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Gatekeeping gender-affirming care is detrimental to detrans people

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ABSTRACT

Background: Gender assessments are often required to access gender-affirming medical interventions. These assessments are typically defended as a way of preventing regret, offering a compromise between the interests of trans and detrans people. Whether they do is integral to ongoing debates about models of care in transgender health.

Methods: Building on previous work demonstrating the inefficacy of gender assessments, this article explores the impact of gender assessments and argues that they are detrimental to detrans people.

Results: Assessments appear to be detrimental to detrans people because they disincentivize honesty and authenticity, inhibit gender exploration, increase shame and anger associated with detransition, foster transnormativity, hinder the development of a strong therapeutic alliance, and diminish the quality of informational disclosure.

Conclusion: Given the detrimental consequences of gender assessments, clinicians should reconsider gatekeeping practices in favor of supporting patient decision-making and offering better care to people who detransition.

KEYWORDS

transgender; gender dysphoria; assessment; diagnosis; detransition; regret

Introduction

The traditional model of gender-affirming care has required individuals to undergo an assessment of gender identity and/or dysphoria by a mental health professional before initiating transition-related medical interventions such as hormone therapy or surgery (Coleman et al., 2012, 2022). Gender assessments may involve diagnosing Gender Dysphoria under the *Diagnostic and Statistical Manual of Mental Disorders*, diagnosing Gender Incongruence under the *International Classification of Diseases*, taking the person's gender history, and/or using standardized questionnaires (Ashley et al., 2024). The model's emphasis on gender assessment has been criticized as a 'gatekeeping' practice and stands in contrast with informed consent models that emphasize supporting patients' decision-making process without asking them to 'prove' their gender identity or dysphoria (Ashley et al., 2021; see also Ashley, 2019a; Deutsch, 2012; Frye, 1993; Hale, 2007; Jacobsen, 2024; Karasic, 2000; Schulz, 2018).¹

The gatekeeping practices that define the traditional model are typically justified as a compromise between the needs of trans individuals, who benefit from unrestricted access to gender-affirming care, and the needs of detrans individuals, who benefit from assessments that may prevent them from pursuing medical interventions that they would come to regret (MacKinnon et al., 2021; cf. Marrow, 2024). However, the assumption that gatekeeping benefits detrans individuals does not seem to be grounded in empirical evidence or robust theoretical reasoning. In a previous article, we reviewed empirical studies on gender assessments and concluded that they cannot reliably predict or prevent decisional regret since they rely on gender stereotypes, arbitrary parameters, and unproven considerations (Ashley et al., 2024).

In the present article, we argue that gender assessments are detrimental to detrans people because they (1) disincentivize honesty and

forthrightness, (2) stifle gender exploration, (3) increase shame and anger associated with detransition, (4) foster transnormativity, (5) hinder the development of a strong therapeutic alliance, and (6) diminish the quality of informational disclosure. Clinicians who wish to improve care for detrans individuals may consider forgoing gender assessments and adopting a strong informed consent model that supports self-directed gender exploration and helps patients make the best possible decisions for themselves regarding gender-affirming care at that point in time.

The arguments we present in this paper are informed by our positionality as researchers. Our authorship team is composed of trans individuals from the United States and Canada, and includes expertise in bioethics, medicine, and psychology. The majority of the coauthors are white. One coauthor is Middle Eastern, and one is Asian American. One coauthor is medically detransitioned and was involved in multiple detrans communities for over a decade, and another coauthor previously medically detransitioned, was involved in detrans communities for several years, and later retransitioned.

Throughout the paper, we use the term 'detrans people' to refer to individuals who discontinue or reverse transition-related medical interventions due to a shift in gender identity or embodiment desires.² For ease of communication, we occasionally refer to trans and detrans communities in ways that may suggest that they are distinct groups. However, detrans people form a highly heterogeneous group that displays a wide range of identities, transition histories, and feelings toward de/transition (MacKinnon, Kia, et al., 2022; Pullen Sansfaçon et al., 2023). Some detrans individuals, for example, identify with a gender that does not correspond with the gender they were assigned at birth and refer to themselves as transgender. Trans and detrans communities are not mutually exclusive groups, and our references to them as separate groups should not be interpreted as suggesting that all detrans individuals are no longer trans.

Disincentivizing honesty and forthrightness

No test can evaluate whether someone is trans and would benefit from transition-related medical

interventions; gender assessments are, in many ways, a fool's errand (Ashley et al., 2024). Were there such a test, its reliable implementation is unlikely to be practicable. Patients are aware of gender assessments and often sanitize their experience of gender to secure desired interventions, circumventing attempts at gatekeeping (Davy, 2015; Spade, 2006). Gender assessments disincentivize honesty and forthrightness by allocating access to gender-affirming care based on factors that may not align with patients' desires and embodiment goals.³

Despite widespread acknowledgment that patients sanitize their experience of gender to access gender-affirming care, few clinicians in the literature have publicly reflected on the impact of fostering a culture of mistrust and lying on the well-being of trans and detrans people. Patients misrepresenting or obscuring their gender history not only thwarts gender assessments but may also interfere with the decision-making process. By incentivizing patients to sanitize their gender history, gender assessments tend to curtail patients' ability and willingness to discuss their doubts and worries, explore their sense of gender and embodiment goals, establish and maintain a strong therapeutic alliance, and secure individualized information about gender transition and transition-related medical interventions. Incentives to misrepresent one's experiences act as a moderating variable for other detrimental consequences of gender assessments and gatekeeping.

Unlike conventional medical care, where the patient seeks out clinical expertise to determine whether an intervention would have the desired outcomes, gender-affirming medical interventions are desired for their well-established physiological effects. Individuals do not typically seek out transition-related interventions because they believe that the interventions will cure an underlying illness; instead, they typically seek them out because the interventions' physiological effects align with their gender embodiment goals (Ashley, 2022a, p. 133ff). Because the physiological effects that patients desire are more or less independent from the patient's individual characteristics—e.g., testosterone stimulates facial hair growth—gender assessments have a limited impact on patient desire for the interventions.⁴

Patients pursuing transition-related interventions are often settled in their decision and fear they may be denied desired interventions if they say the ‘wrong’ thing. The scholarly literature highlights that this fear often leads patients to be less than forthcoming with clinicians about their experience of gender and/or whether they are experiencing any doubts, worries, or uncertainties relating to gender-affirming care (Cavanaugh et al., 2016; Fraser et al., 2021; MacKinnon et al., 2020; Marrow, 2023, 2024; McNeil et al., 2012; Pearce, 2018; Pimenoff & Pfäfflin, 2011; Rowe, 2014; Schulz, 2018; Shook et al., 2022; Stroumsa et al., 2024; Stroumsa et al., 2022; Verman, 2018; Vipond, 2015). Patients often misrepresent the truth to better ‘fit’ clinical expectations, with trans people long having coached one another to better ‘pass’ gender assessments (Spade, 2006). The stricter the perceived gatekeeping, the more common and extensive the misrepresentations are likely to be. This incentive to lie and sanitize is even greater when clinicians’ waitlists are long, as patients can be exasperated by the wait and all the more eager to access transition-related interventions (McKay et al., 2022; van de Grift et al., 2024).

The ubiquity of truth-fuzzing and misrepresentations in trans healthcare is well documented in the scholarly literature. In the late 1960s and early 1970s, trans communities coached each other, carefully preparing and rehearsing ahead of assessments (Fisk, 1973; Knorr et al., 1969; Meyerowitz, 2004). Patients told each other to wear conventionally gendered clothing rather than unisex styles, to lie about their sexual orientation, and not to mention any potential pleasure they might derive from their genitals out of fear of being denied hormone therapy. More recent scholarship also speaks of such realities (Knorr et al., 1969; Spade, 2006).

The effectiveness of gender assessments is not only predicated on the existence of robust predictors of mental health outcomes but also on clinicians’ ability to ascertain whether patients are being truthful and forthcoming in their responses. Yet, it is unlikely that clinicians can reliably identify dishonesty and omissions in patient narratives. Identifying lies and narrative sanitization is difficult and falls outside the expertise of most clinicians. It has long been known that even

lie-detecting tools like polygraphs are unreliable as they can be circumvented with preparation and are prone to misidentifying members of socially stigmatized groups as liars (Iacono & Ben-Shakhar, 2019; National Research Council of the National Academies, 2003). Patients with a history of mistreatment by the healthcare system, which is common among de/trans people, may be even more distrustful of clinicians and have learned to tailor their interactions to secure desired outcomes. The possibility of self-deceit raises further concerns about clinicians’ ability to distinguish forthright honesty from dishonesty and sanitization. Attempts at detecting dishonesty and sanitization would likely be met with increasing sophistication, as evidenced by the astonishing commitment and creativity displayed by trans people seeking gender-affirming care throughout history. Patients have, for instance, been known to hire actors to impersonate family members or forge documents from the earliest days of digital manipulation (Petersen & Dickey, 1995). One can also think of Agnes Torres, who obtained a vaginoplasty after successfully convincing sociologist Harold Garfinkel that she was intersex. Any attempt at stricter gatekeeping would doubtlessly be met with equally creative workarounds. Life finds a way (Spielberg, 1993).

Many of the negative impacts on detrans people that result from disincentivizing honesty and forthrightness arise regardless of whether dishonesty, sanitization, and omissions are detected in the clinical setting. Cultivating a culture of mistrust hinders patients’ ability and willingness to discuss their doubts and worries, explore their sense of gender and embodiment goals, establish a strong therapeutic alliance, and secure individualized information about gender transition and transition-related medical interventions—concerns that we discuss at greater length below. The culture of mistrust fostered by gender assessments is at best unhelpful to detrans people and, at worst, detrimental.

Stifling gender exploration

Requiring formal gender assessments can be detrimental to detrans people by stifling gender exploration, which can prevent or delay the

realization that a transition-related intervention does not or no longer suits the person.

Gender assessments stifle gender exploration in four main ways. First, as we mentioned in the previous section, patients may self-censor, forgoing exploring uncertainties, doubts, and worries due to fears that care could be delayed or withheld. Second, gender assessments are a contributing factor to the long waitlists patients face when seeking gender-affirming interventions, fostering impatience and having negative consequences on physical and psychosocial health (van de Grift et al., 2024). Third, requiring gender assessments prevents patients from using hormone therapy as part of gender exploration. Fourth, gender assessments can foreclose patients' willingness to explore their gender due to defensiveness. Defensiveness can be a self-protective response to a threat such as denial of care. However, self-censorship, impatience, and defensiveness are antithetical to effective gender exploration and impede patients' ability to make the best possible decisions for themselves about gender-affirming care. In other words, gender assessments can make it more difficult for detrans individuals to realize that they are not trans or that transition-related interventions do not suit them.

Being able to discuss uncertainties, doubts, and worries without fear of judgment or of being denied care is essential to gender exploration. While these sentiments are often a by-product of social messaging and internalized transantagonism, they may also reflect tensions in the patient's sense of gender or embodiment goals that, if explored, could support the natural development of their gender identity and transition journey (Ashley, 2023a). Being able to confront and work through these emotions with a health-care professional can be beneficial to patients since it may help them feel more secure in their decision to pursue gender-affirming interventions, realize that they want to wait before initiating care, realize that an intervention would not suit them, and achieve a richer understanding of gender and gender transition. Instead of fostering a welcoming space for patients to explore, gender assessments tend to make patients self-censor out of fear that transition-related interventions would be delayed or denied even if they decided to

pursue them. Under a gatekeeping model, “[n]o one trusts the doctors as the place to work things out” (Spade, 2006, p. 326; see also Stroumsa et al., 2024, pp. 7–8). By contrast, approaches that do not use gender assessments in establishing eligibility for care help patients feel more secure in their ability to confront and work through uncertainties, doubts, and worries since they will be offered transition-related interventions so long as they still desire them and are able to consent (Ashley et al., 2021).

Gender assessments contribute to the long wait times that patients face before receiving transition-related interventions. Waitlists for those seeking gender-affirming interventions are often years long (e.g., Gender Identity Clinic, 2023; Gender Identity Development Services, 2023). Gender assessments can add several months to years to that waiting time. While multiple factors contribute to the length of waitlists, gender assessments comprise a large proportion of appointments at many clinics—with some clinics requiring more than half a dozen appointments on average and some appointments lasting more than 4h—and are thus seemingly one of the leading contributors to long wait times (Edwards-Leeper & Spack, 2012; McNamara et al., 2024). Long waitlists before being seen for a first appointment, let alone receiving care, understandably fosters impatience in addition to having adverse health effects (van de Grift et al., 2024). When finally seen for an appointment, many patients are eager to initiate care as quickly as possible and, as a result, may not want to explore their gender or discuss uncertainties, doubts, and worries with the clinician given that doing so would only cause further delays. These long waitlists may also incentivize patients to lie, fudge the truth, and censor uncertainties, doubts, and worries since being denied care from one provider could mean having to wait years on another provider's waitlist before being able to access care. Abandoning gender assessments can reduce the number and length of appointments required to initiate care, reducing the average wait times before transition-related interventions. Reducing wait times may alleviate patient impatience, facilitating gender exploration among individuals who want to discuss their gender, uncertainties, doubts, or worries but do

not want to wait years before initiating gender-affirming care.

Because gender assessments are predicated on the view that gender exploration should precede the initiation of transition-related interventions, they foreclose the possibility of using these interventions to explore gender. Trying out hormone therapy, for example, can be a way to figure out whether it suits the patient and feels right for them (Ashley, 2019b). The scholarly literature offers examples of individuals who tried out hormone therapy, decided it was not for them, and were grateful at the opportunity to try it out (Turban et al., 2018; Turban & Keuroghlian, 2018; see also Bradford et al., 2019). In a composite case study about a queer woman who discontinued testosterone after one year, Turban and Keuroghlian (2018) explained:

Eventually, Jamie informed her care team that after the trial of testosterone and much reflection, she had come to understand her identity as a queer woman and wished to discontinue hormone therapy. Jamie reported being pleased about the hormone therapy trial, because this allowed her to clarify her gender identity. [...] Gender exploration, including a period of testosterone therapy, was an important part of her identity formation, and she was grateful that her psychotherapist carefully facilitated her process of introspection through her transition period.

Because gender-affirming care can significantly alter people's experiences, priorities, and values, some individuals find it difficult to predict how they will feel after initiating care (Howard, 2022; McQueen, 2017). The opportunity to try out hormones can play an important function in clarifying patients' sense of gender and embodiment goals amidst uncertainty. Being denied this opportunity can significantly slow and even altogether halt the unfolding of someone's gender and transition journey. It is possible that Jamie would never have found a home in her identity as a queer woman had she been denied testosterone.

Lastly, gender assessments can stifle gender exploration by contributing to patient defensiveness. Patients who feel as though they must prove the validity of their gender are less likely to engage in self-reflection and be forthright with clinicians, especially if they resent the clinicians'

role as the arbiter of their gender's authenticity (Spade, 2006; see also Nienhuis et al., 2018). They may notably be reluctant to admit to the clinician and/or to themselves any uncertainty, doubt, or change in their decision to pursue transition-related interventions since it may be seen as justifying the gender assessments that they resent. Defensiveness, spite, and resentment can be significant psychological barriers to self-exploration, potentially undermining the quality of decision-making (see Gold & Castillo, 2010; Snyder & Anderson, 2009). These concerns also arise when pressuring or forcing patients to explore their gender and/or be assessed for co-occurring conditions, even if the ultimate decision to initiate gender-affirming care remains in the hands of the patient (see Ashley, 2022b).

An anecdote shared by a detrans person in *Bell v Tavistock* (Bell v. Tavistock, 2020, p. 20) illustrates the negative impact that gatekeeping can have on gender exploration:

The psychiatrist attempted to talk of the gender spectrum as a way of persuading me to not pursue medical transition. I took this as a challenge to how serious I was about my feelings and what I wanted to do, and it made me want to transition more.

The anecdote, which was offered in support of gatekeeping, instead eloquently shows how gatekeeping can breed defensiveness and foreclose gender exploration in the process. Had the clinician instead offered a judgment-free space within which to explore the patient's embodiment goals without raising barriers to care, the patient may not have felt the need to double down and been more open to gender exploration. While freedom from defensiveness, spite, and resentment does not guarantee that a patient will engage in gender exploration, it fosters conditions that are propitious to it.

Given the personal nature of gender development, patients should be given space to explore and come to conclusions about their gender on their own terms and at their own pace. Effective gender exploration requires earnest engagement, self-honesty, and forthrightness. Patients must feel free to communicate uncertainties, raise doubts, and express worries without fear of negative consequences. Effective gender exploration can be difficult in a space designed for passing

clinical judgment or marked by fear of interventions being delayed or withheld, as is often the case when providers gatekeep access to gender-affirming care. Although intended to benefit them, gender assessments appear to be detrimental to detrans individuals. By virtue of inhibiting gender exploration, people's realization that a transition-related intervention does not or no longer suits them may be delayed, which could lead to regret if the person experiences bodily changes from transition-related interventions in the intervening period.

Increasing shame and anger associated with detransition

Gender assessments may increase shame and anger associated with detransition by reinforcing psychological investment in transition, which could in turn cause individuals to view detransition as a product of personal or institutional failure. Shame negatively impacts detrans individuals' mental health and may lead them to delay or forego detransition even if it would better suit them (Gelly et al., 2024; MacKinnon et al., 2023). Anger can negatively impact detrans people's mental health by fostering rumination, alienation from one's body, and alienation from one's support system.

Gender assessments contribute to the stigma surrounding detransition. Detransition is a possible step in someone's individual journey. Gender assessments may reinforce the belief that detransitioning is attributable to a patient's lack of self-knowledge or, in certain cases, to their attempts to circumvent gender assessments through lying and/or truth-fuzzing (MacKinnon, Gould, et al., 2022, pp. 244–245; MacKinnon, Kia, et al., 2022, pp. 4–6). Barriers to detransition, such as requiring that people socially detransition for a prolonged period before recommending further medical interventions (Coleman et al., 2022, p. S42), likely further contribute to the stigmatization of detransition. Patients who see detransition as just another step in their gender journey may, by contrast, be less prone to shame.

Shame associated with detransition is undesirable. Shame can also contribute to individuals having difficulty admitting to themselves or to

others that their gender identity, expression, or embodiment goals have shifted and that they want to detransition (Sanders et al., 2023; Vandebussche, 2022; see also Gelly et al., 2025). Few people like to admit to being mistaken, especially about something as personally important and politically fraught as transitude.⁵ People who detransition may also fear that they will be accused of misleading others or betraying trans communities for their decision (MacKinnon, Gould, et al., 2022, pp. 245–246). As a result, shame can make detrans individuals reluctant to reach out to trans friends and support groups, alienating them from their previous support system and negatively impacting their mental health. Shame is also a likely contributor to detrans individuals' reluctance to inform clinicians of their detransition and pursue medical supervision (MacKinnon, Kia, et al., 2022).

Gender assessments can also contribute to anger that is linked to a sense of being wronged by the clinician and healthcare system for some detrans people. Gender assessments are intended to weed out and prevent future regret; where they fail to do so, patients may feel betrayed and blame the clinician for misleading them and/or improperly assessing them. Being angry about bodily changes and blaming them on someone else can reinforce social messages that depict detrans people's bodies as mutilated, ruined, or monstrous (MacKinnon, Gould, et al., 2022, pp. 246, 252). These social messages are predicated on ableist tropes that frame disabled bodies and bodies that have undergone medical interventions—such as radical mastectomies for breast cancer—as undesirable and, all too often, subhuman (Cherney, 2019; Hsu, 2022; Reeve, 2018). Internalizing these greatly negative, inflammatory descriptions can foster rumination and may cause or aggravate detrans individuals' sense of disconnection from their body and social networks (Gelly et al., 2025; MacKinnon, Gould, et al., 2022). Anger associated with detransition can foster rumination, which can in turn inhibit psychological healing, obstruct the development of resilience, aggravate regret, and catalyze depression (Ysseldyk et al., 2007). Approaches that focus on supporting the patient's decision-making may, by contrast, defuse anger and

alleviate regret. Outside of gender-affirming care, studies have shown greater surgical regret among patients who felt that they had less control over decision-making or who disagreed with the allocation of decision-making authority (Wilson et al., 2017). Although preventing anger does not and need not guarantee that detrans people will find comfort and happiness in their body—many detrans people, for instance, continue to experience gender dysphoria as well as what is sometimes called reverse dysphoria (Pullen Sansfaçon et al., 2024)—reducing anger could reduce bodily alienation and dissociation, which is psychologically beneficial.

Frameworks that focus on supporting individual decision-making are less likely to result in shame, anger, and regret, to the psychological benefit of detrans people. Outside of gender-affirming care, studies have shown greater surgical regret among patients who felt that they had less control over decision-making or who disagreed with the allocation of decision-making authority (Wilson et al., 2017). Instead of understanding detransition as a personal or institutional failure, clinicians should see detransition as one of many possible steps in a person's gender journey. Finding the gender identity, expression, or embodiment that best suits the person in the present is nothing to be ashamed of or angry about. It is, if anything, something to be celebrated.

Fostering transnormativity

A related way in which gender assessments operate to the detriment of detrans people is by fostering transnormativity, which restricts patients' ability to make care decisions that fully reflect their gender identity, expression, and embodiment goals and may foster resentment and regret (Ashley et al., 2024). Transnormativity is a counter-narrative, offering an alternative to dominant belief systems that assume everyone is cisgender and marginalize trans people. Unlike counter-narratives that emphasize gender self-determination and freedom from gender norms, transnormativity presents a narrow and homogenized understanding of transitude that excludes large swathes of trans communities (Bradford & Syed, 2019; Vipond, 2015; see also Rider et al., 2019; Spade, 2006). Transnormativity

presents transitude as a binary and inborn psychological condition that is invariably treated by hormonal and surgical interventions to make the person conform as closely as possible to social ideals of masculinity and femininity, regardless of the individual's desired embodiment goals. For transnormativity, people who are 'truly' trans want to conform to gender norms, do not experience significant uncertainties, doubts, or worries about their gender identity or embodiment goals, and do not experience shifts in their gender identity. People who have certain psychiatric disabilities or mental illnesses are at times excluded from transitude under the belief that the person's gender identity and/or gender dysphoria is inauthentic and is attributable to their disability or mental illness (Gelly et al., 2025; Gould et al., 2024; MacKinnon et al., 2020). Transnormativity conceptualizes gender-affirming care in a narrow and non-individualized manner. If you are trans, you must take hormones, have a mastectomy, get facial hair removal, pursue genital surgeries, etc. Anyone who does not satisfy these ideals is not 'truly' trans and should be denied gender-affirming care.

While these ideas are being challenged in trans communities, many clinicians and trans individuals continue to hold onto them (Jacobsen, 2024). Many clinicians operate from the assumption that because a patient is trans, they will necessarily want hormones, have surgeries, etc. Moreover, clinicians routinely rely on transnormative assumptions when assessing patients' gender since no reliable predictor of detransition or regret has been identified in the scholarly literature (Ashley et al., 2024; Marrow, 2023; Shook et al., 2022; Vipond, 2015).

Transnormative assumptions are detrimental to detrans people in two primary ways. First, they place patients whose gender identity, expression, and embodiment goals do not align with transnormativity in a difficult position. Either perform transnormativity by internalizing it, misrepresent your authentic self, find a new clinician who does not rely on transnormative assumptions, or lose out on the gender-affirming interventions you desire. Second, it discourages patients who do fall within the expectations of transnormativity from exploring their gender. If there is more or less only one way to be trans and you do not feel at

home in the gender you were assigned at birth, why explore your gender identity, expression, or embodiment goals more—especially if doing so could lead to transition-related interventions being denied?

By not conceptualizing gender-affirming care in individualized terms, transnormativity restricts the decisional space available to people pursuing gender-affirming interventions. Some patients may initiate testosterone because they did not realize they could obtain a mastectomy without it. Some patients may believe that they must socially transition and cannot identify with their gender assigned at birth if they want to secure transition-related interventions. In even rarer cases, patients may even pursue an undesired surgery under the threat of losing access to hormone therapy otherwise. These anecdotes are derived from first- and secondhand knowledge. Historically, several trans people underwent otherwise-undesired transition-related surgeries to change their legal gender marker, a situation that is ongoing in many countries (Dunne, 2017). Patients whose choices are constrained by transnormativity are at greater risk of making care decisions that align with external expectations instead of being based on their own independently derived embodiment goals (Gelly et al., 2024; MacKinnon et al., 2023). Although patients in each of these examples may have made the best decision that was possible under the circumstances, their decision-making does not reflect maximal autonomy and could lead to negative outcomes in terms of psychosocial flourishing or regret. This explanation could account for why many detrans people who re-transition later adopt a more fluid gender identity and pursue less common forms of gender-affirming care (MacKinnon, Gould, et al., 2022; Pullen Sansfaçon et al., 2024; Walls et al., 2024). While instances of patients accepting undesired interventions due to transnormativity appear relatively rare, they might be present in a significant proportion of cases of regret and detransition. Moreover, in our experience, few de/trans people do not struggle with transnormativity in some way (Bradford & Syed, 2019). Transnormativity likely plays a subtler role in many patients' decisions.

Another way in which transnormativity constrains choice and leads to detrimental mental health outcomes has to do with expectation setting. Transnormative gender-affirming care sets unrealistic expectations, which can weaken decision-making and lead to dissatisfaction or regret. For transnormativity, the goal of transition-related interventions is to make the patient's body align as closely as possible with the bodies of cisgender people and, in many cases, bodies that conform to mainstream beauty ideals. In the past, many clinics refused or discouraged gender-affirming care among patients that, in their view, would not seamlessly blend into cisgender society (Assalian et al., 1999; Meyerowitz, 2004, p. 225; N. M. Fisk, 1974). Clinicians who hold transnormative views may intentionally or unintentionally lead patients to believe that their life will be indistinguishable from that of a cisgender person since that is the presumed goal of gender-affirming care (Marvin, 2015; Shook et al., 2022; van de Grift et al., 2018). Many trans people do in fact live their lives without anyone knowing that they are trans. The authors are aware of trans people who were married for years without their spouse knowing about their gender modality—Billy Tipton being one famous example in history. However, this is not possible for everyone. It is typically unreasonable for patients to expect that they will certainly or almost certainly be able to live their social and romantic life without being identified as transgender. Unrealistic expectations beget disappointment. Patients who strongly expect specific esthetic, physical, or functional outcomes from transition-related interventions may experience disappointment or regret when these expectations are not met. Patients may also have unreasonable expectations relating to the psychological effects of transition-related interventions since transnormativity occasionally frames gender transition as a definitive cure to gender dysphoria (Marvin, 2015; Vipond, 2015). Some patients believe that hormone therapy will completely alleviate their dysphoria or that undergoing genital surgery will be a momentous event that will radically change their lives for the better (Ashley, 2018; Marvin, 2015). Hormone therapy is known

to alleviate gender dysphoria but does not always alleviate it entirely. Similarly, genital surgery may not be as radical and life-changing as some hope it to be. These unreasonable expectations may be directed at gender assessments, with some patients believing that gatekeeping can reliably predict how gender-affirming interventions will make them feel and weed out those who would detransition. Those who believe that gender assessments guarantee that they are ‘truly trans’ may be at risk of disappointment and resentment. Merely mentioning that an outcome is possible will not always suffice to dispel unreasonable expectations, as patients may believe the probability to be low and/or fail to integrate the information into their decision-making, especially if they do not trust the clinician or believe that they are only mentioning undesired outcomes to shield themselves from liability. It is better to avoid contributing to unreasonable expectations in the first place. From a theoretical standpoint, choices based on unreasonable expectations may pose an elevated risk of negative mental health outcomes or regret.

Disappointment may play a causal role in regret regardless of whether the person’s decision would have been different without unrealistic expectations. Disappointment may, in some cases, trigger a form of psychological backlash toward the initial transition that leads to regret and fosters hostility toward gender-affirming care. Disappointment may beget resentment. Managing expectations may therefore reduce regret even if it does not change anyone’s mind about pursuing gender-affirming care, by helping patients plan for various outcomes and anticipate their ensuing reactions.

Transnormative beliefs hinder shared decision-making, to the detriment of detrans people. Given the diverse and occasionally unpredictable physiological outcomes of transition-related interventions, managing patient expectations and ensuring that patients are offered the broadest possible range of care options are important elements of supporting patient decision-making. Models of care that center on gender assessments and gatekeeping are not well-equipped to address transnormative beliefs and associated expectations. Informed consent models that center on

supporting patient decision-making are better suited to the needs of detrans people.

Hindering the development of a strong therapeutic alliance

Gender assessments hinder the development of a strong therapeutic alliance, which is detrimental to the physical and psychological health of detrans people. The therapeutic alliance refers to a collaborative relationship between clinician and patient that allows them to work toward a common clinical goal (Ardito & Rabellino, 2011). Because they contribute to distrust and resentment by positioning clinicians as authorities over people’s own gender identity (Jacobsen, 2024), gender assessments tend to disrupt the development of a strong therapeutic relationship. As a study participant explains (Stroumsa et al., 2024, p. 8): “Even the small amount [of gatekeeping] my therapist had to be part of [...] was enough to drive a permanent wedge in our relationship.” By weakening the therapeutic alliance, gender assessments are detrimental to detrans people.

A strong therapeutic alliance is an important determinant of physical and mental health. The benefits of a strong therapeutic alliance are well-established in the scientific literature. In mental healthcare, a strong therapeutic alliance, as evaluated by the patient, correlates with positive clinical outcomes (Ardito & Rabellino, 2011). In the context of trans health, the therapeutic alliance may help increase access and use of other forms of healthcare such as preventive and emergency healthcare (cf. Campbell et al., 2015; Janeiro et al., 2018; Meier et al., 2005). Fostering access to preventive and emergency healthcare is essential given the severe healthcare avoidance found among trans communities due to fear of harassment, discrimination, and violence (Bauer et al., 2014; Giblon & Bauer, 2017). Emerging data suggests that detrans people are also reluctant to access healthcare services (MacKinnon, Kia, et al., 2022). A strong therapeutic alliance can serve to guide patients toward community and peer support resources, which have been linked to resilience and positive mental health (Bariola et al., 2015; Testa et al., 2014). These resources not only provide support and encouragement but also

useful information regarding social and medical transition that may lie outside of the clinician's knowledge (Ashley, 2020). The therapeutic alliance can also be used to encourage psychotherapy for patients who would benefit from it, and play a crucial role in avoiding loss to care—a significant problem in detransition care.

Qualitative studies of trans patients have shown that gender assessments can undermine the therapeutic alliance (Brown et al., 2020; Schulz, 2018). The gatekeeping role inherent in gender assessments undermines collaboration by reducing mutual trust, transparency, and goal alignment. Whereas the patient's goal is to access desired transition-related interventions, the clinician's goal is to assess their potential for regret—sometimes framed as an assessment of whether the patient is 'really trans' or 'really dysphoric.' This assessment necessarily involves a level of clinician distrust toward patients since a summary self-report of gender identity and desire for medical transition are not considered sufficient (Ashley, 2019b). Conversely, patient trust in clinicians is often severely impaired or altogether absent due to the perceived illegitimacy of gatekeeping (Jacobsen, 2024). For patients who have had negative or traumatic experiences with medical or mental health providers, gatekeeping may also be retraumatizing (see e.g., Mizock & Carr, 2021). Clinician transparency may also be undermined by gender assessments insofar as clinicians seemingly rarely set out in plain terms the criteria used to establish eligibility for hormone therapy. Patients who resent gender assessments or fear being denied hormone therapy are more likely to terminate the clinical relationship and turn to gray or black-market hormones (Rotondi et al., 2013; see also Marrow, 2023, pp. 229–230). Since using gray and black-market hormones may be illegal and rarely involves medical monitoring, gender assessments create legal and medical risks for patients. Gender assessments can make patients reluctant to pursue psychological assessments for suspected conditions, due to fear that a diagnosis would lead to gender-affirming care being delayed or withheld (MacKinnon et al., 2020; see also Luka C. J. White et al., 2023). This concern is heightened for conditions that have a history of being used to deny gender-affirming care such as

autism, post-traumatic stress disorder, borderline personality disorder, and schizophrenia. People who are forced or pressured to undergo such assessments are less likely to be honest throughout the process and may attempt to hide parts of their clinical record (MacKinnon et al., 2020). This form of healthcare avoidance is not without consequences, as it deprives people of accommodations, resources, and treatments that could be greatly beneficial. Finally, gender assessments are time-intensive, leaving clinicians with less time to capitalize on the benefits of a strong therapeutic alliance, such as by helping patients with other psychological, social, or medical needs.

The negative impact of gender assessments on developing a strong therapeutic relationship disproportionately disadvantages Black, Indigenous, Latine, and Asian communities. These communities face a high degree of healthcare avoidance due to the exploitation and mistreatment that they have experienced at the hands of a predominantly white medical profession (Kennedy et al., 2007; Olivares & Washington, 2020; Paul et al., 2020; Snorton, 2017; Standing Senate Committee on Human Rights, 2021). Racism has played a structuring role in the history of trans medicine, as historian Jules Gill-Peterson has documented (Gill-Peterson, 2018). Approaches to care that further limit the development of a strong therapeutic relationship compound the negative healthcare outcomes of Black, Indigenous, Latine, and Asian de/trans people (Gehi & Arkles, 2007; Marcellin et al., 2013; Scheim et al., 2013). Cultural sensitivity and reduced gatekeeping are important components of improving the healthcare outcomes of Black, Indigenous, Latine, and Asian trans people (Rider et al., 2019).

Discrimination toward disabled people creates additional barriers to the development of a strong therapeutic alliance. Disabled trans people are much more likely to experience discrimination, harassment, physical violence, and sexual violence in healthcare settings than non-disabled trans people (Kattari et al., 2017, 2021). These disparities are even starker for disabled trans people of color (Kattari et al., 2017). For many disabled trans people, abandoning gender assessments and gatekeeping practices will not be enough to restore the possibility of a strong therapeutic

relationship. Systemic change is needed to banish ableism from the healthcare system. However, moving away from gatekeeping practices is an important step given the ableist attitudes that underpin them. Gatekeeping practices are often predicated on the beliefs that neurodivergence and mental illness can make people falsely believe that they are trans, and that disabled and mentally ill people cannot be trusted with deciding for themselves whether to initiate gender-affirming care (MacKinnon et al., 2020; Shapira & Granek, 2019). These beliefs make it more likely that disabled people will be denied gender-affirming care, aggravating the risks posed by gender assessments with regards to honesty and forthrightness, gender exploration, shame and anger, transnormativity, and the therapeutic alliance.

Diminishing the quality of informational disclosure

Because of the time constraints that are inherent to clinical practice, gender assessments indirectly diminish the quality of informational disclosure and, thus, of informed consent. Clinicians have a limited amount of time with patients during each session, and the patients do not always feel comfortable asking questions that could be interpreted as evidence of uncertainties, doubts, or worries out of fear of being denied care (Spade, 2006). By placing greater focus on ascertaining eligibility than on supporting patient decision-making, gender assessments obscure the most important roles played by clinicians in trans healthcare: to share information, clarify expectations, and support thoughtful decision-making (Neri et al., 2020). Impediments to the informed consent process sit in tension with detrans individuals' right to autonomy and may compromise their ability to make the best possible care decision for themselves, resulting in detrimental outcomes.

Patient-facing time is unfortunately a scarce resource in the contemporary healthcare world. Gender assessments monopolize time that could instead be dedicated to giving the patient information and answering any questions they may have. This problem is not readily resolved by increasing the number and length of sessions, as it could lead to fatigue, inattention, and

impatience, compromising the uptake of information; it may also be precluded by insurance or institutional policies. Understandably, patients may end up hurrying through an informed consent form, the last hurdle before finally obtaining a long-awaited hormone prescription. Moreover, patients may not be willing to ask questions and carefully consider the answers either out of displeasure for the added delays or because they are fearful of being denied care based on the questions they ask. Increasing delays also creates other ethical drawbacks given the mental health benefits of accessing transition-related interventions in the broader patient population (see Ashley, 2022a; Center for the Study of Inequality, 2018). Patients who face shorter delays in obtaining transition-related interventions may, by contrast, be more inclined to take their time and ask all the questions they have, especially if they do not feel that their questions could lead to the requested intervention being denied.

Gender assessments and other gatekeeping practices undermine informational disclosure not only because of their impact on patients but also because of their potential impact on clinicians. Gender assessments define the authority of clinicians and structure their relationship with patients. Gender assessments can unfortunately encourage paternalistic attitudes among clinicians, causing some to neglect their duties as information providers (Jacobsen, 2024). Many clinicians see themselves as bearers of knowledge whereas trans patients are passive recipients of treatment, leading to large variations in clinicians' understanding of how and how much information should be disclosed (shuster, 2019). Some trans people report feeling inadequately counseled by assessing clinicians (Frohard-Dourlent et al., 2017; van de Grift et al., 2017). This problem is exemplified by one study participant, who explained that her assessment "was really just cursory gatekeeping, would have really liked to have more info given about what I was getting into with committing to surgery" (Frohard-Dourlent et al., 2017, p. 21). In extreme cases, anecdotal accounts suggest that clinicians may even lie about or intentionally omit material risks because they believe that the patient is 'truly trans' and that the proposed intervention is therefore in their best interest. Anecdotal

accounts also highlight how clinicians' role in performing gender assessments can sustain and magnify paternalistic attitudes, leading to subpar informational disclosure and informed consent being treated as a mere formality. Informed consent models of care are sometimes accused of fast-tracking interventions; however, the foregoing examples are undergirded not by the logic of informed consent models but rather by the gatekeeping logic that operates in traditional approaches to gender-affirming care. Regardless of whether it calls into question the legal validity of consent, lower-quality disclosure is undesirable from the standpoint of detrans people.

Conclusion

Despite being presented as a compromise between the interests of trans and detrans people, gender assessments are likely detrimental to detrans individuals. Gender assessments stand in the way of patients making the best possible decisions for themselves because they disincentivize honesty and forthrightness, stifle gender exploration, increase shame and anger associated with detransition, foster transnormativity, hinder the development of a strong therapeutic relationship, and diminish the quality of informational disclosure. These by-products of gender assessments are detrimental to detrans and trans people alike.

Many of the arguments presented in this paper can be extended to other forms of gatekeeping such as requiring or pressuring patients to explore their gender, be assessed for co-occurring conditions, or undergo psychotherapy (e.g., Ashley, 2022b). Gender exploration, assessments of co-occurring conditions, and psychotherapy can be beneficial when freely chosen by the patient but are likely detrimental if patients feel that their response could negatively impact their access to gender-affirming care. Requiring gender exploration, psychotherapy or an assessment of co-occurring conditions raises severe ethical concerns, as they would not be fully consensual and undermine patients' ability to end clinical relationships without prejudice. Moreover, involuntary psychotherapy and psychological assessments can be retraumatizing or otherwise harmful to patients who have previously experienced

mistreatment and abuse in the healthcare system (see e.g., Mizock & Carr, 2021).

Our arguments do not extend to assessments of patients' capacity to consent or assent where reasonable doubts arise over whether the person can provide valid consent or assent (see, however Ashley, 2023b). However, clinicians should be careful not to betray double standards or incorporate transnormative or ableist assumptions when ascertaining the person's capacity to consent or assent (MacKinnon et al., 2021). Capacity assessments should not be used as an excuse to deny care to patients based on their gender identity, expression, or embodiment goals or because the clinician believes that individuals of their age are likely to experience regret or detransition. In many jurisdictions, capacity to consent is legally presumed above a certain age.

Detrans people may benefit more from models of care that forgo gender assessments and other gatekeeping practices and instead focus on supporting their decision-making and creating a welcoming space in which patients feel free to explore their gender identity, expression, and embodiment goals without judgment, transnormativity, or risk to their ability to access gender-affirming care. Detransition should not be conflated with regret, stigmatized, or ignored (MacKinnon, Gould, et al., 2022; MacKinnon, Kia, et al., 2022). Instead, detransition should be treated as one of the many possible outcomes or stops on someone's gender journey. Patients should be afforded the bandwidth to explore any confusion, uncertainty, doubt, or worry that they have about pursuing gender-affirming care. Entirely preventing regret is impossible. Medicine commonly tolerates some regret—often at rates exceeding that of transition-related interventions (Thornton et al., 2024). Even the best of choices sometimes turns out poorly. Nevertheless, care models that preserve the patient's power to initiate transition-related care and provide them with tools to make decisions that best reflect their gender identity, expression, and embodiment goals are well-poised to minimize the likelihood and gravity of regret.

Securing gender-affirming care should be a patient-led process that emphasizes collaborative, detailed, and careful disclosure of information

and flexible discussion of the patient's embodiment goals. The process leading up to transition-related interventions should be individualized to the patient's desires and priorities. Patients vary in their perspective on what the clinician's role should be. Some prefer a quicker process limited to the disclosure of medical risks, whereas others may prefer a slower process that involves gender exploration, psychotherapy, assessment of co-occurring conditions, and extensive discussions of psychosocial as well as medical risks. Clinicians should be transparent about how they view their role and actively seek the patient's input on how the clinical relationship should unfold (Chang et al., 2018; Toivonen & Dobson, 2017). By adapting their approach to the patient's desires and priorities, clinicians can build a stronger therapeutic alliance and free up time to work with patients who have greater support needs.

Gatekeeping gender-affirming care is not in the best interests of detrans people. On the contrary, it is often to their detriment. Instead of emphasizing gender assessments and other forms of gatekeeping in their practice, clinicians should strive to reduce wait times, improve their informed consent practices, inform themselves about detransition, and broaden their services to better meet the needs of detrans people. Detransition care is an integral part of gender-affirming care.

Notes

1. Due to our focus on access to medical interventions, we refer to individuals who pursue gender-affirming medical interventions as patients. However, the article is directed at all healthcare professionals who work with trans populations, and our arguments are particularly pertinent to psychotherapists and counsellors who typically use the language of 'client'.
2. For a discussion of terminology surrounding detransition, see Ashley et al. (2024). Although the term is in common use both in academic and de/trans community settings, not all individuals who fall under this definition identify as detrans.
3. Because they incentivize people to misrepresent or obscure the truth in order to access gender-affirming care, which they may need to actualize or live out their sense of gender, gender assessments could be considered a form of epistemic injustice or violence (Ivy, 2016; Dotson, 2011; see also Ashley, 2022a, 2019b). A comprehensive discussion of the ethics of

gender assessments is, however, beyond the scope of this article.

4. We say 'more or less' because individuals may have unreasonable expectations about the physiological effects of interventions, a concern we discuss later in the article. In the future, genetic counselling may also help determine individual variations in the effects of hormone therapy—e.g., the extent of breast growth—and thus better inform patients about whether the intervention will meet their embodiment goals.
5. Transitude refers to the fact of being trans.

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