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"Are we going to accept this silently?": the current debate on health policies for trans* children and adolescents

*"A gente vai aceitar calado?": o debate atual das políticas de saúde para infâncias e adolescências trans**

*"¿Vamos a aceptarlo sin decir nada?": el debate actual sobre las políticas sanitarias para la infancia y la adolescencia trans**

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Abstract: This article discusses the current restrictive laws governing access to healthcare for transgender children and adolescents, emphasizing the Brazilian context between 2023 and 2025. Drawing on ethnographic research and historiographic studies, I analyze: the effects these normative changes have produced in the practices of healthcare professionals and in adolescents' lives; how the categories of "irreversibility," "time," and "linearity" operate in childhood and adolescent transgender experiences; and the ways in which medical knowledge assesses gender through "indices" and "rates" of "detransition" and "regret." Finally, I speculate on the multiple meanings that "detransition" may carry when understood through bodily projects grounded in unpredictability.

Keywords: Childhood and adolescence. Transgender. Detransition. Health. Rights.

Resumo: Neste artigo discuto as atuais leis restritivas de acesso à saúde para crianças e adolescentes com experiências trans, enfatizando o contexto brasileiro. A partir de pesquisa etnográfica e estudos historiográficos, analiso: os efeitos que tais mudanças normativas produziram na prática de profissionais de saúde e em adolescentes; como as categorias "irreversível", "tempo" e "linearidade" atuam na transgeneridade infantojuvenil; e o modo como os saberes médicos aferem gênero a partir de "índices" e "taxas" de "destransição" e "arrependimento". Por fim, especulo os sentidos múltiplos que "destransição" pode carregar a partir de projetos corporais pautados na imprevisibilidade.

Palavras-chave: Infância e adolescência. Transgeneridade. Destransição. Saúde. Direitos.

Resumen: Este artículo analiza las actuales leyes restrictivas de acceso a la salud para la niñez y adolescencia con experiencias trans, poniendo énfasis en el contexto brasileño entre los años 2023 y 2025. A partir de investigación etnográfica y estudios historiográficos, analizo: los efectos que estos cambios normativos han producido en la práctica de profesionales de la salud y en las experiencias de adolescentes; cómo las categorías de "irreversibilidad", "tiempo" y "linealidad" operan en la transgeneridad infantojuvenil; y el modo en que los saberes médicos evalúan el género a partir de "índices" y "tasas" de "destransición" y "arrepentimiento". Finalmente, especulo sobre los múltiples sentidos que puede asumir la "destransición" a partir de proyectos corporales basados en la imprevisibilidad.

Palabras-clave: Infancia y adolescencia. Transgeneridad. Destransición. Salud. Derechos.

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Introduction

In the introductory section, I will briefly explain the current Brazilian context regarding the rights of transgender children and adolescents within the framework of institutional decisions concerning access to healthcare. The way these decisions have reverberated in the daily routine of healthcare services, producing fear and a sense of surveillance on the part of healthcare professionals, and frustration and other interpretations of meaning among adolescents, will be briefly described in the second section, based on some ethnographic accounts from a healthcare service, herein referred to as Service Y, and kept anonymous for ethical reasons[2]. I further reflect on how historical and anthropological perspectives can offer other ways of understanding the public debate on trans childhoods and adolescences: the very history of clinical practices in the constitution of the category "transsexuality" or "transgenderism" is multifaceted; medical categories change meaning, as do interventions (surgeries and hormone use). In contrast to the idea that trans childhoods and adolescences are recent appearances in medicine, dating from the late 20th and early 21st centuries, there are records of young people with trans* experiences being followed by doctors since the 1950s (American Historical Association et al., 2024, p. 14). Finally, in the second half of the article, I discuss the current correlation between transitions in childhood and adolescence and the discourse on rates and indices of detransition. I discuss how studies in the field of medicine have attempted to define what detransition and regret would be, to speculate on the multiple meanings that these phenomena can carry.

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[2] The reflections and ethnographic data analyzed in article are the result of ongoing doctoral research in the Department of Social Anthropology at the University of São Paulo, funded by the São Paulo Research Foundation (FAPESP). The research was approved by the Research Ethics Committee, with Certificate of Presentation of Ethical Appraisal (CAAE): 81958224.9.0000.0138. The service was not identified to protect participants.
The term trans* (asterisk) adopted here indicates experiences of gender transition in a broader sense, and not necessarily gender "identities." Trans* corresponds to the way Halberstam (2023, p. 84) used it: "the term trans* uses the asterisk to maintain openness to many stories of bodily variation and to the many ways in which these stories have been developed." This openness includes transitions that do not start from one place to another, as a destination that crosses over to the opposite gender.

Trans* childhoods and adolescences[3] have been target by a set of political and legal actions in several countries in the world, especially if they produced modifications in norms regulating the access to clinical support. Between 2021 and 2025 in the United States, 28 states approved laws that prohibited or limited medical practices targeting transgender minors. According to data collected by the Movement Advancement Project (2025), the year 2023 is particularly emblematic, with prohibitive laws in 19 states. In the same year, in England, the specialized gender identity service for children and young people closed its doors. After a series of tensions at the Tavistock clinic, which had been developing since 2020, the National Health Service of England (NHS) commissioned a report from pediatrician Hilary Cass, known as The Cass Review, released in April 2024, which concluded that there was weak evidence regarding the clinical procedures adopted for monitoring transgender minors. The Cass Review emerges in a context of high-profile detransition cases in England, the most well-known being that of Keira Bell, who filed a lawsuit against the Tavistock clinic arguing incapacity to consent to medical interventions she underwent (Garland *Et al.*, 2023).

In Brazil, also in 2023, a Parliamentary Inquiry Commission (CPI), headed by far-right parties, was established to investigate the Transdisciplinary Outpatient Clinic for Gender Identity and Sexual Orientation (AMTIGOS), based at the Hospital das Clínicas of the University of São Paulo. To a large extent, the controversies surrounding gender clinics for minors relate to the debate on the capacity for consent, which involves evaluating so-called subsequent "regrets" and cases of "detransition." One of the purposes of this article is to reflect on the various meanings that the phenomenon of regret and detransition has permeated trans minors, and in the final sections I sought to raise analytical questions about transitions and detransitions.

One year ago, in 2024, professionals from the service where I conduct ethnographic research were discussing the effects of the Cass Review. With the election of Donald Trump to the US presidency in 2025, a feeling of insecurity arose, even if seemingly distant from

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Brazilian reality. A few months after Trump's election, on April 11, the Federal Council of Medicine (CFM) published Resolution No. 2,427, which prohibited the use of puberty blockers for transgender youth and raised the minimum age for access to cross-sex hormone therapy to 18 years. After mobilizations by organized social movements, family members, and transgender people, a series of actions took place, including the filing of a lawsuit with the Public Prosecutor's Office. As a result, Resolution 2,427/2025 was suspended on July 25, 2025, by a decision of the Federal Court of Acre (SJAC) in an action brought by the Federal Public Prosecutor's Office against the Federal Council of Medicine (CFM). However, on October 2nd, the Supreme Federal Court (STF) revoked the SJAC's decision to suspend the Resolution, thus reinstating its validity until the STF rules on whether it violates constitutional principles.

This set of political actions that currently target mainly trans children and adolescents is part of a historical process called in the last few years as anti-gender movement, responsible for fostering a sense of fear regarding the term "gender". Butler (2024) wrote about this anti-gender feeling, the bases of the creation of the idea of "gender ideology" by the Catholic Church from documents released since 1990, aiming to demonstrate, not the process through which gender started to be seen as a phantom, but to understand the structure of such "phantom", what it encompasses under its rubric, its mechanisms of incitement, and what makes it vigorous. The point is that such phantom has provoked setbacks in rights, has acted as a destabilizing force in anti-democratic contexts, and has been a powerful electoral symbol. A noteworthy example of this was the Supreme Federal Court's action in accepting the CFM's complaint and reinstating the validity of Resolution 2,427, coupled with the presidential decree that addresses the prohibition of gender-neutral language[4]. Such political actions, taken in a presidential election year, must be seen, at least, as a strategy of the current government to defend itself against accusations of propagating "gender ideology," given the immense mobilization that the gender phantom generates in electoral contests.

The aforementioned Parliamentary Inquiry Commission that investigated AMTIGOS, held in the Legislative Assembly of the State of São Paulo in 2023 in Brazil, is an example of the circulation of this phantom. The conclusions of this inquiry did not affect the functioning

[4] Law nº 15,263/2025 (National Policy for Simple Language) provides in its art. 5th, item XI, that the federal public administration must not use "new forms of gender and number inflection" in disagreement with grammar norms, the VOLP [Orthographic Vocabulary of the Portuguese Language].

of AMTIGOS, unlike the outcome produced in the English context. Throughout the CPI meetings, several doctors were called to testify, and these occasions served for the production of media content on the social networks of some politicians, often with a strongly appealing character about the "protection" of childhood and the terror of "gender ideology," as well as a narrative that children were being subjected to surgeries and the use of hormones. In a report to the Gazeta newspaper, a councilor from União Brasil Party stated:

> Performing hormonal treatment or preparatory procedures for sex reassignment on children is a crime. While these parents use the University of São Paulo's Hospital das Clínicas (HC-USP) to satisfy their own ideological schizophrenia and subject their children to experiments, people with serious illnesses are left without adequate care (Silva, 2023, paragraph 4, our translation).

Misleading headlines in newspapers created the impression that minors under 16 were being subjected to medical procedures under duress[5]. In addition, In the months leading up to the CPI (Parliamentary Commission of Inquiry), videos circulated on social media spreading the false idea that children between the ages of 4 and 12 were undergoing genital surgeries[6]. Another biased headline in the *Oeste* newspaper, written by Crystian Costa (2023), warned: "Hospital has recorded almost 300 minors undergoing gender transition", and continued: "procedures involve puberty blocking, cross-sex hormone therapy, and in some cases, even gender reassignment surgery"[7]. The headline clearly suggested a biased association between minors and "gender reassignment surgery," however, this practice was not legal for minors according to the CFM (Brazilian Federal Council of Medicine) regulations in effect in 2019, which blatantly demonstrates the false information still being disseminated in the online newspaper. As can be seen, the production of this discourse was not an isolated case in Brazil, and "transgender childhood" was becoming a global target of political actions that had concrete effects on the rights and lives of these children and adolescents.

Pursuant to the Brazilian law and the CFM norms in force in 2023, cross- sex hormone therapy was not allowed for individuals under 16 years old, and surgeries were only allowed to those over 18 years old. *Resolution nº 2,265/2019* by the CFM, providing for

[5] See headline and content at: https://www.gazetasp.com.br.

[6] The *Estadão* newspaper carried out a survey and concluded that videos with false information circulated regarding the care provided to transgender children at the Hospital das Clínicas of USP (University of São Paulo), the publication refuted rumors about gender reassignment surgeries on minors. For more details, see: Estadão Verifica (2023).

[7] See article in: Costa (2023). Available at: https://revistaoeste.com.

medical care to individuals with "gender incongruence", was the first to address trans children and adolescents in Brazil and regulates the application of the so-called "puberty blocking", which was not provided for in the previous *Resolution* (*1,955/2010*). According to *Resolution n° 2,265/2019*, puberty blocking is performed on an experimental research basis and, therefore, must be submitted to Research Ethics Committees linked to research centers for its implementation. Puberty blocking consists of interrupting the development of sex hormones, which prevents the development of breasts, facial hair, and menstruation, for example. According to the 2019 *Resolution*, blocking is prohibited before the onset of puberty, allowing its initiation in children or adolescents only from what is designated as Tanner stage II. The so-called "cross-sex hormone therapy" can be initiated from the age of 16, with the express authorization of legal guardians. Before this *Resolution*, there was an *Opinion* (No. 8 of 2013) that regulated puberty blocking for cases of gender variability.

In other words, in practical terms, few places were authorized to perform puberty blocking after the 2019 *Resolution*. Around five services carried out this clinical practice in Brazil in 2023. Given the country's vast territory, there are entire regions without services aimed at children and adolescents with transgender experiences. Families with minors report long journeys to access such services: "I travel 450 kilometers so my child can have access." This account was given by a mother in a chat during a meeting of organizations involved in national protests against a new CFM (Federal Council of Medicine) Resolution which, as mentioned, profoundly altered existing regulations.

Resolution 2,427 published in April 2025 introduced a series of changes, the most relevant appear in articles 5th and 6th. Article 5th prohibits the use of "[...] hormonal blockers for the treatment of gender incongruence or gender dysphoria in children and adolescents" (CFM, 2025). The same article states that the prohibition does not apply to cases of precocious puberty, affirming that in this case it is scientifically indicated. Article 6, on cross-sex hormone therapy (use of testosterone and estrogen), prohibits its initiation before the age of 18, and also establishes a one-year clinical follow-up as a condition for its use, even if the person is of legal age. The emphasis of the indicated follow-up is psychiatric and endocrinological. Several medical associations of different specialties have published statements opposing the Resolution. It is noteworthy that the arguments of this *Resolution* are

anchored in the *Cass Review* report, already criticized for its weak scientific and methodological bases[8].

The rapporteur of *Resolution 2,427/2025*, Raphael Parente, a gynecologist doctor, gave an interview stating a possible "overdiagnosis" and that the CFM decision followed a global trend of restricting access to medical procedures for transgender children and youth. While claiming there was overdiagnosis and an increased rate of "regret," he also cited a lack of robust research data to support these figures. Furthermore, he generally cited health risks associated with the use of puberty blockers. Parente is also known for his opposition to legal abortion in cases of rape, as permitted under Brazilian law. He has defended sexual abstinence as a public policy for teenage pregnancy and served in the government of Jair Bolsonaro (2019-2023) in 2020 as Secretary of Primary Care in the Ministry of Health (Felizardo, 2024).

Entities from organized social movements also spoke out. The National Association of *Travestis* and Transsexuals (ANTRA) and the Brazilian Institute of Transmasculinities (IBRAT) filed a *Direct Action of Unconstitutionality* (ADI 7806) with the Supreme Federal Court. Movements of mothers and family members published statements and organized a national mobilization with public events in several cities across the country[9].

"What have we done to them?": Transgender teenagers challenging medical rhetoric throughout history

April 11, 2025, witnessed a tense morning, the *Y service* health team discussed discusses how to proceed with potential questions or referrals from teenagers beginning hormone therapy. They express a sense of frustration. Hormone therapy before the age of 18 was prohibited, and the conversations revolved around what to do, how to handle the

[8] A critical analysis of the *Cass Review* report published in the scientific journal *BMC Medical Research Methodology* (Noone *Et al.*, 2025) identified high risk of bias in systematic studies founding that review and methodological errors. See also Moore *Et al.* (2025).

[9] In response to the context of CFM Resolution, AMTIGOS, the most renowned outpatient clinic in Brazil for its pioneering work in childhood health, organized the 1st Symposium on the Health of Children and Adolescents with Gender Variability between May 24th and 25th, 2025, at the Institute of Psychiatry of the Hospital das Clínicas of the Faculty of Medicine of USP. All specialized services in this field were present, totaling six at that time. At the end of the Symposium, the services met to develop technical positions requested by the Supreme Federal Court (STF) in the aforementioned Direct Action of Unconstitutionality (ADI) filed by ANTRA and IBRAT, which is still ongoing. The process can be accessed through the Supreme Federal Court's website at: https://redir.stf.jus.br.

situation, and the practical implications, which proved to be a dilemma not only of medical practice, for some, but also of what would be ethical. Two professionals are having a conversation at the end of their appointments that day their positioning in the event of possible questioning or referral of adolescents that were starting a process for cross-sex hormone therapy, they express a sense of frustration. Hormone therapy before the age of 18 was prohibited, and the conversations revolved around what to do, how to handle the situation, and the practical implications, which proved to be a dilemma not only of medical practice, for some, but also of what would be ethical. Two professionals are having a conversation at the end of their appointments that day:

> Lisis: well, then, I, from my point of view, I'm not going to pick this fight. Because I know we are on the weaker side, it's not worth it, I won't prescribe it anymore. Why were we prescribing? [rhetorical question to herself] Because there was the Resolution.
> Fild: It's not only about not prescribing it anymore, but then, what I am going to do?
> Lisis: You're going to do in your office the same thing we do here.
> Fild: I have the same concern, Lisis. I don't prescribe it anymore, but then, do what? (notes in the field observation notebook, April 2025).

Fild's[10] concern in this dialogue that I witnessed in the field was at another level, Fild question was not about what to do in legal terms, but rather about the ethical and political stand they should adopt regarding the new norms. Fild asked whether not prescribing would be unethical with their patients. Feelings of surveillance, insecurity and anger were expressed by the team, the idea that "we're on the weaker side", expressed by Lisis, revealed a dispute and a series of layers that make it impossible, from an ethnographic and anthropological point of view, to designate what would be "the" medical discourse on trans childhoods and adolescences, since this area of knowledge reveals itself in frank conflict within medical discourses. This conflict is also revealed in the various statements issued by medical associations disagreeing with CFM *Resolution 2,427*. In particular, healthcare professionals working with services aimed at the transgender population under the age of 18 work with the constant concern of being targets of investigation and attacks at any moment[11].

Resolution 2,427 was suspended between July 25 and October 2, 2025, by a preliminary injunction from the Federal Court of Acre in a lawsuit filed by the Federal Public

[10] The names used here are fictitious to keep anonymity of the participants.
[11] The president of the Federal Medicine Council, Hiran Gallo, declared that there would be penalties for doctors that were not in compliance with *Resolution 2,427* (Ferreira, 2025)

Prosecutor's Office against the CFM. The injunction requested the suspension of the *Resolution* and monetary compensation for moral damages caused by the Council. Among other various objections, the judicial decision that suspended the *Resolution* also demonstrated that the reason given by the CFM is not consistent with the very basis adopted by the Council to legitimize its decision, since "[...] the aforementioned *Cass Review* report does not legitimize the prohibition of hormone blockers, but rather recommends their adoption provided it is within the scope of scientific research" (Brazil, 2025, p. 7). Furthermore, the preliminary injunction argues that *Resolution 2,427* was not discussed with other sectors of civil society, and points to the absence of debate with other fields of knowledge, unlike the process of drafting the *2019 Resolution*. Given the recognition that this is a "cross-cutting" issue across various areas, a recognition previously made explicit by the Council itself, the injunction argues that trans, *travestis*, and other notions "[...] are not purely medical or technical [concepts], but depend on the participation and contribution of sciences such as sociology, social work, anthropology, and psychology" (Brasil, 2025, p. 4, our translation).

Such an instable political context of institutional decisions made, suspended and, later on reestablished is similar to what has been occurring in some states in the United States of America. It is worth nothing that participation such as that of *amicus curiae*[12] in those processes. Regarding the action filed with the STF, the Collective "Mães Pela Diversidade" [Mothers for Diversity] joined as *amicus curiae*, and in the United States, in a lawsuit Against the state of Tennesse, a series of plaintiffs also filed as *amici curiae*, but special attention should be drawn to the *American Historical Association* contribution, as well as that of historians' organizations, with emphasis to Jules Gill-Peterson, trans woman, professor at the Johns Hopkins University. The legal document is compelling in its demonstrations of historical records of medical interventions that are the main target of legal controversies, considered purely technical and biomedical, with debate separate from Human Sciences.

In February 2024, the *American Civil Liberties Union* and the *Lambda Legal* sued the State of Tennessee, on behalf of transgender minors' families, after approval of the Senate

[12]*Amicus curiae*, free translation: "Friend of the Court", is a legal condition where a person, Entity or Institution can join a lawsuit in the conditions of Court auxiliary, with technical or scientific information about a theme in a specific legal process. They usually produce a document that is added to the legal process.

law in that state, which prohibited medical practices and healthcare such as the use of puberty blockers, hormones, and surgeries on transgender minors, was a political process similar to the action of the CFM (Federal Council of Medicine) in Brazil. In this context, the American Historical Association and other historians' organizations joined the case as *amicus curiae*. Among the arguments in their brief, they pointed out, through a series of historical evidence gathered by the historiographical field of trans studies in the United States, that the medical interventions used today in the clinical management of so-called "gender dysphoria" have historical records dating back at least to the 19th century, contradicting the argument that they are experimental or a novelty from the point of view of biosafety or the history of modern medicine. Surgical procedures have records dating back more than a century to 1900. The use of hormones has been occurring for almost a century, and the use of puberty blockers for four decades. Furthermore, the possibility of transitioning between genders, or the public recognition of such a transition, has diverse historical records in various societies and contexts that do not fit within the medical understanding of "transgender."

Gill-Peterson, in *Histories of the transgender child* (2018), demonstrated how trans youngsters appear in historical and medical records since at least the early 20th century, and with the use of medical procedures since the 1960s. One of the strong arguments in that legal text was to demonstrate that courts, when judging the wellbeing of trans adolescents characterized the medical interventions used as "experimental" or "novel", making a historical mistake. Since the *brief of amici curiae* (*American Historical Association Et al.*, 2024) launch, the access of transgender adolescents to hormones and surgeries has been reported. With the consent of their guardians, they were treated at university clinics in the 1960s and 1970s, even if that was not a widely accepted practice (American Historical Association Et al., 2024, p. 11):

> As the university gender clinic system grew in the 1960s, adolescents with parental support and consent were approved for and received gender-affirming surgeries through several programs and affiliated surgeons, typically several years after initiating cross-gender hormones, and at the developmentally appropriate moment in late adolescence. (Gill-Peterson at 176-79, 192-193 Apud. *American Historical Association Et al.*, 2024, p. 18)

In addition, Gill-Peterson describes other cases of trans childhoods, who experienced their transitions outside the bounds of medical understanding in the early 20th century, such as the case of Val and a transgender man interviewed by psychiatrist John Hampson, who had

lived publicly as a man since the age of 13 in upstate New York (Gill-Peterson, 2018, p. 92). In the second half of the 20th century, there are records of transgender adolescents in clinics, such as the case of 15-year-old Giorgina, who was treated by Dr. Lawrence in the 1960s, who assisted with her name change and hormone therapy. Also relevant is the case of Vick, 16 years old, whose use of estrogen under a doctor's supervision was documented in the 1970s. It is known that the formal pediatric clinic model for transgender youth and children was structured between the 1980s and 2000s, based on documents from the Harry Benjamin International Gender Dysphoria Association (HBIGDA), now known as the World Professional Association for Transgender Health (WPATH). However, this required an accumulation of medical knowledge and practices in previous decades, according to the *amici curiae* brief. The US Supreme Court's decision on June 18th was favorable to the Tennessee prosecutor, as Gill-Peterson had anticipated. In an interview with *Them* magazine, she argues that regardless of the outcome, what happens after the decision is more important than the decision itself (Walker, 2025).

Letters written by children, mothers and parents were attached to the document *amicus curiae* by the collective *Mães Pela Diversidade,* from Brazil. They describe the consequences of access to procedures and demonstrate the material effects in the lives of those families, so that such changes cannot be understood if considered "smoke curtains". The excerpt below was extracted from a letter written by Ben, a 17 year-old adolescent:

> The Decision to use hormones must always involve health professionals, the family and mainly the adolescent. There should never be a generalized prohibition. For this reason, I request that the new legislation be reviewed with sensitivity and respect to the experiences of trans people. Access to hormone therapy is, for many of us, a matter of health, dignity and survival (Associação Mães pela Diversidade, 2025, p. 73, our translation).

In the period immediately after the publication of *Resolution 2.427*, adolescents who attended the *Y service* questioned and elaborated their ways of understanding the problem. One of them, a 17-year-old male trans, who had already started cross-sex hormone treatment, and in that case the regulation alteration would not affect his individual life, wrote a letter template to send to the CFM saying: "[...] guys, I wrote an e-mail to send to them CFM members. If you can, send one too, at least to the president" (do Fogo, trans boy, 17 years old, field register, April 2025). In the letter excerpt he states: "I believe that such alteration is unethical and will only worsen the mental health of trans children and adolescents" (do Fogo,

trans boy, 17 years old, field register, April 2025)[13]. Concern about the collective future among adolescents was a present feeling, as well as questions about what to do. Another adolescent questioned in a conversation within the context of therapeutic groups at the Y service: "Are we going to accept this silently? I know there are demonstrations and things like that, but like, they don't give a damn about us" (Shawn, trans boy, 16 years old, field record, April 2025). Adolescents already in treatment were anxiously waiting to turn 16 and felt frustrated: "limited," as Liv (a 14-year-old trans girl) said about how she felt in the face of the CFM restrictions.

They questioned why such changes were happening, what had they done to be targeted in that way: "isn't this wrong? Wasn't it our right?" (Cowboy, 17 years old, field register, April 2025). However, those 'whys' were transformed, at that moment in a collective talk, not only as a paralyzing cry, but it followed as a reflection upon the reasons why that decision was possible in the historical present, and other elaborations about their existences "What have we done to them?", asked Gorrinho, 15 years old. *"We challenge God",* Esperanza, 16 years old, answered (field register, April 2025)

Challenge God might mean to challenge what was created, the world as it was conceived by the entity who created it, an unquestionable and inviolable entity. The law of sexual differences, understood as binary and unchangeable is understood as a creation of divine nature, in the view of some sectors of the Catholic Church, such as, for example, in the public letter of Joseph Ratzinger (pope Bento XVI) (Santa Sé, 2004), where he stated the destructive power of "gender" on the divine creation and "female values". As analyzed by Butler (2024, p. 42, our translation), "[...] What follows from this set of beliefs is that if a person has a will or acts intentionally, they not only defy God and the natural order He created but also threaten to usurp His will". This is what the female adolescent affirmed in few words: that they are attacked because they are seen as defiers of divine powers. Meanwhile, part of their everyday lives is permeated by reports of violence in school and prohibition to use toilets. I have heard reports of use of toilets that were hidden, a long-distance walk, sometimes without any lock, or simply prohibition to use according to the gender with which the adolescent identified. There are also reports of sexual harassment

[13] All the names appearing here are fictitious due to research ethical issues and protection of the minor participants.

by colleagues and teachers in schools, exposure of their birth register names (or the so-called "dead name" by some) in public lists on the school corridor walls. Also, some had experiences similar to "exorcisms" at home, performed by religious figures.

In the late 1960s, after publication of Christine Jorgensen's autobiography[14], a trans adolescent wrote to endocrinologist Harry Benjamin: *"For approximately 5 years the wish to become a female has [been] and still is with me. This wish is very strong in me. . . . When I read your book my hopes raised to their highest level"*(Gill-Peterson, 2018, p. 151). Benjamin received several letters from minors reporting their wishes, how they felt and spoke about managing their hormones. According to Gill-Peterson's research, Benjamin's answers followed the development rethoric: '*You are very young yet and must give yourself a chance to mature',* wrote Benjamin. *'In 2 or 3 years, life might seem different for you'* (Gill-Peterson, 2018, p. 152). In response to that rhetoric, another adolescent wrote: "'[...] *I want to be a girl now so that I can grow up the rest of the way as a normal girl"* (Gill-Peterson, 2018, p. 153).

Although the development idea seemed to be incompatible with transsexuality, that is, the idea that there is a gradual and linear formation of a subject which follows the maturation of features of somebody "truly" transexual, also in those decades some adolescents and medical doctors, for understanding body, transsexuality and a medical practice distinct from the current one, performed transitions using medication and legal name changes. In the 1970s, in the United States, there are records of access to hormone and surgery in minors in a less restricted manner than in the previous decade, 1960, and later, the 1980s, is when "gender dysphoria" in children and adolescents appears in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Gill-Peterson shows how Harry Benjamin makes the reception of minor in his clinic less restrict and points out how the medicine archive of the 1970s records surgeries in minor after puberty. At the same time, in that period, the child's body plasticity notion prevailed, Thus, before the onset of puberty, it was considered possible to prevent the development of transsexuality in adulthood, as Gill-Peterson points out (2018)[15].

[14] Christine Jorgensen (1926–1989) was a North-American trans woman who became one of the first high-profile cases in the media about transgenderism in the 20th century.
[15] About this topic, see chapter 4.

Such historiographical notes are relevant in discourse analyses of the medicine field in the early 21st century, which signal the appearance of transgender children and adolescents with specific clinical setting in the late 20th century, which is a historiographical mistake that implies in lack of knowledge of the medicine field. It is argued, for example, that

> Unlike in the past when clinicians actively worked with children and their parents to lessen gender dysphoria or adopted a neutral strategy of "watchful waiting", many of today's youth undergo some form of gender social transition (e.g., change in clothes, haircut, name, and pronouns; breast binding; use of opposite sex facilities, etc.) before contemplating medical interventions (Jorgensen, 2023, p. 2176).

This excerpt is reproduced almost integrally in the 2025 CFM *Resolution*. It indicates implicitly that "in the past" gender transitions with adoption of changes were almost inexistent and that is different from what occurs "today". Not only does this "watchful wait" represent the entire past in clinical practice for trans young individuals, archives and historiographical research, as we could see, reveal more complex developments regarding the myriad of medical practices and conceptions on body modification and transgenderism throughout the 20th and 21st centuries.

In 2025, youngsters such as Ben and do Fogo, in Brazil, wrote and continue to record how adolescents deal with and can decide about medical interventions and their interactions with their bodies. They also recorded ways of relating with medical discourses in certain specific contexts. As in the conclusion of the *brief of amici curiae*, current prohibitive laws rule "[...] an entire generation of transgender adolescents towards the destiny those adolescents have feared for over half a century" (*American Historical Association Et al.*, 2024, p. 27, our translation).

Some other ideas disseminated through *Resolution 2,427/2025*, such as the notion of "overdiagnosis" of trans people in childhood, and the notion of "regret index", which are only possible within the "transsexuality" history category built up by the medicine field, based on a notion of gender that can be diagnosed and, therefore, verified. These notions seem to be supported by an idea of linear and cumulative temporality, present both in the Western idea of childhood (and of personhood), and in the idea of diagnosing "dysphoria" or "gender incongruence" in childhood and adolescence; I will address this issue in the following pages.

Childhood and adolescence as fleeting experiences, and irreversible transsexuality: time and linearity in the rhetoric of "development"

The idea of cumulative and linear time understands childhood in the Western conception, set from the 18th century onwards (Ariès, 1986) as a specific phase in the life of "developing" human beings, where it is the first phase, thus considered "incomplete". The idea of incompleteness could operate, in childhood experiences in relation to the so-called gender and sexuality roles, as an allowed fluidity phase.

According to Gill-Peterson, between 1910 and 1940, in the United States at the Brady Institute and at *Harriet Lane Home*, before the "transsexual" category, notions such as "inverted" and "sexual perversion" were clinically used to describe a series of behaviors and physiological conditions. The idea of experiencing a gender/sex different from that assigned at birth was explained by the intersex idiom (hermaphroditism, at the time), based on some physiological disorder. A letter from a certain Bernard to Hugh H. Young, demonstrates the way those diagnostic categories could mingle from an endocrine conception of inversions and the way in which these diagnostic categories could merge from an endocrine conception of inversion and the way in which the category of sex did not present itself in a univocal way, but multidimensionally with the thesis of natural bisexuality.[16]

At that time, the emergence of a psychiatric model of inversion was observed in medical reports by Thommas Rennie at the Brady Institute, alongside the idea of development from Freud's notions. In that conception, sexuality develops in phases: the first, in childhood, involves curiosity and manipulation, next, there is latent phase of uninterest followed by a pre-puberty phase which is "strongly homosexual" and, in adolescence, heterosexual interest appears, with slow maturation into adulthood. Thus, for Rennie, homosexuality, as the inability to develop beyond a certain phase cannot be seen as something serious in early adolescence since it is characteristic of that phase. Sexual development is seen as having plasticity, shaping itself in its maturation phases or failing to

[16] Excerpt from Bernard's letter: "As I understand it, a person may have secondary sexual organs which control his mental and emotional life; while the primary organs are of the opposite sex. What I want to know is can these secondary organs really be developed in such a way that a person who has been known as a female becomes a male? I know that sex books say that no one is really 100% of either sex. If this can be done, I would like to know about what the cost would be and the time required' (...) The letter cuts a fascinating line through the web of hermaphroditism, sexual inversion, homosexuality, and transvestism. Presenting himself as intersex, Bernard comes across as well read on the theory of natural bisexuality and expertly deploys it to legitimize sex reassignment." (Gill-Peterson, 2018, p. 84-85)

progress beyond certain phases, hence the inversion. According to Gill-Peterson (2018), this clarifies the absence of diagnoses of sexual perversion, inversion, and homosexuality in children at Harriet Lane Home, and why Hopkins separated intersex children from cases of inversion:

> If children were naturally inverted to some degree during childhood, then there was little reason to assign them diagnoses like homosexuality that were understood to be meaningful only insofar as they indicated arrest. Inversion, in other words, was significant only in adults. (Gill-Peterson, 2018, p. 88)

The idea of indeterminacy in childhood appears in an article in the Brazilian magazine *Pais & Filhos* [Parents & Children], in the 1975 issue. The article is called "homossexualismo infantil" [children's homosexualism] and it reveals certain medical and cultural understanding of the behaviors related to gender and sexuality in childhood in the second half of the 20th century. The article explains: "Although most parents tend to face this fact as a tragedy, children's homosexual manifestations are perfectly normal up to a certain age" (Ventura, 1975, p. 89, our translation). He continued:

> [...] there are certain occasional children's attitudes or behaviors that should not alarm their parents. For example, sexual experimentation and investigation, sometimes wearing clothes destined to the opposite sex. This is because they are isolated and transient attitudes. (Ventura, 1975, p. 89, our translation)

The article sustains, with the support of Miguel Chalub, MD (Psychiatrist at the Federal University of Rio de Janeiro), that homosexual behaviors should not be of concern in a certain phase since up to puberty some behaviors are considered experimental, rather than definitive exactly for occurring at that phase, that is, in childhood.

Another aspect about how temporality works in the meanings of "childhood" and "trans" in the Western cultural scheme is that childhood is defined as the phase of indetermination and incompleteness, while "transsexuality" is a diagnosis that needs to be verified, and it is also measured by cumulative temporality considering how long a person presents certain behavior. On the one hand, there is an idea of *plasticity* in formation; on the other hand, the action of presenting a diagnosis indicates exactly the *stagnation* point. In other words, it is impossible to diagnose – find the stagnation point – in an ongoing process. This seems to be the general prevalent idea, with variations in meaning and intensity, in part of the medical and legal discourses throughout the 20th and 21st centuries about trans

childhood and adolescence, as observed in the development rhetoric in the letters by Harry Benjamin to those adolescents.

In such logic, childhood is a benchmark to define transsexuality in adult life, and "transsexuality" when mixed with childhood might provoke a change in the childhood meanings, making it less experimental and undetermined, and more fixed and diagnosed within medical knowledge. This conception is observed in current discourses of conservative politicians when they state that "trans children do not exist", according to the idea that a child cannot be sure of something that "impacts their whole life". This means that in childhood, experience always refers to adulthood, from the idea of "persistency" which is many times employed in longitudinal studies to set rates about the number of adolescents that remain transgender in adult life. In this logic, trans children can only confirm their transgenderism is they become a trans adult.

Temporality as cumulative certainty also acts, in a different way, in medical discourses that oppose conservative discourses since they state that "trans children do exist", and this might be clinically confirmed, they can be "recognized" by clinical methods and knowledge based on "investigative" and "longitudinal" approaches, which permeate the time notion. This can be Illustrated by debates occurred in the CPI in 2023. When asked by a congressman (from the conservative wing) what the criteria are for diagnosing "gender dysphoria," the psychiatrist, coordinator of the first clinic that treated transgender children in Brazil, replied:

> […] For each adolescent, for each child, we observe how that child functions, which is the expressed behavior, and how they see themselves, which is the identity research. If there is persistence, if it is consistent, if it is intense and this is maintained over time, that is a sign that this child is not - how can I say - inventing, it is not a game, it is not a phase. *There is a phase in childhood where children play, they exchange, but it is during play. When we talk about gender identity, it's all the time, it's morning, afternoon, night, it's on weekends, it's on vacation*. [...] These are nuances and details that we observe over time in order to then make the diagnosis. So, it is investigative.
> [...] it is longitudinal, it is over time that this configuration and this objective criterion are established, deputy (ALESP, 2023, p. 11, our translation).

Although keeping distinct stances, the congressman and the psychiatrist act on the same principles: identity is fixed at a certain time in life, the identity or decision is different from "phase" and "play", thus, it is objective and follows objective parameters. The issue is childhood, which shortens the time accumulation to be observed to reach "certainty" or

"identity". For this reason, there is a question about "criteria", and the psychiatrist answers with the criteria.

Anthropological investigation acts mainly based on historical-cultural principles, which set some ways of posing an issue at a given time by a specific social group, and in this case, time appears as a fundamental cultural category, in the constitution of the "problem" formulation in the Euro-American culture context about trans childhood and adolescence. In *Trans*: a quick and quirky account of gender variability*, Jack Halberstam (2023, p. 30) states "[...] this book explains how we came to be trans* and why having a name for oneself can be as damaging as lacking one" (Halberstam, 2023, p. 30). Halberstam is thinking the trans* experience (with asterisk) to differentiate it from what has been defined by the medical and also identity-based conception of what transsexuality is, in the sense that the asterisk "[...] holds open the meaning of the term "trans" and refuses to deliver certainty through the act of naming" (Halberstam, 2023, p. 29). According to Halberstam, the appearance of trans* children does not challenge the gender notion only, but also the idea of time, development and order. In psychological reports for name change, the *time* of medical treatment for a minor is a relevant factor, as reported by a grandmother in her grandson's name change process: "at least six months". In a psychological report template for name/gender change in a birth certificate I had access to, I found the following:

> At no point was it observed that their gender identity is the result of external influence and imposition, such as from parents/family/legal guardians or friends. Nor was it presented as a playful, experimental, superficial, or fleeting process (excerpt extracted from a document model accessed during the field research).

This last observation, which confirms the report, aims to dispel the idea of playfulness or games, of experimentation and of the transient nature (as something momentary) of the transition, in the same way that the psychiatrist responds in the Parliamentary Commission of Inquiry: "it is all the time," not just during playtime. In fact, the trans child seems to be permeated by the constant sense of their future trans adult, and only from its persistence – in the clinical model of verifying statistical persistence rates – can their rights be ensured.

Measuring transitions and detransitions: remnants of the imponderable

When discussing the CFM *Resolution 2,427* in Brazil, the development and irreversibility rhetoric is updated in a text defending the prohibition of blockers and hormones:

> Medical care must respect human diversity, but it must also adhere to science, ethics and caution, especially when irreversible interventions for individuals still in development are under consideration. (Parente *Et al.,* 2025)

Just as the diagnosis of inversion was not possible in minors until a certain stage (because sexual development carried a character of plasticity, whereas inversion was a significant point of stagnation), in this passage, medical interventions function in the same place as the diagnosis of "inversion" in the past: in a subject considered unfinished, one cannot give it a finished product, as appeared in Rennie's argument in the 1930s. Given this argument, we can invert the terms and point out the contradiction in the medical practice that legitimizes irreversible medical interventions in intersex babies. Beyond that, it is necessary to understand the framing of the issue and to be critical of the very terms of the statement.

The arguments emphasized by the authors of the Resolution point to an increase in experiences of "regret" and "detransition," while also stating that the methods for verifying "regret" and/or detransition are not accurate. Some of the studies cited by the CFM, conducted using data from Finland (Kaltiala et al., 2024), investigate statistical rates of discontinuation of hormone use, of 7.9% between 1996 and 2019, where those authors themselves state that "[...] registers include no information on the reasons for discontinuing hormonal GR" (Kaltiala, 2024, p. 8). Also, data regarding hormone use discontinuation only include official sources of cross-sex hormone treatment from the Finish health system. In other words, the analytical path to state that discontinuation indicates regret or detransition does not exist, and the data of that study do not state that. It seems relevant to contextualize it, in Finland, authorship has pointed out that there are comprehensive public health services and special reimbursement programs covering the costs of hormone treatments. This is a completely different context from that of public policies in Brazil, where hormone costs are not covered in most of the territory, with regions lacking outpatient service to assist transpeople.

Another interesting fact to observe in some current studies in the biomedicine field are attempts to produce indices and rates of notions such as "discontinuation in the use of hormones", "regret" and "detransition", aiming to make them statistically demonstrable in unambiguous definitions. In the annex to the CFM *Resolution*, those authors state: "Likewise, not all of those who detransition feel regret about their decision to transition" (CFM, 2025, p.

10, our translation). However, in the study cited by the CFM, a more curious statement appears: "[...]discontinuing hormonal GR, desisting from identifying in a sex-discordant way, detransitioning and regretting medical GR are concepts referring partly to the same phenomenon but not totally overlapping" (Kaltiala *Et al.,* 2024, p.8-9). The study did not aim to investigate the reasons for the discontinuation, but only to demonstrate a greater discontinuation between analysis groups in recent decades, and argues that data collection through records cannot capture this phenomenon. However, possible reasons for this discontinuation do emerge in lapses of supposition:

> It is also possible that some achieved their goals and therefore discontinued, although this seems implausible in the case of discontinuation after many years. A more profound understanding of the reasons for discontinuing medical GR will require studies using information elicited directly from patients (Kaltiala *Et al.,* 2024, p. 8).

Even affirming that reasons must be obtained by research with patients, the assumption of authorships records their analytical preconceptions. Why would it seem improbable that someone would discontinue hormone use for being satisfied with changes even after many years? Or, what would be the objective? If it refers to experimentation with hormone use for some time, would the objective not be achieved? In search of both temporary change or more permanent modifications, objectives can be diverse. One case is even considered in biomedical studies that report quantitative data[17]. Taking into account the idea that phenomena such as *detransition*, *regret*, *hormone treatment discontinuation* and "*desistance* to identify in a way that is inconsistent with one's sex", are interdependent, that is, one term does not trigger the other as a necessary effect, as formulated in Kaltiala *et al*. (2024) – there is also another aspect to be considered: "the desistance" to identify in a way that is inconsistent with one's "[assigned] sex" can be multiple, depending on the consideration of the level of desistance or the level of inconsistency. A woman assigned person might give up on identifying as so but might still navigate through femininity signs in multiple ways.

The desistance to disagree with the identification of a sex/gender does not lead to the broad adoption of an opposed term. Such desistance might even indicate a transition to one of the forms of non-binarity, if thinking in the perspective of a person who gives up identifying

[17] "Among the two patients that stopped hormonal therapy, one viewed their experience as negative and the other reported meeting their gender-related goals" (Jorgensen, 2023, p. 2177)

in a *totally inconsistent* way with the assigned gender. In other words, such movement might indicate detransition from an initiated transition, and that might imply regret or not, hormone use discontinuation or not, while indicating a detransition that is not going back to cis genderism. It seems that the ideas of "detransition" and "regret" in the current biomedical discourse are stated as supposedly verifiable in indices and rates. However, they also appear partially defined and scape univocal definitions of indices. Detransitioning is a process as multiple as transitioning, since it seeks to refer to a demobilization of a set of actions and meanings involved in the transition, it therefore depends on which sets of actions and meanings these are. In some studies, the definition and characterization of detransition is made by researchers based on medical records; others originate from networks of people who define themselves as detransitioners, but with a wide range of experiences: those who detransitioned and restarted their transitions, those who detransition due to discrimination, others included as detransitioners but who do not fully identify with their assigned gender again.

Detransition appears as a widely defined phenomenon in contexts where transitions are measured according to medical interventions and might imply, in these terms, interruption in the use of hormones, identification with the gender assigned at birth, and in some cases, surgeries to reverse the effects of medical interventions on the individual. This means that it is defined in relation to medical transition procedures. Studies analyzing detransition rates focus mostly on European and United states situations. Articles cited by the CFM were developed in countries such as the United Kingdom, Sweden, Finland and the United States Gender transition body projects from some Latin-American countries present a diverse history from that found in the United States and many times do not go through clinical "transsexualization processes" or are related to them creating other meanings collectively. For example, in the research published by Silvana Nascimento (2019), conducted at the Alto Solimões Amazoninan triple boundary — Letícia (Colombia), Tabatinga (Brazil) and Santa Rosa (Peru) — the strict separation between gender and sexuality, observed in the predominant discourse of the LGBT activism is not included. In those contexts, ethnographic examples pointed out other ways of experiencing and transforming bodies with multiple models of femininity. The cis/trans dual opposition is not elicited either, but there is what the author calls trans* multiverse "trans girls, children who change, sissies, faggots, moths,

women, *travestis*, gays (word used as male and female), trans women, and so on" (Nascimento, 2019, p. 532). Based on research like those, I question whether the grammar of "hormone use discontinuation", "detransition" and "regret makes sense in those contexts. Let's consider Mariana's case, a Peruvian, who after having lived as a *travesti* for years and changed her body with hormones, and identified as "a gay woman" as she aged, while still retaining the female name by which she is socially recognized.

Other transitions that are non-linear and without a given destination are revealed, trans children can be something more than the foundation of a transgender adult future. We could conceive other forms of understanding what trans children and adolescents challenge: would it not be another notion of time? We have seen that transition as a playful, experimental, and fleeting movement is dismissed as "false" transsexuality, just as other forms of gender transition have been considered false throughout history. These falsifiability claims were produced by verifying the "true transsexual" through medical protocols that required testing, and common narratives of body hatred to attest to the diagnosis. For example, the infamous "real-life test," which was the obligation to wear clothing of the gender with which the person identifies at all times, for several years. Berenice Bento (2017) describes these protocols and the daily lives of trans people in clinics in the early 2000s.

In this respect, there has always been the history of transsexuality considered "false," that is, of those people who were and are unintelligible to medical discourse, or who related to it from other forms of power, such as Black trans* adolescents, poor, from peripheral contexts, from prison contexts. Other names and ways of transitioning gender emerge from these contexts: Anderson Herzer's autobiography, in *The Fall to the Top* (1982), is a historical document of non-normative gender childhood and adolescence in contexts of restricted freedom, in which the notion of "macho," typical of prison, is central to Herzer's experimentation with masculinity. This notion denotes other kinship relations in the prison system that constituted gender: a macho man was someone who had wives and daughters. Lory Girshick (2015), in an article about people who identify as masculine in women's prisons, reports the use of the terms "macho," "aggressive," or "tomboy." These nomenclatures do not indicate the absence of a more appropriate term in these people's experiences, of which they would not be aware, such as "trans" or "transgender," and by which they would be saved by the discovery of these names, but rather that "trans" and

"transgender" were terms fundamentally constituted from the absence of these experiences and the falsifiability of others.

As Gill-Peterson demonstrated, before the category was seen as a possible diagnosis in childhood, children experienced gender transitions in school contexts, even if there was no name for it. Having a name and a clinical apparatus only delimits some ways of producing gender transitions. B. Camminga (2019) paid special attention to how the term transgender can travel globally and produce political complexities, misinterpretations of cultural terms, and colonial discourses. The analysis of the emblematic case of Tiwonge Chimbalanga in Malawi in 2009 clearly demonstrates this aspect. Tiwonge Chimbalanga had been arrested and accused of "unnatural offenses"" and "indecent practices between men" after her engagement ceremony with Steven Monjeza was made public. Journalists made the ceremony public and, according to the Malawi law, Chimbalanga and Tiwonge were arrested. According to Chimbalanga "one of the journalists questioned Steven Monjeza, "Steven are you gay?" and he said "yes" because he does not go to school [he was not well educated] … So another question come, "Auntie Tiwonge are you gay or straight?" I didn't answer because this was a nonsense question". (Camminga, 2019, p. 104).

Chimbalanga was raised as a girl by her uncle in their village and this is how she was introduced to Monjeza's family. The international media reported the case as the first "gay" marriage in Malawi, activists from other countries protested against the government and accused Chimbalanga from having had a celebration paid by foreigner LGBTs. The Western weight of the word "gay" intensified the accusations. However, she said that the first time she heard this term was when it appeared next to her photo in the newspaper. As demonstrated by Camminga (2019), trans organizations found out later that Chimbalanga self-identified as a woman and embraced the discourse that there was an erasure of "trans" identity, and that it was not a "gay" marriage. One of the organizations in the continent, *Gender DynamiX* (GDX), published a note: "If she knew the word transgender she would come home to a world of understanding of herself" (Hamblin *apud* Camminga, 2010, p. 106). These are forms of colonial erasure of other ways of understanding oneself that might make people ignore themselves.

The word "transgender" is unintelligible to Chimbalanga, as the terms indicate other corporealities, other temporalities, in short, other notions of person. As we have seen, the

nomenclature "transsexual" or "transgender" can indicate something irreversible, or a point of stagnation, as an identity or as a diagnosis. That is, gender transitions are multiple and not universal, but become intelligible from a specific grammar and historical context, mediated by senses and meanings that are linked to an experience. Chimbalanga does not articulate an experience of gender identity or transsexuality, nor is it linked to a diagnosis. On the other hand, the entire discussion of medicine and jurisdiction regarding transgenderism and medical care is linked to the senses of diagnoses and assessments that are of the order of irreversible decision-making, that is, they produce another grammar.

Other examples of research addressing body transformation and transvestism in Brazil could be considered (Benedetti, 2005; Kulick, 2008). It is common knowledge that institutional policies regarding access to healthcare have limited transsexuality to the adaptation of linear processes of medical interventions (continuous hormone therapy, followed by "sex reassignment" surgeries), which legitimized legal name changes and legal recognition as "transsexual." The organized social movement, with the historical presence of transvestites/*travestis*, was fundamental in decoupling adherence to medical interventions from gender self-determination. Research that has pointed to a "refusal of a script" in the trans trajectory (Teixeira, 2012), the way in which the transsexuality device is effective in erasing ambiguities in bodily practices and discourses, and making them linear, focusing on the denial/hatred of the body (Bento, 2009), or that demonstrates other practices of embodiment of femininity (by people not assigned female at birth) outside of biomedical knowledge, the diagnostic model and/or identity, such as the transvestites in the Venezuelan context of Marcia Ochoa's research (2014), or the research of Silvana Nascimento (2019), already mentioned.

What this research in the field of Human Sciences demonstrates is that there are always bodily productions of gender transition that remain outside the scope of diagnosis (and identity definitions), or that go through it and deal with it ambiguously, blurring conceptions, presetting separations between gender and sexuality, and pre-molded body designs. Thus, if detransition is defined as a phenomenon that seeks to detect gaps in transitions (discontinuities, interruptions in hormone use, disidentifications, discontinuation in clinical follow-up), it is not a current phenomenon, but one that is always observed on the edges, on the margins of the very categorization of the transitions made possible.

On the one hand, although rates and indices cannot indicate significant interpretations of the so-called detransition phenomenon, they are considered scientific or objective data. On the other hand, rapporteurs of the CFM *Resolution* qualified with suspicion a supposed "diagnostic expansion" of "gender dysphoria" because, according to them, they appear to be based on "highly subjective" criteria. Are the criteria used to define detransition in those studies not as subjective? Is the search for an objective criterion regarding sex/gender not a "highly subjective" decision? When Young and Quinby, at the Brady Institute in 1915, suggested a sex reassignment surgery for a 10-year-old boy after performing an exploratory laparotomy and finding an "infantile uterus, fallopian tubes, and ovaries," despite young Robert presenting secondary sexual characteristics considered masculine, is not also a highly subjective decision?[18] When the International Olympic Committee (IOC) decides that athlete Maria Patiño cannot compete in the 1988 Olympics because they find a Y chromosome in her "sex test" (Fausto-Sterling, 2001), is that not also a subjective criterion? The attempt to define the effectiveness of gender issues through rates is accompanied by a desire to purge subjectivity from diagnostic criteria. In the search for objective criteria and the measurement of effectiveness and health rates, there is a specific calculation involved, which maintains, even if not overtly, a pathological principle. According to Sofia Favero (2024, p. 13), this "[...] generates a very specific economy, whose balance would be more or less the following: whoever attends to the largest number of children and has the fewest cases of detransition could be considered to be offering a successful treatment." This type of assessment produces medical knowledge as that which has the power of rightness or wrongness of a diagnosis, and imputes to detransition a sense of error. It is under this suspicion of diagnostic error that clinics are evaluated and placed under the discourse of promoting "gender ideology".

During the CPI already mentioned in this article, the congressman from the Liberal Party, Lieutenant Coimbra, questioned the psychiatrist doctor Alexandre Saadeh from AMTIGOS, about the existence of objective criteria for the "diagnosis of gender dysphoria" in childhood:

[18] This case is analyzed by Gill-Peterson (2018) in the Brady Institute archives. According to the classical paradigm of sexual development (of gonads as the determinant of sex), female reassignment was suggested before puberty, which was considered the window to medically alter what the body seemed to indicate in its development, according to medical understanding. Quinby advised the father that Robert was a girl, but the father refused and left Baltimore, where the Brady Institute was located.

> [...] Could you cite some of these behaviors that help determine whether the child is actually confused at a certain point in their development, or if they truly have this feeling, this lack of gender awareness? Is there anything more objective than the doctor's own perception? I ask this with all due respect because perception is very individual. Subjectivity can also stem from each healthcare professional's assessment. So I'm concerned about that too, doctor (ALESP, 2023, p. 10-11).

In a study conducted by Sarah Jorgensen (2023), *Transition Regret and Detransition: Meanings and Uncertainties*, from which the CFM rapporteurs cut and paste excerpts, there is this discursive statement of distrust of subjectivity and the pursuit of objectivity as a principle of medical science: "solely relying on a subjective sense of gender identity might not be a reliable basis for medical decision-making about often irreversible interventions" (Jorgensen, 2023, p. 2176). I do not want to claim that there are no other complexities and aspects that need to be considered in clinical follow-up; what I want to draw attention to is the implicit assumption that subjectivity, for the success of the analyses, should be excluded rather than involved. However, in the statements of some of these studies, there is no objective analysis, but rather subjectivities that can be involved, and which are legitimate as analyses, and others that are not. For example, at a certain point in Sarah Jorgensen's article (2023), the author says that the term detransition was considered forbidden by "transgender advocates" due to its possible use as a way to deny medical care.

> Phrases such as "gender-identity journey" and "dynamic desires for gender-affirming medical interventions" have been proposed as alternatives. However, we should be cautious about adopting euphemisms that might mask iatrogenic harm (Jorgensen, 2023, p. 2180).

Why should iatrogenic harm indicate the objectivity of the phenomenon behind those expressions? Iatrogenic harm is an adverse, unwanted effect not resulting from medical error, but rather from a medical intervention; therefore, it defines detransition as harm. Euphemisms would be expressions that indicate the same phenomenon in a softened way. However, detransition appears in these studies as an elusive fact, accompanied by regret or not, difficult to define, and lacking further study. The qualification of what constitutes harm, and the very expression "regret," are permeated by subjective processes. Another example: commenting on studies in the United States on high rates of discontinuation of hormone therapy among adolescents, the author says that despite "not being synonym of regret", such discontinuation rate "of a therapy that is usually destined to last a lifetime is remarkable". She added: "[...]

Moreover, regret can take up to 10 years to materialize, thus these numbers probably underestimate the whole extent of regret and detransition" (Jorgensen, 2023, p. 2177).

In the paragraph's construction, it is unclear which numbers she is referring to, since the last data she cites is from the US, where the author herself states that regret or detransition cannot be inferred. The assertion that regret can take 10 years to materialize is curious because it is a suggestive phrase, not related to the data from the cited study, but to another study, as is the statement: "it is generally destined to last a lifetime." Destined by whom? And what is this data "remarkable" about? In "objective" terms, it is data indicating a discontinuation of hormone use; would inferences from this data not be subjective?

Those studies describe detransitions that are qualified as generated by "internal reasons", others by "external reasons" (prejudice and discrimination) and other definitions such as retransitions. They are placed together forming an amalgam, but often with distinct methodological frameworks and objectives: qualitative research with pre-structured questions to generate statistics, or qualitative and descriptive research based on people's experiences. The way biomedical studies define "criteria of detransitioning" to measure rates, and the methodologies employed, would be the subject of exhaustive study in light of anthropology, impossible to do for the purposes of this article. These *detransition* criteria seem to demonstrate an interesting historical link with old medical criteria of what constituted "transsexual," which defined a transition. What delimits a transition and what delimits a detransition? When transition is measured as an intrapsychic truth, its verification becomes certainty and, therefore, the exhaustion of possibilities for regret, that is, its prevention. Regret is a measure of the subject's truth. But there are other forms of trans production that employ other terms in opposition to the logic of preventing regret, as Favero pointed out (2024, p. 24).

Since detransition is commonly defined as a change in the perception of "gender identity," it can be constitutive of transition, where these perceptions can change all the time, insofar as transition is not viewed in a binary way and gender experiences take on other contours based on other designations. Detransition is not always a constitutive movement towards cisgender identity, nor is it solely indicative of leaving transgender identity; it can also (why not?) be indicative of leaving cisgender identity, since when someone transitions, a detransition from cisgender identity is also occurring, as it implies the re-signification and/or

destitution of gender signs attributed to that person. The issue is that this data is not converted into a "regret rate" that argues against cisgender identity. Could we argue that there is an uncalculated rate of cisgender regret? It is necessary to make explicit the processes of cisgender identity settlement, as Viviane Vergueiro (2016) has already indicated. In the case of intersex transgender people, the detransition from cisgender identity becomes explicit, sometimes involving the interruption of hormone use during adolescence that maintained "normal" estrogen or testosterone levels corresponding to the gender assigned at birth. In provocative terms: would transition not be the result of an initial "iatrogenic harm"—the sex/gender assignment at birth?

There seems to be a pathologization and mediatization of detransition, just as there was in the framing of "transition." In this process, detransition needs to become univocal, often of an exclusively harmful character, within the vocabulary of regret (which seems to be the analogous role that "dysphoria" played as a feeling/symptom of the classic transsexual constituted by medicine). Excluding its multiplicities, the intelligible detransition is only the unidirectional one (from "trans" to its "cis" return – just as the only intelligible transition was once the one that adopted all the signs of the "opposite sex," crossing over to a destiny). However, detransition can be understood as constitutive of the ever-open possibility of modifying gender. Body modifications and body projects undertaken by transgender people are not always adopted solely in the sense of "becoming" or "being" men or women, but rather in the sense of experimenting with the modification of their bodies in relation to socially circulating gender signs, undertaking hormonal experiments and modifying skin textures, smells, and new body geometries. In this sense, just as there are detransitions that do not lead to a return to cisgender identity, there are transitions that are not transgender, or that are partially transgender; these relate more to the productivity of the modifications than to processes of identification.[19]

[19] Paul Preciado (2018) and Jack Halberstam (2023) invest in understandings of gender transitions that engage more with processes of experimentation than with identification. I consider an excerpt from an interview with Linn da Quebrada on the Mano a Mano podcast (2022) to be the most illustrative of this: "I don't feel a feminine essence that makes me want to behave this way, that makes me feel that I am a woman. I never felt that I am a woman or that I am feminine. I wanted to live my body in a certain way, and in living it I felt so many things… that I can say are feminine, that I can say are disobedient. I can't explain it, but I feel something. I never felt, for example, the lack of breasts, but at some point, I wanted to have a surgery, I wanted to get a prosthesis. And when I got it, then I felt it. And then I felt that the relationships changed" (Linn da Quebrada, 2022, 72:27–73:01min).

Final Considerations

While I consider it important to debate the data and bring to the discussion good evidence that indicates the opposite of what the CFM *Resolution* documents claim, and also to present studies of good rates of "clinical outcomes," low "detransition rates," this is a task that has been done by fields of knowledge in health and medicine, in terms that are possible to dispute within a debate that, unfortunately, is conducted only through an epistemic framework, that of medicine. What the anthropological perspective questions is: what is gender evidence? How is it produced? How is it possible to speak of gender in terms of "regret," "clinical outcome," "evidence," and "irreversible" procedures? Biomedical studies point to analytical limitations, insofar as gender is not a strictly objective concept, but contextual, historical, social, and cultural, and produces multiple materialities, not univocal ones. Furthermore, the history of medicine has produced multiple practices regarding bodily interventions since the 19th and throughout the 20th centuries, which seem to be largely ignored in the current field of biomedical studies. As we have seen from the historiographical debate presented throughout this article, other forms of knowledge need to be considered in the political and legal decisions that dictate the rights of transgender youth, and especially the desires and analyses of children and adolescents.

If the theme of transition gained space throughout the article, is because the discourses about it and childhood and adolescence transitions are seen as correlated phenomena, since detransitions are seen as symptoms of mistaken diagnosis in childhood and adolescence, regarding the overdiagnosis described as increasing in lower ages when compared to previous historical series. Such correlation must be further studied so that we understand the meanings childhood and adolescence produced in transsexuality in the medical-psy's (psychology, psycho-analysis and psychiatry) discourses, and about the meanings transsexuality produced in childhood and adolescence. For example, in the CPI psychiatric discourse we saw that in trans childhood, one has to monitor "whether it is persistent, consistent and intense", while other meanings such as "playful or experiential movements" which are commonly integrated to children's world, must be ruled out, according to the medical report model.

I conclude this article with some questions about the meaning that "irreversible" has gained. Is there anything irreversible in terms of gender? If we adopt the language of

irreversibility, would we not be assuming that certain bodily conformations (whether technically mediated, such as surgeries, or so-called natural) would ensure an immutable stability in someone's gender? However, is assuming this not affirming the assumption of the immutability of sex-gender (being born with a penis makes one irreversibly male and a vagina makes one irreversibly female) that has sustained and continues to sustain the alleged non-existence or disorder of transgender people?

I do not want to say that changes are not material, that is, that there is no materiality in the changes and that everything is a matter of perspective or culture. On the contrary, the idea is to bet on multiple forms of material production of the body that are not tied to the grammar of irreversibility, but, for example, to the idea of making a body-archive, and a grammar of the body inspired by Lego architecture, as adopted by Halberstam (2023, p. 174). Lego is game of pieces to assemble that children play by improvising combinations of pieces not necessarily predicted in the instructions. In the film that inspired Halberstam, *Uma Aventura Lego* [A Lego Adventure], the characters need to find an amulet that prevents Lord Business from gluing the Lego pieces together in the shape he wants. This amulet is a simple glue cap that prevents the Lego pieces from permanently fixing into shapes imposed by Lord Business. The Lego pieces are not irreversibly placed in the same combinations; they are open to improvisation, which Lord Business sees as disorder. Similarly, the bodily designs that transgender people produce are like that: men with breasts and vaginas, with breasts and pubic hair, or mastectomized; women with penises, women without breasts, women with chest hair, neither men nor women with breasts, or without breasts, with silicone and neovagina, or vagina... an infinite series of bodily combinations where each materiality is *reversible* in its sign according to a bodily design, and where all these materialities, whether a vagina or neovagina, a straight techno-thorax from a mastectomy, or a straight bio-thorax, can indicate femininity, masculinity, both, more than two, or neither.

I conclude with na example by Voraz, a 17-year-old trans girl who uses the Y service and elaborated a graphic project aiming to indicate, capture and visualize different perception of body and hormone effects from different colors and several drawings of parts of the body. The use of different marks in alternatives with distinct colors indicated in the graph the ideal hormone for a certain person. She concluded that a person marking certain combination of colors on one side of the graph would indicate: "[...] the ideal is to use both hormones

[testosterone and estradiol], however, in smaller doses" (graphical register by Voraz visualized in the field). These types of bodily speculations, which may be illogical from a clinical point of view and cannot be translated into rates, blur preconceived plans for transitions and detransitions.

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