



Beyond Transition: A Brief Guidance for Therapists

INTRODUCTION

This guidance provides a brief outline of issues involved in the experiences of detransition, transition regret, and transition disappointment. It has been developed in consultation with a number of experienced clinicians directly involved in the care of detransitioned people and those who believe they have been harmed by medical transition. These guidelines are aimed at psychotherapists, counsellors, and clinicians already working or who are interested in working in this field.

The presumption that only gender specialists can work with gender-related distress is not supported by any evidence and has hampered the provision of care for a wide range of people seeking psychotherapeutic support. Our hope is that this Brief Guidance will aid and encourage more clinicians to work in this field.

GENERAL CONSIDERATIONS

Supporters of the gender affirmative approach insist that it is the best and only way to treat gender-related distress, but there is no substantial long-term evidence base to demonstrate its effectiveness. Many people who have moved beyond transition, perhaps through the detransition process or as a result of rejecting gender identity theory, have explicitly stated that they have been harmed by the gender affirmative approach. We reject this approach as it excludes an in-depth exploration of the whole client and forecloses other therapeutic options.

The gender affirmative approach has been shaped by political activism and for this reason we recommend avoiding political or ideological positions; instead, we advise clinicians to make positive use of a conventional therapeutic approach alongside their unique skills and expertise when working with individuals who suffer from gender-related distress.

While gender dysphoria may appear to be a single, well-defined condition, clinicians should bear in mind that it often embodies or conceals other types of psychological distress. Childhood sexual abuse and other forms of early trauma, internalized homophobia, discomfort with bodily changes at puberty, and even a fear of growing up may initially present as gender dysphoria and are best understood through the lens of depth psychology. From this perspective, a desire to change one's gender identity may represent a concrete physical solution to a psychic trauma; it may reflect a belief that parts of the self can be discarded or left behind. It is the role of the clinician to help clients understand their psychological defences and unrecognized motivations which often lie outside conscious awareness. This can be painful work and should be done in an empathic manner, respecting and adapting to the client's tolerance for facing painful new truths.

We find it helpful to adopt a bio-psycho-social approach encompassing the totality of the individual's development *in context*, rather than adopting an atomized view of the person which focuses on a single issue. Open-minded therapists operating from humanistic, cognitive-behavioural, and psychodynamic perspectives view their clients as unique individuals rather than embodiments of a single well-defined disorder. Because co-morbidities are common with gender dysphoria – especially ASD, ADHD, OCD, social anxiety, depression, suicidality and eating disorders – it is crucial to take a holistic approach that includes a comprehensive exploration of the ways these conditions impact the individual and contribute to gender-related distress.

It is important for clinicians to validate their client's experience of distress, including gender-related distress, and to encourage them to express themselves freely by building trust and creating a strong working alliance. This does not mean accepting at face value every idea and belief a client might hold, especially when those views impede the process of self-exploration.

In general, we recommend that clinicians work to establish rapport, build trust, and create a strong working alliance with their clients using generic skills of engagement commonly employed in their everyday practice. Such a working alliance will permit clinician and client to engage in thoughtful and exploratory talk therapy. By focusing on the inner world and life experiences of their clients, clinicians can support them in gaining a deeper understanding of themselves, including the long-term effects of trauma.

GENDER AND IDENTITY

Some people unhappy with their medical transition may continue to experience gender dysphoria, while others may have found relief from dysphoria but still face other challenges related to gender roles and expectations. Depth-oriented work helps such clients to explore their feelings and fears about gender roles, gender expressions, and expectations from society. Such therapeutic exploration often helps clients to accept their identity as someone who does not conform to social gender roles and expectations.

We will better help our gender-distressed clients if we approach them just as we would anyone else presenting with symptoms of psychological distress. It is both limiting and counterproductive to treat gender identity issues in isolation from other issues of identity. In other words, gender-related distress is not an encapsulated condition that independently occurs but rather unfolds within a life context. Clinicians need to acknowledge and understand the complex, pre-existing familial, social, psychological and/or psychiatric conditions that have impacted identity formation and led the individual to seek medical transition. Therapists also need to understand identity formation and body acceptance as both a lifelong process and, specifically, as a universal psychosocial stage of development for young people between the ages of 12 and 25 years.

Many gender-distressed adolescents rely on transition as a way to escape from or evade the age-appropriate challenges of identity formation. Should they later detransition or begin to doubt gender identity theory, they may find themselves confronted anew with difficult and often frightening questions about who they are and what they would like to do with their lives. Transition appears to offer an idealized and absolute solution to the complex challenges of becoming an adult; doubt and detransition return the client to a state of uncertainty and may stir up intense feelings of anxiety and dread concerning the demands of adulthood.

MEDICAL AND BIOLOGICAL ISSUES

Given the heavy medical burden associated with physical transition, further medical assistance is often necessary but difficult for clients to find, especially for clients who have moved beyond transition. The lack of available medical expertise often poses a challenge for detransitioned clients in particular, and so the therapist needs to offer meaningful and empathic support as their clients adjust to living with these uncertainties. Where possible, the therapist can also help the individual to access the most up-to-date information and resources.

Some young and vulnerable people have been led to believe they can fully change their sex through medical interventions but learn through painful experience that this is untrue. Therapists working with this cohort have a responsibility to discuss the reality of biology and sex in an age appropriate way, and to correct any misconceptions developed as a result of absorbing gender identity ideology. Therapists often need to compensate for inadequate informed consent prior to transition and to provide clients with evidence-based materials that more accurately describe the consequences of gender medicine.



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ESTABLISHING TRUST AND ADDRESSING SHAME

Without the establishment of a trusting relationship between therapist and client, the work of therapy cannot proceed, of course, and detransitioned clients pose a particular challenge in this regard. They often feel they've been betrayed by the medical and mental health establishments, and so are slow to reach out for help and slow to trust. They may also believe they were exploited by a political agenda waged on one side and are leary of becoming a pawn manipulated by the other. Such concerns are understandable; acknowledging and validating them as they arise during early sessions will help the client to feel safe.

Detransitioned clients often struggle with high levels of shame and guilt. Shame about same-sex attraction, about gender non-conformity, or about outsider/misfit status may have fuelled the wish to transition, which at one time may have been viewed as an idealized solution to unbearable shame. Shame resurfaces upon detransition, possibly compounded by the shame of having disfigured one's body and made a poor if understandable choice to medicalize, and so too may guilt for having hurt family members and other loved ones. Detransitioned clients are often highly sensitive to these emotions and therapists are advised to proceed slowly and with caution.

SENSITIVITY TO LANGUAGE

Clinicians need to maintain professional records according to the legal requirements of their jurisdiction, colleges, or associations, of course. At the same time, they should be aware that, for some detransitioned individuals, the use of specific personal names and pronouns may be fraught. Many detransitioners strongly feel that using their transition-name, though it may be their current legal name, evokes and perpetuates the harm caused to them by inappropriate medical transition. We recommend clinicians to begin consultations by asking how the client prefers to be addressed. A sensitive, compassionate, curious, and flexible approach towards using the individual's preferred names and pronouns is crucial.

The language and terminology involved in gender-related issues is constantly changing, and this may lead clinicians to the mistaken belief that they do not understand the issues at hand. We recommend taking some time to learn the language, terminology and acronyms so they do not become superficial obstacles to the provision of mental health assessment and support. At the same time, bear in mind that a client's overly-sensitive focus on names and pronouns may reflect psychological defences at work and operate as a shield against shame.

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SUICIDE AND SUICIDALITY

Clinicians should always follow [best practice protocol](#) when assessing suicide risk. From our clinical experience, gender-distressed individuals appear to be at higher risk *post* medical transition. The first stage of detransition or transition regret/disappointment also appears to be linked with high suicidality. Clinicians should bear in mind that suicidality sometimes reflects a desire to eliminate hated aspects of the self rather than a genuine wish to die. It may also embody unconscious feelings of rage. At the same time, the desire to take one's own life is often intensely real, and safeguarding the client must come first.

CONCLUSION

While we offer these general guidelines to help clinicians in this practice area, it should be stressed that, in order to work with detransitioners and those questioning their transition, therapists must inevitably tolerate a large degree of uncertainty. At this point, we don't even have reliable research that yields an estimate of the rate and timing of desistance from a trans identity. The field is wide open, and we must rely heavily upon our own intuitions and clinical experience going forward.


What we do know is that psychological difficulties typically endure after transition, often with the added burden of medical complications, disappointment, shame, loss of a belief system that provided a sense of meaning, and abandonment by a formerly supportive community. The original causes of gender distress and the desire to transition may only become clear with the benefit of hindsight, once the process of exploratory therapy has shed light on factors such as trauma and unmetabolized grief.

As individuals work through post-transition regret and disappointment, they may come to a deeper understanding of themselves. The clinician's role is to support their clients in broadening self-awareness and, through the therapeutic work and recovery process, to build self-compassion and self-acceptance.

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FURTHER READING

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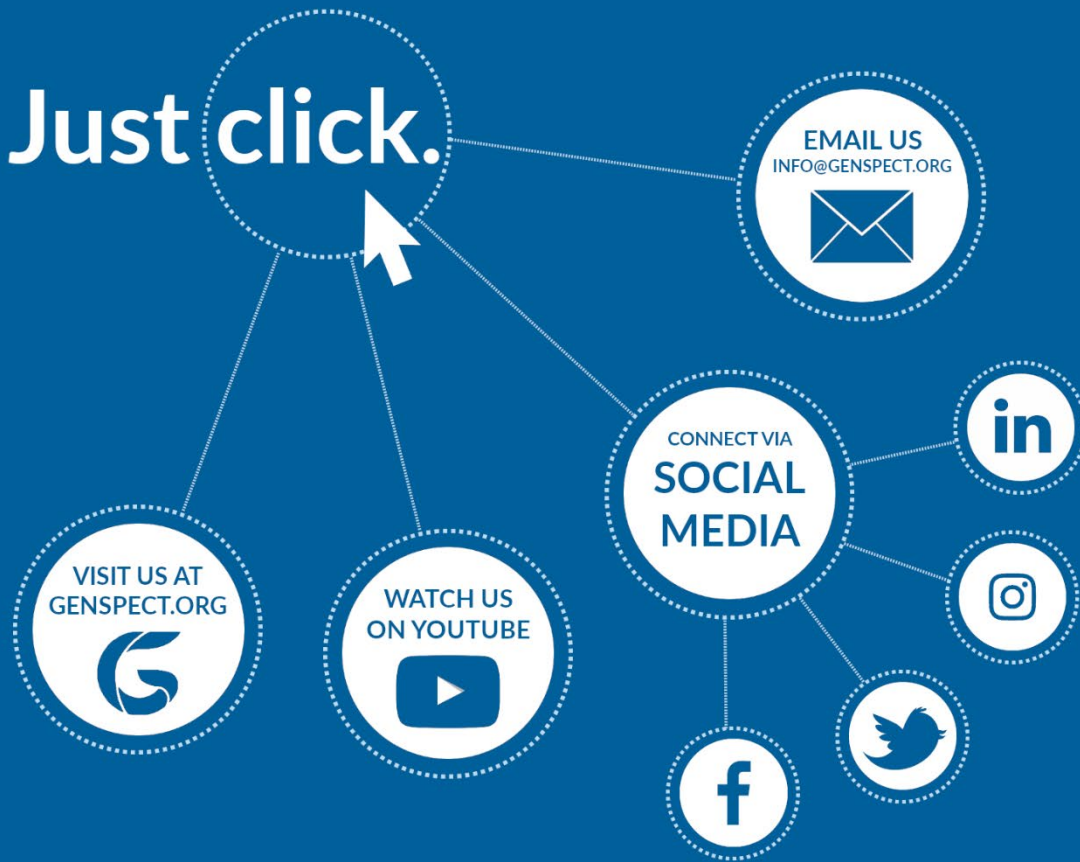
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