preventing transitude failed.

2023). Participants felt that gender assessments were “less about support and ensuring they had good outcomes, and more about enforcing binary trans identities and placing limitations on treatment options.” Despite suggestions by opponents of gender-affirming care that detransition and regret are associated with the absence or brevity of assessments, few participants in the study had received care under an informed consent model. One participant who had received care under an informed consent model reflected positively on it, identifying the provider as “the only doctor that I felt comfortable enough with to tell her that I had detransitioned.” Rather than supporting more assessments, participants recommended improving informed consent processes to better support their decision making, in line with existing recommendations by proponents of informed consent models (Ashley, 2020; Ashley et al., 2021).

The empirical data, while limited, suggests that gender assessments are not effective at preventing regret. Current regret rates may reflect an underlying, unavoidable rate of regret attributable to the dynamicity of gender identity and the transformative nature of gender-affirming interventions (Ashley, 2023, 2019b; Howard, 2022; McQueen, 2017). Such an interpretation seems suggested by the long average time to detransition reported in the literature, and the comparable rates of retransition, detransition, and various forms of regret under informed consent models. Regret was present under the exacting assessment processes of decades past and does not seem to have grown in incidence as gender assessments became less stringent.

### Conclusion

Despite gender assessments being pervasive, we were unable to find theoretical or empirical evidence that gender assessments can reliably predict or prevent regret. The considerations mobilized by gender assessments roughly fall under two categories: self-reported gender identity and embodiment goals, and stereotyping or arbitrary considerations. The former does not necessitate an assessment, and the latter is unreliable as a predictor of regret. While most studies demonstrating the mental health benefits of gender-affirming care involved gender assessments, our review suggests that these benefits are not causally related to gender assessments. Our findings accord with research suggesting that assessments were initially developed to appease public perception, gain acceptance from peers, guard against litigation, and severely restrict the availability of gender-affirming care (Marrow, 2023; Pearce, 2018a; Shuster, 2021; see also MacKinnon et al., 2021). Many factors used by gender assessments are historically grounded in prejudiced beliefs about which lives are socially desirable (Marrow, 2023).

Since gender assessments are meant to be a compromise between the needs of trans communities and detransitioners, their lack of proven effectiveness brings their ethical status into question. In addition to the harm that may be caused by delaying care, some studies suggest that gender assessments are experienced as distressing, invasive, degrading, and unjust by trans individuals (Fraser et al., 2021; Horton, 2022, 2021; MacKinnon et al., 2020; Shook et al., 2022; Stroumsa, Maksutova, et al., 2022; see also Ashley, 2019a). Reliance on gender norms and stereotypes in pediatric practice is particularly concerning since it risks inculcating and reinforcing these norms and stereotypes among children, restricting their freedom and perpetuating inequalities (see e.g., Eliot, 2010; Weisgram & Dinella, 2018; Yu et al., 2017). Authors have reported that gender assessments create unnecessary

delays in accessing gender-affirming care and aggravate inequities in access to such care for marginalized trans people (MacKinnon et al., 2020; Stroumsa, Minadeo, et al., 2022; Tordoff et al., 2022). For those reasons, many practitioners are opposed to gender assessments (Stroumsa, Minadeo, et al., 2022). Gender assessments may also infringe upon the right of gender self-determination (Ashley, 2022a; The Yogyakarta Principles, 2007; The Yogyakarta Principles Plus 10, 2017). Given the apparent detrimental aspects of gender assessments, our findings provide additional support for informed consent models and tend to suggest that gender assessments are unethical.

Blanket regret from gender-affirming care is an undesirable outcome that should be reduced by proportionate means where possible. However, existing evidence does not support the view that gender assessments are effective at predicting or preventing regret. Faith is a dubious foundation for clinical practices. Instead of relying on gender assessments, we recommend that clinicians focus on supporting patient decision making, improving informed consent practices, educating themselves on the realities and needs of detransitioners, and adapting their services to better meet their needs (MacKinnon, Gould, et al., 2023; MacKinnon, Kia, et al., 2022). In a companion article, we argue that gender assessments are detrimental to detransitioners and discuss how informed consent practices can be improved to better serve their needs (Ashley et al., 2023).

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