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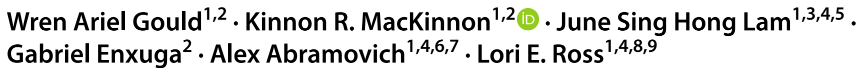
ORIGINAL ARTICLE

Detransition Narratives Trouble the Simple Attribution of Madness in Transantagonistic Contexts: A Qualitative Analysis of 16 Canadians' Experiences



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Abstract
Emerging evidence suggests that transgender individuals are more likely than cisgender peers to receive a diagnosis with a primary mental disorder. Attributions of madness, though, may serve the social function of dismissing and discrediting transgender individual's self-perceptions. The narratives of individuals who stop or reverse an initial gender transition who also identify as living with mental health conditions can sometimes amplify these socio-political discourses about transgender people. Through a critical mental health lens, this article presents a qualitative analysis of 16 individuals who stopped or reversed a gender transition and who also reported a primary mental health condition. Semi-structured, virtual interviews were conducted with people living in Canada. Applying constructivist grounded theory methodology, and following an iterative, inductive approach to analysis, we used the constant comparative method to analyse these 16 in-depth interviews. Results show rich complexity such that participants narrated madness in nuanced and complex ways while disrupting biased attitudes that madness discredited their thoughts and feelings, including prior gender dysphoria. Instead, participants incorporated madness into expanding self-awareness and narrated their thoughts and feelings as valid and worthy. Future research must consider provider's perspectives, though, in treating mad individuals who detransitioned, since alternate gender-affirming care models may better support the identification and wellness of care-seeking individuals who may be identified (in the past, present, or future) as mad.

Keywords Detransition · Madness · Mental health · Autism · Borderline personality disorder · Transgender

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Introduction

> All this is to say that madness discourse plays a social function. It insists on certain norms. It tacitly identifies actions, ideas, and people who fall outside those norms. Yet it also tries to hide its action as it becomes a word of exceptional commonality and adaptability". (Fabris, 2011, p. 29)

Attributions of madness (i.e. mental disorder and/or illness) often serve socio-political functions (Fabris, 2011; LeBlanc & Kinsella, 2016; Legault et al., 2021) as insinuations of mental disorder may be used to "dismiss and discredit" (LeBlanc & Kinsella, 2016, p. 67) individuals who deviate from social norms. Though attributions of madness may serve this social function across a wide spectrum of human thought, feeling, and behaviour (summarized in the *Diagnostic and Statistical Manual of Mental Disorders*, *DSM-5*, American Psychiatric Association, APA, 2013), these social functions are often observed in the diagnosis of gender dysphoria. For instance, pundit Ben Shapiro has argued (perhaps buoyed by the inclusion of gender dysphoria in the DSM) that "transgender people are unfortunately suffering from a significant mental illness that is deeply harmful, and it's not a solution to pretend that transgender people are the sex that they think they are in their head" (Guttman, 2016), elaborating that "biology is biology; men can't magically become women, and women can't magically become men". He thereby demonstrates how attributions of madness may be used to dismiss and discredit transgender individuals within American contexts. Attributing transgender subjectivities to mental disorder may thus have deleterious consequences, legitimating obstructed access to gender-affirming medical care (Corradi, 2015; D'Angelo, 2018, 2019; Temple Newhook et al., 2018) and inhibiting social and legal progress for transgender people (Minter & Keisling, 2010). Attributions to madness may even predict individual-level discrimination, as cisgender individuals are less likely to hire hypothetical transgender applicants in the context of a workplace hiring vignette due to reported assumptions regarding underlying mental illness (Reed et al., 2015).

Even so, gender dysphoria continues to be recognized as a mental disorder (primarily to maintain pathways to access gender-affirming medical care, Riggs et al., 2019; Coleman et al., 2012; Lev, 2006; Fraser et al., 2010), such that scholars and health professionals (in addition to lay individuals) may cast doubt on transgender subjectivities via attributions of mental disorder; that is, by designating transgender individuals outside of social norms of thinking, feeling, or behaving in such a way that their self-perception may be discredited. For instance, Raymond (1979, 2021) suggests that transgender subjectivity emerges from mental conflict related to gender role, thereby discrediting transgender individuals: "Those who advocate medicalized transsexualism as the answer to a desperate emergency situation of profound

sex-role agony only serve, in my opinion, to prolong the emergency. They seem sensitive only to Band-Aid solutions that ultimately help to make more medicalized victims and to enhance the power of the medical empire" (Raymond, 1979, p. 175). As a medical ethics scholar, she critiques the identification of transgender subjectivity as a medical condition. However, she simultaneously insinuates madness (depicted as abnormal feeling or "sex-role agony") in order to discredit transgender subjects. Though psychoanalytic/psychodynamic scholars often affirm transgender individuals (Coffman, 2017; Ehrensaft, 2021; Farley & Kennedy, 2020), these treatment models sometimes permit scholars and health providers to similarly use attributions of madness, construed as "abnormal" thoughts or feelings, which discredit transgender subjects (Lemma, 2018; Posadas, 2017). Meyer (1982) explains that transgender identity emerges from:

> "the outgrowth of developmental trauma affecting body ego and archaic sense of self and caused by peculiar symbiotic and separation-individuation phase relationships. The child exists in the pathogenic (and reparative) maternal fantasy in order to repair her body image and to demonstrate the interconvertability of the sexes… Transsexualism is closely linked to perversions, and the clinical syndromes may shade from one into another. However, what is kept at the symbolic level in the perversions must be made concrete in transsexualism. In this regard there is a close relation to psychosis (pp. 407–408)".

Meyer explicitly attributes transgender identity to madness and makes the comparison to psychosis, in which psychiatric professionals discredit a mad individual's sense experiences (i.e. hearing, sight) as false, despite the insufficiencies of pathology-based explanations even for these forms of madness (Geekie & Reed, 2016; Deleuze & Guattari, 1977/2009). Some contemporary clinicians follow suit in discrediting or dismissing transgender identity due to attributions of underlying mental disorder (D'Angelo, 2020; Marchiano, 2021). For instance, D'Angelo (2020) interprets his transgender male client's repudiation of his assigned-at-birth sex as resentment due to internal, sexual competition with his mother such that "the process of transitioning involved perfecting the body, until it looked convincingly male, but it involved an act of murder in which he destroyed those things that made him recognizably who he was" (p. 964). It follows from these clinical formulations that psychotherapy or wellness may sometimes require re-identifying with, or detransitioning to, one's assigned-at-birth sex (Marchiano, 2021).

Even when not deemed "inherently disordered" (World Professional Association for Transgender Health, WPATH, 2012, p. 12), though, transgender subjectivity may continue to be discredited and dismissed as "mentally ill", as emerging evidence suggests that transgender individuals are more likely than cisgender peers to carry

a diagnosis of a primary "mental illness". Transgender people are more likely than cisgender peers to carry diagnoses of anxiety and depression (Millet et al., 2017; Nuttbrock et al., 2010; Warren et al., 2016; Witcomb et al., 2018), borderline personality disorder (BPD) (Anzani et al., 2020; Furlong & Janca, 2022; Lam et al., 2022), schizophrenia or bipolar disorder (Stusinski & Lew-Starowicz, 2018; Warrier et al., 2020; Hanna et al., 2019), as well as autism spectrum disorder (ASD) (Warrier et al., 2020; Thrower et al., 2019; Wattel et al., 2022)[1], leading some scholars to consider that transgender identity may share etiologies with some of these diagnoses (Saleem & Rizvi, 2017). Notably, transgender identity appears to co-occur with some of the most highly stigmatized diagnoses (i.e. schizophrenia, ASD, BPD), which may be used as legitimation to discredit and dismiss them further (Goldhammer et al., 2019). Co-occurrences between transgender identity and autism have received particular scholarly attention, with Warrier et al. (2020) publishing their findings in high-tier natural sciences journals, such as *Nature*. Because of these high-profile observations, though, transgender youths diagnosed with ASD often anticipate that providers will dismiss their transgender identity by using attributions of mental disorder, in this case autism, to discredit their sense of self (Strang et al., 2023). Mental health providers have also historically dismissed transgender identity via attributions to underlying BPD (Goldhammer et al., 2019), with some scholars considering transgender identity to be a form of BPD (Lothstein, 1984).

Given the potential for harm, many transgender community activists, advocates and scholars have adopted several strategies. Some observe that the diagnosis of gender dysphoria (GD) simply designates deviation from social norms rather than a *true medical condition* (the ontological status of which is generally not interrogated), leading them to call for the exclusion of GD as a mental disorder (Ault & Brzuzy, 2009; Burke et al., 2011; Davy, 2015). Similarly, WPATH emphasizes that "transsexual, transgender, and gender-nonconforming individuals are not inherently disordered" (Coleman et al., 2012, p. 12), suggesting that the diagnosis again only identifies deviation from social norms, rather than constituting a *real* medical condition. Following this logic, some authors argue co-occurring psychiatric distress, such as depression, anxiety, and BPD are attributable to social causes, such as minority stress (Goldhammer et al., 2019; Nuttbrock et al., 2010; Witcomb et al.,

[1] The DSM conceptualizes ASD differently from other diagnoses, including them as "neurodevelopmental disorders" due to an abundance of data suggesting biological precursors (i.e. genetic, neurobiological) and early emergence of characteristics (APA, 2013; Harris, 2014). Notably, there are polygenetic precursors of many other mental disorders included in the DSM (Hyman, 2018), such that ASD may not be unique in this regard. These biological precursors often undergird essentialized ideas about ASD characteristics (i.e. that they are immutable, Chapman, 2020) which serve to consolidate related activisms, generally drawing from critical disability studies (Chapman, 2020; Ellis, 2023). The result is an autistic activist community that adopts description as "neurodivergent", sometimes as a kind of distinction from other madnesses (Ellis, 2023). We use "neurodivergence" to encompass identity descriptors used by autistic individuals, generally from a critical disability perspective. We also use diagnosis-first language, i.e. "autistic individuals", as many individuals with lived experience find this more humanizing than person-first language, i.e. "individuals living with autism" (Pyne, 2020). However, we also include autistic individuals as vulnerable to attributions of madness that may be used to dismiss and discredit them, and so as included under the rubric of madness, not the least since they have been historically entangled and co-constructed (Nadesan, 2013; Wolff, 2004).

2018), rather than common biological underpinnings (Saleem & Rizvi, 2017).[2] A second approach validates transgender subjects (and their requests for medical intervention) by suggesting that gender-affirming medical care reduces psychiatric distress (i.e. Fisher et al., 2016; Murad et al., 2010; White Hughto & Reisner, 2016) such that obstructing care is implicitly inhumane.

However, advocacy strategies that address intersections with madness rarely critique the socio-political uses of "mental illness" labels to discredit mad individuals, more broadly. These strategies may show limitations, then, in rehabilitating transgender individuals from presumed madness, since their evidence is vulnerable to considerable critique. For instance, minority stress, though contributing to psychiatric distress for transgender individuals, likely does not explain all mental distress for transgender individuals. The Amsterdam Cohort of Gender Dysphoria study conducted retrospectively between 1972 and 2017 concluded that suicide risk in transgender people "seems to occur during every stage of transitioning", with a slight decrease in transgender women's suicide risk over time and no change for transgender men (Wiepjes et al., 2018). Though social factors, such as minority stress, may account for decrease over time (as Wiepjes, et al. did not control for social factors), the prevalence of suicide risk across the life span suggests that minority stress is not the only and may not be the strongest predictor of psychiatric distress for transgender individuals. Similarly, evidence suggesting that gender-affirming medical care relieves psychiatric distress may exaggerate findings, for instance by treating statistical significance as practical significance and by overlooking characteristics of more stigmatized conditions entirely (i.e. schizophrenia, ASD, BPD). Branstrom and Pachankis (2020) suggest that gender-affirming surgery significantly reduces symptoms of anxiety and depression for transgender people, which legitimizes surgeries to reduce GD. However, upon re-analysis of the original data, and in comparison with those diagnosed with gender incongruence who were not surgically treated, there was no evidence that gender-affirming surgery meaningfully affected psychiatric distress (Kalin, 2020). Furthermore, mental health conditions outside of depression and anxiety were not considered in the first place. Other researchers have reported evidence demonstrating only small or limited reductions in depression (from mild depression to the "normal" range or within the "normal" range entirely, Aldridge et al., 2021; White Hughto & Reisner, 2016), while others sometimes show no change at all (Aldridge et al., 2021; Tordoff et al., 2022). Regardless, Aldridge et al. (2021) are cited in the WPATH Standard of Care, 8th version (Coleman et al., 2022) as evidence that "mental health symptoms" should not present a barrier to gender-affirming care, as the latter reduces the former. So, public health scholars sometimes show excessive optimism in findings that validate GD as a "real" medical condition with an identified cure or that minimize overlap with other diagnoses (via attribution of mental distress to minority stress), rather than critique the medicalization that casts doubt on transgender subjects in the first place. However, the preliminary nature of their evidence leaves these advocates vulnerable to critique themselves.

[2] Notably, BPD is often construed as related to past trauma in the public health literature, more generally (Bozzatello Rocca & Bellino, 2020; Martin-Blanco et al., 2016; MacIntosh Godbout & Dubash, 2015).

Further evidence that may present some vulnerability to GD "cure" claims are those who discontinue or reverse gender-affirming care interventions—also referred to as detransitioning. Detransition may disrupt advocacy efforts since detransition may occur when individuals live with mental distress that continues despite gender-affirming care interventions (validating critique of findings that these interventions consistently reduce anxiety and depression). Littman (2021) surveyed 100 individuals found that 45% of those assigned female at birth (AFAB) and 35% of those assigned male at birth (AMAB) detransitioned because their mental health did not improve while transitioning, with roughly one-third of the sample indicating worsening mental health during transition. Overall, 38% of detransitioners believed that their prior GD had been caused by trauma, abuse, or mental illness (Littman, 2021). Vandenbussche (2022) surveyed 237 detransitioners (92% AFAB) and found that 70% detransitioned because they realized their GD was related to another issue, with 50% indicating transition did not resolve GD. In re-analysing the 2015 US Transgender Survey, Turban et al. (2021) also identified a cohort of 2242 who described having detransitioned, 3.9% of whom (n=87) endorsed having been motivated for "psychological reasons".

Though available evidence suggests that rates of detransition are relatively low (<1–10% of individuals who begin gender-affirming healthcare; Hall et al., 2021; Boyd, 2022; Bustos et al., 2021), these outcomes may legitimize uses of madness to invalidate transgender subjectivities or experiences of GD as they appear to follow narratives in which individuals dismiss *their own* transgender identity due to presumptive madness. However, very little research has offered in-depth analysis of self-narrative at the intersection of detransition and madness, especially with regard to the uses of madness attributions to discredit or dismiss transgender individuals. The current study aimed to address this gap. Through in-depth, qualitative interview with 16 Canadians who detransitioned and also lived with additional mental health struggles, we explored how these individuals self-narrate interconnections between prior transgender subjectivity and madness.

Method

The current study used a critical, qualitative approach to analyse the narratives of a sample of individuals who discontinued or reversed their gender transitions to examine these questions. The study uses a constructivist grounded theory (CGT) methodology approach to uncover emergent themes from selected interviews. CGT (Charmaz, 2006) is an iterative approach in which researchers systematically extrapolate emergent themes from in-depth narrative interview data. CGT, however, conceptualizes of assorted power relations and mechanisms that both affect the research process, the ways in which researchers construct knowledge, as well as broader social structures that act upon the study participant. To enhance rigour in data collection and analysis, our research team engaged in research reflexivity practices, such as examining how our own lived experiences, epistemological and theoretical assumptions, and beliefs about gender, trans identity, and mental health may impact

our study findings. We are a team comprising a majority of LGBTQ+ identified individuals, many of whom have medically transitioned, and some of us have since discontinued or reversed these interventions. We also involved two Canadian project consultants with experiences of detransitioning in the development of study recruitment and data collection materials.

Participants and Procedure

Between October 2021 and January 2022, we recruited participants into our study. Eligible participants were residents over age 18 who were living in Canada, could participate in an interview conducted in either English or French, and who self-labelled as: stopping a gender transition, detransitioning, retransitioning, re-identifying, among other terms relevant to detransitioning. Participants were recruited via social media (i.e. Twitter, TikTok, Facebook) using materials naming a broad spectrum of eligibility for individuals who had “detransitioned”, “stopped transition”, “retransitioned”, and so forth. Forty-two individuals contacted the study, and those who were responsive to follow-up e-mails were screened by telephone or Zoom video software to confirm eligibility and to discuss the study. Twenty-eight people met all eligibility criteria and consented to participate. Participants completed semi-structured 1:1, in-depth interviews that were audio-recorded and transcribed verbatim. Interviews ranged from between 50 and 90 minutes in length, and were completed by one of three members of the research team (blinded). Of the 28 participants who were interviewed regarding their experiences of detransition/retransition, 16 discussed having mental health challenges. For this analysis, we focused on these 16 participants’ narratives in order to understand further how those who transitioned and subsequently detransitioned conceptualize their experiences. At least two team members initially read transcripts (blinded) with codebook themes finalized across the final interviews, as the data reached saturation. Three team members (blinded) then completed focused coding of each transcript using the codebook in Dedoose software version 9.0.17. Last, we used the constant comparative method to analyse the themes related to co-occurrences between transition, detransition, and mental health challenges. The last stage was also completed by a team member with experience of detransition and extensive experience as a credentialed mental health professional.

Results

[Place Demographics Table Here] The 16 participants who self-reported a history of a mental health-related disability on the demographics questionnaire indicated a wide range of past conditions (for more complete demographics, please see Table 1). These included autism (n=5), attention deficit and hyperactivity disorder (ADHD; n=3), borderline personality disorder (BPD, n=5), post-traumatic stress disorder (PTSD; n=1), traumatic brain injury (TBI; n=1), a “learning disability” (n=1), depression (n=2), bipolar disorder (n=2), schizophrenia (n=1), anxiety (n=1), a “cognitive” condition (n=1), and general “mental health” complaints (n=4). Some of these participants

Table 1. Demographics

Participants (n=16)	No.	%
Age of social transition		
<15	3	19
15–17	3	19
18–24	7	44
25–29	2	13
30+	1	6
Age of first de/retransition		
<18	0	0
18–24	8	50
25–29	7	44
30+	1	6
Current sex/gender identity		
Trans & nonbinary	2	13
Female	5	31
Nonbinary	4	25
Trans	1	6
Nonbinary & male	2	13
Unsure	2	13
Number of past gender identities		
One	1	6
Two	7	44
Three	5	31
Four	1	6
Five	1	6
Six	1	6
Sexual orientation		
Bisexual/pansexual	6	38
Gay/lesbian/homosexual	7	44
Heterosexual	1	6
Queer	2	13
Race/ethnicity		
Mixed (includes Black, Indigenous, Arab, Latinx, & South Asian)	3	19
White	13	81
Mental health condition*		
Depression	2	13
Anxiety	1	6
Bipolar disorder	2	13
Autism spectrum disorder	5	31
Schizophrenia	1	6
Attention deficit and hyperactivity disorder	3	19
Borderline personality disorder	4	25
Intellectual disability	1	6

Table 1. (continued)

Participants (n=16)	No.	%
Traumatic brain injury	1	6
Unspecified cognitive disorder	1	6
Post-traumatic stress disorder	1	6
General "Mental Health"	3	19

*Participants often disclosed a history of multiple mental health conditions.

explained having confused mental/emotional distress due to GD with distress due to mental health conditions (unidentified at the time of beginning gender-affirming medical care), such that their motivation to reverse some aspects of gender transition was because gender-affirming interventions had not significantly reduced symptoms of underlying mental/emotional distress. Others felt that gender-affirming hormones and/or transgender-related discrimination may have compounded their pre-existing mental health concerns. Importantly, participants rarely dismissed or discredited their prior experiences of GD by attribution to mental health conditions. Below, participants' narratives are presented thematically, according to how they described intersections between GD, transgender identity, and two broad types—mental health conditions related to trauma (i.e. BPD) or social communication (i.e. ASD, ADHD). For context relating to participants' transition and detransition, participant narratives are accompanied by their assigned sex at birth (i.e. AFAB), followed by the language they currently use to describe their sex or gender (i.e. female), and their age.

Gender Dysphoria as a (Valid) Trauma Response

A common narrative emerged across several interviews in which participants partially attributed their GD to past trauma and associated ways of thinking and feeling. These participants were most often diagnosed with BPD and/or PTSD (n=6). However, participants largely did not believe that this connection to past trauma discredited their prior GD. Furthermore, they often self-narrated madness (i.e. BPD, PTSD) by describing observed traits or past experiences (and their effects/affects), as well as dense interconnections, rather than implying that madness, in general, discredited their thoughts and/or feelings.

Participants who identified BPD as a current mental health struggle offered detailed accounts of pathways by which observed characteristics and ways of thinking/feeling may have contributed to their feelings. Participants diagnosed with BPD generally self-narrated their madness as emerging from trauma and emphasized that their experiences of GD were real, even if they emerged in the context of trauma-related thoughts and feelings. Because of the developmental context of trauma, thoughts and feelings were rendered immediately valid, disrupting the social uses of madness attributions to discredit their thoughts/feelings. We draw extensively from an interview with Participant 22, as she offered rich reflections:

> I just wish somebody would've gone into the trauma first. To just really figure out what was going on, why was I feeling the way I was feeling. Because the feelings were real. I hated my breasts. I hated my genitals. I hated my body. (AFAB, female, age 29).

The context of past trauma was important not because her experiences of GD were inauthentic, but because deeper sources of her psychiatric distress were overlooked by her care providers, who initiated gender-affirming medical treatments after two appointments (an intake interview and initial bloodwork). Indeed, Participant 22 implies that gender-affirming care might reasonably have been considered as her symptoms of GD were real. However, she suggests that mental health treatment ought to have been expanded to include therapeutic trauma work from the outset (rather than comprising one intake interview), as she expressed upset and confusion about having been diagnosed with BPD years after initiating transition. Participant 13, who had a history of detransitioning for several years to identify as a butch lesbian, and who at the time of interview identified as transmasculine and nonbinary, also stressed the reality of their transgender identity. Yet they also recognized it may have emerged within a context of trauma:

> [I] definitely had a bit of a rougher time growing up. I definitely also saw [transition] as a portal to escape, my girlhood, AFAB childhood. Actually, I had this narrative for a while and I actually do still believe in it…Transphobes, TERFs [trans exclusionary radical feminists], and detransitioners often talk about wanting to be a man because they don't want to be a woman. Often from origins of abuse and things like that. And I think that can be a reality, with also people actually being trans for real, and also, it's just more nuanced than someone wants to be trans, someone wants to transition because they hate being a woman, you know? Because I've definitely felt that and thought that, but then I also still know that I'm trans. (Participant #13, AFAB, transmasculine nonbinary, age 25).

For Participant 13, trauma may contribute to GD, but there may be many more influences and/or pathways comprising GD such that trauma did not preclude a real transgender identity and/or position. Similarly, thoughts and feelings related to trauma, including GD, were simply valid, rather than constituting madness to be dismissed.

When mental health conditions had not been identified prior to beginning gender-affirming medical interventions, participants critiqued ways that providers appeared to minimize or overlook any possible interconnection with madness and/or mental health, plausibly because these providers worried that they may invalidate their patients' transgender identity. Participant 22, again, offered insights:

> I think what hurt, what made me feel frustrated was after I had my double mastectomy… my mental health started spiraling pretty quick… I really had this expectation that transition was just—everything was going to be better. Like I was just going to be this new person and I—everything was going to be fine and it just wasn't. And I think what hurt was [my doctor] had sent me

> to the hospital to get a [psychiatric] assessment done and I got diagnosed with BPD and PTSD. I felt a little frustrated because I didn't understand why this stuff was getting diagnosed after and not before (Participant #22, female, age 29).

Participant 22 critiques the ways that providers overlooked mental health care options until
her mental distress worsened after surgical intervention, as any prior mental distress was attributed to GD. Participant 10 offers a more stark example, as she presented with persistent suicide ideation and was hospitalized while beginning gender-affirming care. She shared:

> Nobody's questioning if transitioning is benefiting my mental health because it clearly wasn't. But it was considered this separate untouchable thing, that's innate, that couldn't be playing a factor into my mental health…. Nobody hesitated. Nobody thought (AFAB, female, age 29).

As this quote demonstrates, she felt that her experiences of GD were seen as separable and discrete from other experiences of madness, and that these other experiences were overlooked by providers. Indeed, Participant 10 describes dissatisfaction that providers did not appear to recognize on-going psychiatric distress (only her GD), such that they never "hesitated" to consider mental health treatment options. Ultimately, there appeared to be a trans-affirming clinical context that motivated providers to minimize mental health needs outside of gender-affirming care. Participant 10 further reflected on the political context that may have contributed to providers overlooking her mental health needs:

> The kind of the [trans] activist side of things [says that] "we have to affirm or else people are going to harm themselves. And if somebody doesn't transition, there is six times higher chance of committing suicide. So we need to push people into transition right away"….And you know, [people accessing gender affirming care] deserve the same help [as] people who have other body issues. Like, you know, anorexia, eating disorders, or body dysmorphia, or all these people. They all deserve good care. And it's almost like… these people are not high priority. So why provide them good care?…politics is interfering (AFAB, female, age 29).

Having other mental health needs outside of GD might invalidate the transgender-affirming "activist side of things", which claims that gender-affirming care is sufficient to relieve mental health distress plausibly to advocate for the validity of transgender self-perceptions. For Participant 10, expanding treatment options helped her to find wellness:

> I was on a very long wait list for DBT [Dialectical Behavioral Therapy], but I got in because I was moved to priority after I had almost died [by suicide]. And then, once I was starting to connect with my body, we did work with values and beliefs. Like what, what do I believe? Who am I? And as we did these explorations of self and I learned therapy skills to deal with distress

> and dissociation and emotional regulation and stuff... The more [negative feelings] started to become, sort of... something I dealt with all the time. Where it's like, you know, transition is never going to actually make me male. Like, I'm never going to have this new life, this better life. I have the life that I have. It's just the one that I've got. That kind of reality acceptance and stuff. I ended up detransitioning two months after I finished DBT.

Recognizing the larger context of BPD symptoms helped connect Participant 10 to expanded treatment options, like DBT, such that she was able to feel more connected to her body and to tolerate extant GD, ultimately leading to detransition. Recognizing presumptive madness (BPD) helped Participant 10 to further expand her understanding of herself and to pursue wellness more holistically, not the least because recognizing madness enriched her self-experience, rather than discrediting her thoughts/feelings.

When participants had already been diagnosed with BPD prior to beginning gender- affirming care, they encountered obstacles, since their presumptive madness invited questions about the validity of their gender-affirming treatment goals. Despite endorsement of gender-affirming medical care by other mental health professionals, participants diagnosed with BPD experienced delays in accessing gender-affirming care presumably due to providers' worries that GD was primarily caused by underlying symptoms of BPD, thereby discrediting their GD. For instance, in demonstrating her providers' wariness of the connections between her trans identity, BPD diagnosis, and risk of regret, one participant explained she was required to discontinue hormones for approximately one year before being permitted to resume the treatment again.

> So then when I had a—it was more of a depression episode, but you know because of my diagnosis with BPD they were like "OK, well we want to make sure that you're actually sure. And that you're not making a mistake". So I think I had to wait a year [before re-starting testosterone] (Participant #20, AFAB, female, age 25).

If madness was already identified before beginning gender-affirming medical interventions, providers sometimes showed a prevailing concern that symptoms of GD were reducible to BPD in the absence of any clinical evidence.

Participants who were living with trauma-related conditions, such as BPD and PTSD, sometimes related GD to past trauma. However, their narratives described detailed pathways by which they felt their own GD emerged from, or intersected with, trauma-related conditions. Within these narratives, presumptive madness did not discredit prior experiences of GD nor their general thoughts/feelings, instead offering opportunities for expansion of self-awareness. Many were disappointed with trans-affirming providers who overlooked psychiatric distress outside of GD. Instead, participants suggested expanding treatment options outside of simply gender-affirming care that incorporated a holistic approach to wellness, from structured therapies like DBT to "trauma work" that might support expanding self-awareness. Rather than imply that madness invalidated prior GD, participants highlighted the

complexities and nuances of interconnections between madness and GD that were significant to their experiences of transition and detransition.

Differences in Social Communication and Prior Gender Dysphoria

Participants often also reflected on the intersections between experiences of gender non-conformity and differences in social communication, i.e. ASD, sometimes explicitly self-labelling as "neurodivergent" in interviews. Autistic participants reflected on how their neurodiversity gave them different perspectives about (social) gender, such that accepting neurodivergence had been vehicles for authentic gender expression that freed them from limiting narratives about social gender. By extension, madness did not discredit experiences of prior GD, instead considerably enriching self-understanding and operating as a liberatory vehicle (from "neurotypical" standards).

Several participants reflected that recognizing and accepting neurodivergence offered pathways to greater authenticity with regard to their social lives and gender expression. One participant reflected that:

> I realized that some of my feeling like I didn't like fit in socially with other women was actually just, you know, because I was neurodivergent. Not having the same understanding of gender roles as neurotypical cis people did (Participant 7, AFAB, cis woman, age 29).

Participant 7 considers that she may have come to GD as an explanation for her experiences because that was the only explanation of her experience that could be determined using "neurotypical" frameworks. While assuming that she was neurotypical, the only way she could initially explain her feelings of difference from neurotypical, cis women in social communication (including gender non-conformity) was through a transgender narrative. Later recognizing her neurodivergence offered new explanations, which ultimately led her to re-identify as a cisgender woman and discontinue medical transition. Similarly, Participant 13 also reflected on how initial GD arose from attempts to assimilate into popular ideas about transgender identity:

> And I feel like a lot of things that were, like, that were dysphoria that I had, that I no longer have, it was, I felt like a lot of it was imposed because, you know, the narrative back then for me was you can be trans, but you have to hate yourself, you know? You can be trans, but you have to want to be cis[gender]. And I never would have wanted to be cis. I never would have wanted to be a cis male (Participant #13, AFAB, transmasculine nonbinary, age 25).

Participant 13 felt that their prior GD arose because their ideal gender presentation included traditional masculinity and the only explanation for their desires (assuming they were neurotypical) was a transgender narrative of severe, embodied discomfort. Though they did not initially experience body dysphoria, the "imposition" of a prominent transgender narrative of bodily discomfort led to an immanent experience of discomfort, precipitating initial transition. However, expressing an exclusively male identity and presentation worsened discomfort because it was not

an accurate reflection of Participant 13's felt sense of self as nonbinary and neurodivergent. Recognizing themself as neurodivergent and conventional transgender narratives as "imposed" helped Participant 13 to detransition to live as a butch woman for a period of time, followed by re-identifying as nonbinary and thereby expressing a more androgynous, nonbinary self. Furthermore, Participant 13 began to see gender expression as continuous with a more-expansive social "mask" that they used to cope with neurotypical expectations:

> Before I detransitioned, I did have a full beard. And yeah, and I think I masked, or not masked, my mannerisms were very masculine, and I guess I do copy how people socialize in general. But I kinda just build off of that, in general, not even in regards to gender.

Participant 13 reflected that they had learned to carefully attend to non-verbal and verbal social communication strategies used by neurotypicals, and had learned to selectively use them to camouflage in social situations, like a "mask". For them, gender expression, including wearing facial hair, as well as non-verbal communication (i.e. "mannerisms") were continuous with this social "mask". Participants described initial transition as motivated by attempts to fit in with (neurotypical) social worlds, as participants assumed that they were neurotypical at the time. Accepting neurodivergences related to social communication freed participants to express themselves either by eschewing transgender identity entirely or by re-identifying with a nonbinary identity. Far from discrediting or dismissing participants' thoughts or feelings, madness instead offered pathways to expand self-understanding, such that participants revealed dense interconnections between their experiences of gender and presumptive mental disorder. Many autistic participants also reported realizing they were nonbinary, not binary transgender, in connection with their detransition, using expressive metaphor to describe an imbricated nonbinary neurodivergent identity. In these cases, detransition was motivated by the emergence of an integrated sense of self at the intersections of neurodivergence and nonbinary identity that troubled the relatively binary goals of their initial transition. These rich metaphors offered further vehicles for authentic self-expression and new confidence, as well as deviating from both reduction and erasure discourses. One participant elaborated on their identification as "faery":

> I've identified a lot with changeling figures in stories when I was younger. Which is partly gender stuff, and partly to do with neurodiversity. That's kind of the word that I like the most to talk about gender in a sort of metaphorical way. Isn't talking about gender always sort of metaphorical anyways…To me being faery gender means not just that I place myself outside of man and woman, but also that I'm so utterly removed from those concepts as to make them meaningless. My gender does not exist in relation to manhood or womanhood in any way. Not even to say it's definitively not one of those. I am a stranger to that paradigm in a way where my expression of gender is intense, whimsical, mystical, mutable, frightening, unknowable, and unconstrained. (Participant 16, AFAB, nonbinary and "faery", age 30).

Participant 16 collapses gender non-conformity and neurodivergence into a singular identity that is irreducible to either. They use metaphor to simultaneously invoke "changeling" myths that have been adopted by autistic people (some scholars argue that changeling myths historically emerged to explain autistic traits in children, Leask et al., 2005) and also to invoke metaphors of gender identity outside of male/female binaries and any reference to them. Participant 1 (AMAB, "doll", age 25), though not explicitly identifying as autistic, but as having a "mental health" disability, explained that "my gender is amorphous blob". Their identity as alternately a doll or amorphous blob offered new confidence, though:

> I don't really feel an urge to hide any of the things that I've experienced or any parts of myself. People can tell that I'm a little weird, and people also tend to pick up on the fact that I'm extremely mentally ill very quickly. And so I figure it's also coming from this place of I'm just confirming things that people already know. Plus, like I said, it's just I don't get anything out of keeping it secret.
>
> Participant 1 continued to explain the appeal of non-human metaphors:
>
> [I]t was this realization that the kinds of dysphoria I experience are about a lot of things that aren't traditionally gendered. Like, for example, I feel worse about having a belly button than I do about having stubble…And that kind of set these dominoes falling because it made me realize that my experience of gender was very non- – like obviously it's not binary, but also kind of inhuman…"

Feelings of detachment from parts of one's body fell at the intersections of GD and neurodivergence, inviting non-human metaphor. When words failed, autistic participants adopted rich metaphors to describe their alienation from traditional gender categories, as well as human categories, yielding new positionalities that transcended both. In so doing, participants subverted mental health (and gender-related) stigma that may be dehumanizing, by explicitly embracing in-humanity to instead imply transcendence of mundane, human categories. Rather than discredit their experiences, then, recognizing madness (or "neurodivergence" in the case of autistic participants) offered validation and integration of a holistic self.

Discussion

Participants who identified themselves as living with additional mental health-related disabilities narrated dense, nuanced interconnections between presumptive madness and prior GD. However, identifying thoughts and feelings that might be pathologized as madness supported rich, expansive, and holistic self-understanding, rather than leading participants to discredit or dismiss their own experiences, including prior experiences of GD. Reflecting Littman's (2021), Pullen Sansfacon et al (2023), Turban et al (2021), and Vandenbussche's (2022) studies on detransition,

participants observed that prior GD was often related to unidentified madness or mental health conditions, such that gender-affirming care did not reduce their psychiatric distress, leading to detransition. However, our analysis revealed that participants did not construe madness as invalidating or discrediting their prior experiences of GD. Instead, they used clinical definitions to expand self-awareness, to conceptualize dense interconnections between presumptive madness and GD, and to narrate more holistic selves.

Participants in this study described having genuine experiences of GD in the context of pervasive patterns of thought, feeling, or behaviour regarding their sexed bodies, gender non-conformity, and gender roles in society. Discontinuing or reversing gender transition occurred in the context of expanding self-awareness, such that some participants gained new insight that hormones and/or surgeries were insufficient to resolve distress, and they learned new skills that more concretely supported their well-being and ability to cope with distress relating to their bodies and gender non-conformity (e.g. DBT). Many participants also described emergent identities that could not be delimited to mental health conditions nor gender non-conformity, alone. These identities emerged after initiating a first gender transition in the context of expanding self-awareness, and they were articulated through metaphor (i.e. “amorphous blob”, “faery”, “inhuman”, “doll”) and other tools to express a dynamic self that resisted male/female binaries (among others) and fluid movement between them.

Participants also narrated madness in a way that challenged dismissal or discrediting of their thoughts and feelings, more generally. They reflected on the developmental context for their mental disorder, such as developmental trauma, such that thoughts and feelings pathologized as madness instead were reasonable responses to extreme events. Participants also narrated their madness as a valid neurodivergence, rather than construing differences in social communication as invalid and in need of correction. Furthermore, participants used rich metaphors to describe a dialectic between their experiences of gender non-conformity, and mental health, culminating in integrated identities at their intersection (Akhtar et al., 2022). Rather than adopt a narrative in which autistic individuals were invalid or vulnerable to external pressures to adopt a transgender identity (such that autism discredited their thoughts and feelings of GD), participants in our study narrated neurodivergence as a part of human diversity that expanded their own understandings of themselves and their relationship to gender. Thoughts and feelings that might be pathologized as madness and subsequently dismissed were instead depicted as valid ways of knowing. To more fully understand these experiences, more research with detransitioned neurodivergent people is needed.

Future Directions and Implications for Healthcare

Participants critiqued providers for their singular attention to GD despite the presence of other conditions that may be meaningfully connected—the phenomenon of “diagnostic overshadowing” which was also identified by an external review of the Gender Identity Development Services for children and adolescents in England

(Cass, 2022). For instance, BPD and ASD were sometimes identified after initial transition, such that participants were dismayed that these conditions had not been identified prior to beginning gender-affirming care. Participants speculated that the socio-political context, or "activist side of things" led providers to validate GD, but to overlook mental health conditions (as the these may discredit individuals presenting with GD). However, healthcare providers were not included as participants, such that it is unclear what motivated particular clinical decision-making. For instance, participants may not have presented with overt differences in thinking and feeling or may have concealed them in meeting with the provider, thereby preventing detection, findings presented in previous research on transgender people seeking gender-affirming care (MacKinnon et al., 2020). Alternately, the providers observed by participants may not have developed particular competencies in the detection or diagnosis of mental illness (if they were general practitioners, for instance). Indeed, there is emerging evidence that women with ASD are underdiagnosed or are diagnosed considerably later than men, rather than simply having low prevalence rates (Green et al., 2019; Lockwood-Estrin et al., 2021; Isaac et al., 2022). This low rate of identification may have introduced further obstacles for AFAB participants, who frequently reported ASD. Similarly, BPD may be easily confused with simple depression in the context of relatively brief clinical engagement (1–2 sessions), preventing detection (Silk, 2010). Future research may consider the competencies of gender-affirming healthcare providers to identify and treat additional psychiatric distress, whether or not healthcare providers frequently observe disclosures of additional psychiatric distress when beginning gender-affirming care (or suspect concealment from patients), or draw from a public health literature that suggests (weakly) that gender-affirming medical interventions are sufficient to relieve presenting psychiatric distress (Murad et al., 2010; White Hughto & Reisner, 2016; Fisher et al., 2016; Branstrom and Pachankis, 2020).

Gender-affirming healthcare providers may also plausibly adopt disease models in conceptualizing madness (Manderscheid et al., 2009), such that they may enact dismissal and discrediting of "abnormal" thoughts, feelings, and behaviour, including GD, when madness is already identified. According to one participant in our study, her providers delayed and withdrew access to gender-affirming medical treatments due to her BPD diagnosis, suggesting her providers considered it a root cause of gender non-conformity or GD. Insofar as BPD is disproportionately diagnosed among AFAB individuals (Bjorklund, 2006), as well as sexual or gender minorities (Eubanks-Carter & Goldfried, 2006; Lam et al., 2022), several scholars have suggested over-diagnosis in the context of sexist and heterosexist bias (Rodriguez-Seijas et al., 2021; Eubanks-Carter & Goldfried, 2006; Bjorklund, 2006; Johnson, 2021). In this case, BPD may constitute a unique understanding of madness used to discredit and dismiss women, as well as sexual and/or gender minorities. Notably, healthcare providers generally hold negative attitudes towards individuals diagnosed specifically with BPD (Black et al., 2011; Bodner et al., 2015), and further research is necessary to evaluate if these negative attitudes extend to individuals who pursue gender-affirming care and carry a diagnosis of BPD. Further research is necessary to disentangle providers' attitudes towards BPD and other forms of madness, in particular if they align with

disease models that support discrediting or dismissal of patients' thoughts and feelings due to presumptive madness. Future research may consider healthcare providers' application of diagnostic labels, as well as possible biases, as there may be particularly complex entanglements between madness, presumed womanhood, and GD.

Participants in this study were disproportionately AFAB, rather than AMAB. This difference may reflect simple underlying differences in the disproportionate number of AFAB people those who have transitioned in the past decade or so—64% per systematic review (Thompson et al., 2022). However, there may be unique disincentives to understanding oneself as having detransitioned for AMAB individuals despite superficially similar processes, since a narrative of AMAB detransition may uniquely validate transantagonistic discourses. Scholars and laypeople often target transgender women for critique over transgender men (Arayasirikul &Wilson, 2019; Colliver, 2021), such that AMAB individuals may be more concerned that their detransition may be leveraged for further transantagonistic critique. Given this context, it is also plausible that some AMAB individuals may narrate discontinuation or reversal of transition using different language or concepts, and these experiences are in need of inquiry. Further study is necessary to identify if there are particular limitations or obstacles in recruiting AMAB individuals who have detransitioned that have been unaddressed in prior research.

Detransition phenomena may also vary internationally given diverse understandings of "transgender" (Dutta & Roy, 2014; Jones, 2016). The present study observed detransition phenomena in a Canadian context, such that experiences are unlikely generalizable to other Organization for Economic Co-operation and Development (OECD) countries with differing healthcare systems. Further research is necessary to examine the extent to which our findings apply to other countries, such as neighbouring countries like the United States.

Conclusion

Attributions of madness often serve social functions, such as discrediting or dismissing transgender subjects who claim an internally felt sense of self at odds with assigned-at-birth sex. Recent research considering the intersections between madness and detransition superficially validate these logics, as some individuals name identification of madness as motivation for detransition, as GD did not relieve psychiatric distress (Littman, 2021; Pullen Sansfacon et al., 2023; Vandenbussche, 2022; Turban et al., 2021). Critical, qualitative inquiry reveals, though, that these same individuals may disrupt notions that madness invalidates or discredits their thoughts and/or feelings, including prior GD. Providers may find themselves in a highly polemical context when attempting to provide excellent care to transgender and other gender minority patients. However, intersections with mental health appear to complicate the polemic even further. Future research may consider healthcare providers' perspectives in identifying/detecting mental health conditions, mobilizations of disease models (or alternate models) of madness/mental illness when

providing gender-affirming care, and approaches to cultivate trust and collaboration with transgender people without dismissing madness.

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Declarations

Conflict of interest On behalf of all authors, the corresponding author states that there are no competing personal nor financial interests to declare.

Ethical Approval This research was approved by York University's Research Ethics Board, Human Participants Review Committee. All procedures involving human participants were performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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