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ORIGINAL ARTICLE

Transsexuality: Transitions, detransitions, and regrets in Spain☆

Mario Pazos Guerra[a,*], Marcelino Gómez Balaguer[a], Mariana Gomes Porras[a], Felipe Hurtado Murillo[b], Eva Solá Izquierdo[a], Carlos Morillas Ariño[a]

[a] *Unidad de Identidad de Género, Servicio de Endocrinología y Nutrición, Hospital Universitario Doctor Peset, Valencia, Spain*
[b] *Unidad de Identidad de Género, Hospital Universitario Doctor Peset (Centro de Salud Sexual y Reproductiva Fuente de San Luis), Valencia, Spain*

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Abstract
Introduction: Health care demand by transsexual people has recently increased, mostly at the expense of young and adolescents. The number of people who report a loss of or change in the former identity feeling (identity desistance) has also increased. While these are still a minority, we face more and more cases of transsexual people who ask for detransition and reversal of the changes achieved due to regret.
Objective: To report our experience with a group of transsexual people in detransition phase, and to analyze their personal experience and their associated conflicts.
Material and methods: A cohort of 796 people with gender incongruence attending the Identity Gender Unit of Doctor Peset University Hospital from January 2008 to December 2018 was studied. Four of the eight documented cases of detransition and/or regret are reported as the most representative.
Results: Causes of detransition included identity desistance, non-binary gender variants, associated psicomorbidities, and confusion between sexual identity and sexual orientation.
Conclusion: Detransition is a growing phenomenon that implies clinical, psychological, and social issues. Inadequate evaluation and use of medicalization as the only means to improve gender dysphoria may lead to later detransition in some teenagers. Comprehensive care by a multidisciplinary and experienced team is essential. As there are no studies reporting the factors predictive of detransition, caution is recommended in cases of atypical identity courses.

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* Corresponding author.
E-mail address: mario_pazos_guerra@hotmail.com (M. Pazos Guerra).

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PALABRAS CLAVE
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Variantes de género

Transexualidad: transiciones, detransiciones y arrepentimientos en España

Resumen
Introducción: La demanda de atención sanitaria a personas transexuales o con incongruencia de género ha aumentado en los últimos años, sobre todo a expensas de jóvenes y adolescentes. También en paralelo ha aumentado el número de personas que refieren una pérdida o modificación en el sentimiento de género inicialmente expresado. Aunque siguen siendo minoría, nos enfrentamos cada vez más a casos complejos de personas transexuales que solicitan detransicionar y revertir los cambios conseguidos por arrepentimientos.
Objetivo: Relatar nuestra experiencia con un grupo de personas transexuales en fase de detransición. Analizar su experiencia personal y los conflictos generados y reflexionar sobre estos procesos nunca antes descritos en España.
Material y métodos: Cohorte de 796 personas con incongruencia de género atendidas desde enero de 2008 hasta diciembre de 2018 en la Unidad de Identidad de Género del departamento Valencia Doctor Peset. De los 8 casos documentados de detransición y/o desistencia se relatan los 4 más representativos y que consideramos más ilustrativos de esta realidad.
Resultados: Las causas observadas que motivaron su detransición fueron la desistencia identitaria, las variantes de género no binarias, la psicomorbilidad asociada y la confusión entre identidad y orientación sexual.
Conclusión: La detransición es un fenómeno de presentación creciente que conlleva problemas clínicos, psicológicos y sociales. Una incorrecta evaluación y recurrir a la medicalización como única vía de mejora de la disforia en algunos jóvenes puede conducir a posteriores detransiciones.
Es fundamental una atención integral dentro de un equipo multidisciplinar con experiencia. A falta de más estudios que determinen posibles factores predictivos de detransición, es recomendable proceder con prudencia en casos de historias identitarias atípicas.

Introduction

In recent years there has been an important increase in the demand for endocrinological and surgical measures for the management of transsexualism (transsexuality) (ICD-10) or gender incongruity (ICD-11). This increase in demand has been reported in all western countries, including Spain.[1–5] We are also seeing a change in the sociodemographic profile of the people visiting the clinics, with an increasing prevalence of young people.

The suggested reasons for this trend include increased social acceptance, the coverage of such cases provided by public health services, strong media exposure and – at least in some parts of Spain – the application of different regional laws and the introduction of new healthcare models. The cases represented by adolescents and young adults are particularly complex, since in these stages of life identity is still under development and might not be sufficiently consolidated.[6]

In this regard, there is concern that more and more people believe hormone therapy to be the solution to their problems, not only those referring to self-identity, but also those referring to personal frustrations inherent to this phase of life. Some of these individuals visit the endocrinology outpatient clinic without prior psychological assessment or counselling, demanding urgent and hurried medical and surgical treatment.

The main clinical practice guides[7–9] agree in proposing prior evaluation and psychological counselling. Such evaluation and counselling should also make it possible for professionals to examine patient identity, improve resilience, assess whether the decision is reasoned and with realistic expectations, work on self-image and self-esteem, and rule out psychological comorbidities and other identity confounding factors.[10,11]

New care models focusing on transsexual affirmative management allow for greater accessibility to care among such individuals, but they sometimes collide with the abovementioned approach, leading to reductions to or shortcomings of the evaluative periods, and with psychological evaluation and diagnosis being viewed as a discriminatory act.[10] Establishing a balance between the classical care models and the promptness and autonomy demanded by some people constitutes a challenge for professionals.

Inadequate decision-making leads to more frustration and forces backtracking. In this context, an increasing number of people are requesting detransition/retransition or reversal of the somatic or administrative changes achieved.

Although detransition due to regret has been described for years,[11] the phenomenon is still little known. In addition to its indisputable scientific interest,[12,13] this circumstance has had a significant media impact.[14]

The true prevalence of the phenomenon is not known but is possibly underestimated. A number of factors have been associated with detransition, though none have been validated to date.[15–17]

The present study describes different personal experiences in which detransition occurred after a body readjustment process had been started because of gender incongruity. Our aim is to draw attention to and highlight this

little explored but growing issue at Gender Identity Units (GIUs) in Spain.

They represent the first cases reported to date in this country.

Material and methods

The GIU of Dr. Peset University Hospital (Valencia, Spain) was formally established in 2008. Between then and December 2018, the Unit had assisted a total of 796 people. With regard to the follow-ups performed, information is available on 8 people who requested some form of detransition. The four cases considered most relevant or illustrative are detailed below.

All the described cases were evaluated before the start of pharmacological and surgical intervention by a psychosexologist with expertise in gender identity (a minimum evaluation time of 6 months). Evaluation follows a uniform protocol and assesses the following elements: personal status, childhood history, evolution of the incongruity, differential diagnosis, the use of psychoactive substances and prior psychopathology. Its aim is to expertly explore and guarantee therapeutic choice, ensure stability and consolidation of the gender identity process, correct any potential conflicts generated, detect psychological problems that may cause confusion, work on reasonable expectations, and provide the broadest possible information on the procedures to be carried out.

Psychological counselling is maintained once the hormone treatments have been started, in order to confirm gender identity stability or fluctuation.

Given the confusing and constantly changing terminology, a number of terms used in the descriptions below should be defined:

- *Gender variants*: these encompass all gender identity processes, both binary (male, female) and non-binary (agender, bigender, gender fluid individuals); over 40 gender variants having been described.[18]
- *Identity desistance:* modifications or changes in initially expressed identity.
- *Detransition/retransition*: reversal of changes made to the gender reassignment process, whether medical, social or administrative. It may or may not be associated with identity desistance.
- *Regret:* discomfort or distress experienced due to the changes made during gender transition. It may or may not be accompanied by identity desistance and may or may not lead to detransition.

Results

Case 1

A 31-year-old individual with no relevant medical history started follow-up at our Unit in 2008. He reported incongruity with gender as assigned at birth (male) from 11 years of age, with social transition starting as early as 14 years of age, acting, living and interacting as a female at all levels. The psychological evaluation made at another centre suggested dysphoria due to gender incongruity. Hormone therapy with estrogens and antiandrogens was therefore started at 18 years of age. This treatment resulted in an improvement of the dysphoric symptoms. The patient first visited our Unit three years after the start of hormone treatments and requested gender confirming surgeries (augmentation mammoplasty, feminizing genital surgery and thyroid chondroplasty). Repeat evaluation confirmed the existence of an identity conflict, and the standard follow-up protocol was started. The patient reported self-harm and genital self-mutilation ideation since adolescence.

A few years later, follow-up started to become erratic, with the patient missing several consultations, and treatment compliance also proved irregular.

A new psychological evaluation reconfirmed the existence of a strong identity conflict, so augmentation mammoplasty was performed in 2010. That same year saw the official change of name and gender.

Clinical follow-up was maintained on an annual basis until the patient stopped reporting to the clinic in 2014.

The patient returned in October 2018 requesting breast explantation and a report for a new gender modification.

The patient explained that for years, before and during management in the Unit, he suffered severe dysphoria with suicide ideation. An affective relationship with a gay male helped him to discover himself as a bisexual man and taught him to accept his own genitals.

To all effects, the patient currently lives, acts and relates to others as a male. He is receiving no type of pharmacological treatment and is in the process of reassignment of name and gender in the civil registry, subject to court ruling. Breast explantation is also pending.

Case 2

A 26-year-old individual with no relevant medical history started assessment in our Unit in 2009 due to gender incongruity, with a self-reported identity not consistent with the gender assigned at birth (female) since 16 years of age. The patient presented no suggestive behaviour during childhood.

Following psychological evaluation and follow-up for a little under 6 months, and based on the aforementioned standard protocol, testosterone treatment was started. In 2011, at 19 years of age and after approximately one year of hormone treatment, mastectomy was performed in a private hospital because of severe dysphoria due to large breasts, with a mild improvement of the dysphoric symptoms after the operation.

The patient presented poor tolerance to testosterone, with hyperexcitability, hyperorexia, insomnia, cystic acne, menstrual disorders and pelvic pain, which did not improve despite GnRH treatment. Hysterectomy with double adnexectomy was therefore decided upon, followed by the disappearance of the symptoms, and allowing for the testosterone dose to be reduced. The patient reported severe genital dysphoria, was refusing to have any type of sexual intercourse, and insisted upon the need for genitoplasty. Borderline personality disorders and other obsessive compulsive disorders were discarded.

In 2013 the patient suffered an acute psychotic episode requiring psychiatric treatment; the administrative process

for the change of gender was therefore stopped (the process was in course at the time).

The patient claimed to be gradually regaining a more feminine identity, already preferring to be treated as a female, though without initially regretting either the surgery or the treatment provided. With regard to sexual orientation, the patient felt bisexual.

Over successive visits to endocrinology and sexology outpatient clinics, the patient showed changing identity and dysphoria, sometimes requesting to be treated as a male and sometimes as a female. This in turn was associated with severe depressive symptoms and a psychotic disorder with hallucinations, requiring antipsychotic drug therapy that continues to date. The patient remained under psychiatric supervision and stopped reporting for scheduled visits to our Unit.

The patient returned three years later, and reported having been without hormone therapy of any kind until a few months earlier, current treatment being provided in the form of parenteral testosterone. The patient currently maintains a female identity, regrets having undergone mastectomy, but acknowledges that her male features will be maintained as well as social treatment as a male. The request of an administrative change of gender to male was proposed in order to avoid situations of social risk, and the patient generally acknowledges the irreversibility of the changes.

Case 3

A 16-year-old individual with no relevant medical history started evaluation at our Unit in July 2017 due to gender incongruity. Personal gender identity was not consistent with the gender assigned at birth (female) since 13 years of age. The patient presented mild to moderate dysphoric symptoms (especially referring to voice, with lesser concern about breasts or menstruation). Her partner is a transgender male, and the patient is very active in social networks and LGTBI groups. The patient has partially undergone social transition.

After ruling out associated psychological comorbidity capable of causing identity confusion, and with an evaluation period of a little more than 6 months, treatment was started with transdermal testosterone and social transition was completed in May 2018, at 15 years of age.

At the first post-treatment controls, the patient claimed to feel comfortable with the changes that had occurred, especially regarding tone of voice, with increased acquisition of social skills and lessened dysphoria.

One year later the patient expressed the desire to discontinue hormone therapy. The patient questioned the binary concept of gender: ''What is it to be male and what is it to be female?'', maintaining male gender identity and expression, and preferring to be treated as a male, but without rejecting her secondary sexual characteristics or menstruation. The patient considered that the hormone treatment was offering no benefit at identity level, and attributed the improvement of dysphoria to her own maturity gained over time, increased self-esteem and the social transition made.

The patient also explained that before and during transition, she gained the idea from various information channels (including the Internet, her partner and other transgender people she related to) that hormone therapy was the solution to both her identity problems and other concerns, such therapy being seen by her as the only possible option.

Hormone therapy was therefore withdrawn, and active follow-up by Sexology was decided upon.

The patient currently lives, acts, identifies and relates to others as a male, without rejecting her sexual characteristics and receiving no treatment of any kind.

Case 4

A 21-year-old individual with no relevant medical history started assessment at our Unit in 2016 due to gender incongruity, with a self-reported identity not consistent with the gender assigned at birth (male) since approximately 17 years of age. There was no clear previous suggestive behaviour and minimal social intervention.

At 18 years of age and after associated psychological comorbidity capable of causing identity confusion had been ruled out, and with an evaluation period of a little more than 6 months, feminizing hormone treatment was started and his level of social intervention was expanded. Approximately four months later, the patient informed us that he had discontinued this treatment.

The patient explained that as his social interventions gradually increased, he felt less comfortable being treated as a female or with the physical changes that had occurred. These changes failed to meet his expectations in terms of improved emotional wellbeing. In addition, the patient had a partner (a cissexual male) who helped him accept his body, thereby improving the dysphoria, and allowing the patient to finally identify himself as a man with a homosexual orientation.

The patient currently lives, acts, identifies and relates to others as a male, and is receiving no treatment of any kind.

Discussion

The first of our patients corresponds to a classical ''detransition'' case. This was a person who, several years after social, medical, surgical and administrative transition, changed his sense of identity (identity desistance) and requested reversal of all the changes achieved. The case was evaluated by an expert psychologist before the start of treatment and during the subsequent medical-surgical interventions.

The lateness of onset distinguishes this case from the majority of reported cases.

The cases reported in the literature are early detransitions (with identity loss or modification) occurring in the early stages of social transition or hormone treatment.[19,20] In this person there was confusion between identity and sexual orientation, which was discovered when he explored and experienced new forms of sexuality which he had not previously explored.

That is why all individuals presenting with a gender identity problem should be encouraged to explore all possible options and not insist on the idea that medicalization is the only possible way to resolve their dysphoria.

Another important aspect is the presence of surgical and administrative changes at the time of desistance; detransition is therefore much more complex.

At present, administrative reversal or detransition referring to name and gender has not been legalized in Spain, in contrast to the situation in other countries.[21,22] This is an issue that should be addressed by future legislation in our country.

With regard to detransition with established surgical interventions, no protocols have been established to date. Such protocols should be considered by future clinical guides.[23,24]

The second of our patients corresponds to a case of identity desistance in an individual with a non-binary gender variant, without clear identity consolidation. The case history included certain features common to those described in the Rapid Onset Gender Dysphoria (ROGD) pattern,[17] such as a late onset with no previous suggestive behaviour, and with insufficient improvement with social transition and pharmacological treatment. However, the fact that the identity crisis coincided with the onset of psychiatric disease, which was not present at the start, leads us to believe that this was the most decisive factor. As in the previous case, irreversible surgical adaptations had been made in the form of mastectomy and gonadectomy. However, it is not only the irreversibility of the surgical changes that needs to be taken into account; cross-sex hormone therapy also implies changes that are only partially reversible, and some of the features acquired as a result of such therapy (voice, hair, body distribution) often persist.

Another important issue arising from this case is the need for psychological care not only before, but also during follow-up.

The third of our patients presented a peculiarity with respect to the other cases in that detransition was not associated with identity desistance, though the observed evolution in her non-binary ideas could in future possibly lead to a gender variant. This is a very illustrative example of the difference between identity desistance and detransition. This case also allows us to reflect upon how gender identity does not have to condition the expression of that gender or be accompanied by dysphoria due to the sexual characteristics. It highlights the usefulness and need of social transition, working on self-esteem and constantly reassessing sexuality, moving away from rigid binary models. A sexual psychologist who is an expert in gender identity should therefore be a pivotal element in the multidisciplinary team.

Finally, this case raises questions regarding the role excessive and inadequate media exposure may play in decision making among some people with gender diversity. Directing all people with gender variants towards medicalization might generate strongly binary models, based only on aesthetic concerns and possibly resulting in frustration and regret. Guidance limited to the testimonies of other transgender individuals in the social media, without other options being explored, can be counterproductive. It is our responsibility to inform our patients that medicalization is not the only way to avoid personal and social conflicts.

The last of our patients corresponds to an individual characterized by detransition with identity desistance shortly after the start of pharmacological treatment, in the absence of surgery of any kind. In this case, social transition triggered the initially expressed identity modification. Very possibly, the patient was confusing identity with sexual orientation. This once again highlights the importance of social transition as a form of identity self-exploration and knowledge. Social transition should be progressive and comfortable for the individual, avoiding situations of risk. It is very enriching to be able to live through experiences and situations, exploring and recognizing the changes in wellbeing that occur.

We again run into confusion between identity and orientation. This is a common and widely described condition, particularly in prepubertal and adolescent boys and girls. As a result, the most widely recognized clinical guides[7–9] advise caution and individualized evaluation.

The difference between a ''desire to belong'' to the opposite sex (social advantages, sexual relations, role and gender expression) and true gender incongruity is something that should be worked upon by the psychologist before starting any intervention.

Although in the last year special emphasis has been placed on ROGD as a possible risk marker for detransition, none of the cases in our series presented a clear pattern, nor was ROGD the factor triggering detransition. Nevertheless, it is advisable to identify cases with ROGD criteria and to try to adopt more progressive strategies, promoting management options other than medicalization.

Other proposed detransition risk factors have been non-binary genders, the late appearance of identity perception, a lesser intensity of dysphoria, and decompensated psychological disorders.[15–17]

All the cases described herein were re-evaluated by an expert sexologist, and it was concluded that based on the data obtained during the initial assessment, we were dealing with stable and sustained identity processes which today would again have been classified as gender incongruity, with the offer of the possibility of medical and surgical support. Likewise, in all of the cases, the facilitation of social transition and the start of medical treatment initially resulted in an improvement of the dysphoric symptoms, but with the subsequent appearance of conflict (in some cases more than 10 years later).

Conclusions

Demand for care in GIUs and endocrinology clinics because of gender incongruity has increased significantly in recent years. There have also been major changes in the user profile. Young people, who may be very demanding and are often highly informed, account for a large percentage of such demands. In addition, there are also increasing numbers of people living with gender variants who possibly might not benefit from medical action. Many of the new care models attempted in Spain place Endocrinology at the frontline of care, though in many cases there is a lack of teams capable of comprehensively assessing the situation and the personal needs of each individual.

Excessive and hasty medicalization without other alternatives being explored can lead to subsequent frustrations, with regret, desistance and detransition. We believe that management should be provided by an experienced multidisciplinary team, capable of individually assessing the

particular needs and circumstances of each person. It should always be taken into account that there are situations that do not benefit from medical-surgical therapies. Medicalization is not the only option. All individuals should explore and decide their own course of life, but with the support of as much information as possible, so boosting both their self-knowledge and self-esteem. We should act with increased caution in atypical identity cases. However, we consider that the existence of detransition cases does not invalidate the need for public and specialized care for these people, most of whom clearly benefit from such management.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

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