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"Providers had no idea what to do with me": A mixed-methods analysis of detransition/retransition support, care, and information needs among sexual and gender minority individuals

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ABSTRACT

Background: Detransition refers to stopping, shifting, or reversal of an initial gender transition. Some people detransition temporarily, and later re-start a transition process, or retransition. Despite calls for research and care surrounding detransition/retransition, these experiences remain poorly understood by care providers and LGBTQ2S+ community-serving organizations.

Methods: Between December 2023-April 2024, a cross-sectional survey was administered to 957 individuals (aged 16 and older) living in the US or Canada who self-identified with experiences of detransition. Participants were recruited *via* advertisements across eight major social media platforms, direct emails sent to ~1200 former research participants, and to >615 LGBTQ2S+ organizations and gender-affirming care providers. Mixed qualitative and quantitative data were collected and analyzed regarding participants' experiences and care needs during detransition and, if relevant, retransition. Data about care experiences and needs were analyzed descriptively using frequencies and percentages. Interpretive description was utilized to analyze qualitative responses.

Results: Participants reported a wide range of current gender identities/expressions such as: woman ($n=386$; 40.3%); gender nonconforming woman ($n=241$; 25.2%); nonbinary ($n=238$; 24.9%); and/or detrans woman; ($n=152$; 22.5%). A majority of the sample were sexual minorities. A majority reported being bisexual ($n=429$; 44.8%), queer ($n=277$; 28.9%), and/or lesbian ($n=254$; 26.5%). Qualitative analysis identified three key themes: (1) *accessing detransition-related care needs within the gender-affirming care system*; (2) *detransition-related social/legal needs to navigate a second transition*; and (3) *detransition preventative and retransition needs*. Each of these themes encompassed four subthemes, including *access to detrans-knowledgeable care providers* ($n=162$; 28.8%); *medical information* ($n=62$; 11.0%); *mental healthcare and supports* ($n=92$; 16.3%); *interpersonal supports* ($n=124$; 22.0%); and *community supports* ($n=163$; 29.0%).

Conclusion: Greater understanding and community-led care relating to detransition/retransition from an LGBTQ2S+-affirming lens can help to mitigate minority stressors and distress associated with these experiences.

KEYWORDS
Detransition; gender-affirming healthcare; LGBTQ+; minority stress; retransition

Introduction

There is growing consensus among gender care providers and researchers on the need to develop better understanding and formal care relating to gender detransition (Ashley et al., 2025; De Vries & Hannema, 2023; Irwig, 2022; MacKinnon et al., 2023a).[1] The phenomenon of detransition has occupied significant space in socio-political and scientific discourse, particularly with regards to gender-affirming healthcare policy debates in

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numerous high-income countries including the United States (US), the United Kingdom, and Canada (MacKinnon et al., 2023a). This is particularly the case in the US, where the National Institutes of Health (NIH) has de-funded research focused on the health and care of lesbian, gay, bisexual, transgender, queer, and two-spirit (LGBTQ2S+; sexual and gender minorities [SGM]) people (Kinitz et al., 2025). Notably, it has also been suggested that the NIH will prioritize research into detransition and decisional regret with regards to gender transition (Kozlov, 2025). Detransition has thus emerged as an important topic in public policy and gender-affirming healthcare provision. The World Professional Association of Transgender Health (WPATH) Standards of Care 8 (Coleman et al., 2022) has also identified a need for further research to inform detransition-related care.

Detransition does not currently have a consistent, mutually agreed upon academic definition (Walls et al., 2025). However, it has been conceptualized as stopping, shifting, or reversing aspects of an initial gender transition, often motivated by a shift in how one understands their sex/gender (Ashley et al., 2024; Hildebrand-Chupp, 2020; MacKinnon et al., 2023b; Vandenbussche, 2022). This process can prompt social, legal, or medical changes, including altering gender expression/presentation, changing name and/or pronouns, discontinuing transition related hormonal therapy, or seeking to reverse the effects of prior hormonal/surgical interventions. Some people who detransition may self-label as "detrans" for short. Due to methodological inconsistencies across studies, estimates for the prevalence for detransition can range from <1% to as high as 30% (Feigerlova, 2025; Yaish et al., 2025). Some individuals who detransition may elect to later reengage with gender transition, resuming gender-affirming medical treatments, which can be referred to as "retransition." While retransition prevalence is unknown, retransitioning may be especially relevant to those who experienced an involuntary, forced detransition due to external pressures, discrimination, or loss of access to treatment (Walls et al., 2025).

Irrespective of their current gender identity, those undergoing a detransition often retain "atypical" sex characteristics from prior hormonal and surgical treatments, leading to vulnerability to gender minority stressors and, potentially, an experience of "reverse dysphoria" (Lomax & Butler, 2025; MacKinnon et al., 2022a; Pullen Sansfaçon et al., 2023). Reverse dysphoria refers to distress with physical changes caused by hormonal or surgical interventions from the initial transition, creating distress with gendered social experiences. Detransition is experienced largely by LGBTQ2S+ people, and many people who detransition identify across a broad spectrum of sexual and gender diverse identities, including nonbinary, lesbian, gay, bisexual, queer, butch, fluid, and gender nonconforming (MacKinnon et al., 2022a; Maragos et al., 2024; Pullen Sansfaçon et al., 2023). Hence, some scholars situate detransition experiences outside the cisgender/transgender binary (Hildebrand-Chupp, 2020; MacKinnon et al., 2022a; Sanders et al., 2023). We understand detransition as an *emerging sexual and gender minority experience*, derived from (and intersecting with) experiences of transition, being gender nonconforming, and having an LGBTQ2S + identity. Detransition, though, can carry some unique minority experiences apart from those who are TGD without an experience of detransition (MacKinnon et al., 2022a).

There are currently no formal healthcare guidelines or care provider education frameworks dedicated to addressing existing gaps. Consequently, the needs of detrans people, and those who may be seeking to retransition, remain poorly understood by practitioners, despite a wide range of medical and psychological needs (Expósito-Campos et al., 2024; MacKinnon et al., 2022b; Turban et al., 2021; Vandenbussche, 2022; Walls et al., 2025). Given sparse empirical research on the healthcare experiences and care needs of people with experiences of detransition and retransition, this paper aims to address gaps in care provider knowledge with a mixed-methods, bi-national study conducted in Canada and the US.

Detransition as heterogeneous phenomena

Emerging research indicates that detransition experiences are highly heterogeneous, with numerous potential pathways (Expósito-Campos et al., 2023;

MacKinnon et al., 2023b; Pullen Sansfaçon et al., 2023). For some, detransition can be an involuntary suppression of their transgender and gender diverse (TGD) identity, influenced by external factors such as discrimination, lack of social support, financial insecurity, or lack of access to affirming medical care (Littman, 2021; MacKinnon et al., 2024; Turban et al., 2021; Vandenbussche, 2022; Yaish et al., 2025). This pathway is sometimes termed an "interrupted gender transition" (Walls et al., 2025), where an individual may retransition at a later point in their life when circumstances are safer and more affirming (Expósito-Campos et al., 2023; Turban et al., 2021; Walls et al., 2025). Individuals who detransition temporarily may seek access to gender-affirming healthcare (retransition services) at a later date, requiring a flexible, detrans-inclusive and individualized approach to care. For others, detransition is motivated by internal factors, such as shifts in identity or a realization in hindsight that gender dysphoria was connected to other social or mental health-related factors, such as trauma or internalized homophobia (Maragos et al., 2025; Vandenbussche, 2022). Detransition can also be motivated by the complex interplay of multiple factors, with external and internal influences not being necessarily mutually exclusive.

Although diverse in their experiences, recent research utilizing a wide range of methodologies indicates that detransitioning people are predominantly young adults, with those assigned female at birth (AFAB) comprising between 64 and 100% of community and clinical samples (Boyd et al., 2022; Cavve et al., 2024; Littman, 2021; Lomax & Butler, 2025; MacKinnon et al., 2022a, 2023a, 2025; Nyquist et al., 2025; Pullen Sansfaçon et al., 2023; Vandenbussche, 2022). For a conceptual and methodological critique of the extant literature, see MacKinnon et al. (2023a).

Detransition/retransition, minority stress, and care needs

Minority stress theory posits that the unique stressors faced by marginalized groups, rooted in structural prejudice, lead to health disparities (Frost & Meyer, 2023; Hendricks & Testa, 2012). In clinical settings, anticipated discrimination or an expected lack of practitioner knowledge can lead SGM patients to avoid or delay treatment, or to not disclose their identities, preventing their needs from being met (Ayhan et al., 2020; Hobster & McLuskey, 2020; Jaffee et al., 2016; James et al., 2016; Kcomt et al., 2020; Liu et al., 2024; McNeill et al., 2023; Poteat et al., 2013). It is also worth highlighting that other intersecting aspects of identity, including neurodiversity, disability, race, geography, and socioeconomic status, can create compounding minority stressors for LGBTQ2S+people who transition, detransition, and/or retransition (Adams et al., 2025; Cyrus, 2017).

Despite some understandings of detransition positioning the process as a return to cisgender, heterosexual identification (Holloway & Walls, 2025; Sanders et al., 2023), literature suggests a high prevalence of SGM identification among samples of detransitioned people (Kettula et al., 2025; Littman, 2021; Lomax & Butler, 2025; MacKinnon et al., 2022a, 2024; Pullen Sansfaçon et al., 2023). The healthcare needs of detrans people, therefore, likely reflect broader LGBTQ2S+communities such that they may also struggle with clinical discrimination (both anticipated and actualized), avoidant or identity/regret concealing behavior, including selective disclosure even if they do see a provider, and health disparities due to SGM-specific minority stressors. Like other SGM groups, detransitioned patients can become disengaged from care providers due to anticipated stigma or ongoing barriers to access (Gelly et al., 2025; Littman, 2021; MacKinnon et al., 2022b; Vandenbussche, 2022). This contributes to a lack of clinical knowledge, as practitioners likely have limited first-hand exposure to these experiences (MacKinnon et al., 2022b; Pullen Sansfaçon et al., 2024a). Healthcare avoidance is also significant from an academic perspective, as clinical research often relies on detrans people self-reporting these experiences to clinicians (e.g. Hall et al., 2021; Narayan et al., 2021; Wiepjes et al., 2018). Distrust may be further exacerbated among detransitioning people who feel they were either insufficiently supported, informed, or provided opportunities to explore their treatment options during their initial gender transition (Ashley et al., 2025; Gelly et al., 2025; Haarer, 2022; MacKinnon et al., 2023b; Maragos et al., 2025; Pullen Sansfaçon et al., 2023; Sanders

et al., 2023). Other detransitioning people report a lack of information about stopping or altering transition-related hormonal therapy, with some ending treatment "cold turkey" or without the support of a provider (e.g. MacKinnon et al., 2022b; Vandenbussche, 2022). Limited access to detransition-related procedures, such as reconstructive surgeries, has also been identified (Gelly et al., 2025; Vandenbussche, 2022).

Concurrently, detrans people can experience alienation from previous support systems, notably SGM networks, due to stigma (Gelly et al., 2025; MacKinnon et al., 2022a; Vandenbussche, 2021). Isolation may additionally be reinforced by limited opportunities to connect with other detrans people in offline spaces, or by insufficient representation (Sanders et al., 2023; Vandenbussche, 2022). Building on the gender minority stress model, MacKinnon et al. (2022a) proposed *detransphobia* to encompass the multifaceted detransition-related stressors and ideologies (e.g. transnormativity) that negatively affect individuals who detransition. According to the *detransphobia* model, individuals who shift their gender *after* an initial transition may encounter social rejection and barriers to accessing support within SGM communities due to misrecognition, gender identity fluidity, and detransition-related stigma (MacKinnon et al., 2022a).

Furthermore, some experiences of detransition do not result from a genuine internal desire to detransition, but rather from external pressures. In these cases, retransition may follow if these pressures disappear or the social context changes. Importantly, detransition due to external factors followed by retransition seems to be more frequent among transfeminine TGD people (MacKinnon et al., 2023b; Turban et al., 2021), which may be due to higher levels of social stigma and minority stress and transmisogyny (Miller & Grollman, 2015). However, there is still a paucity of information about the experiences of people who detransition and later retransition (or wish to retransition).

The present study

As part of a broader investigation into detransition, the current study sought further insight into care needs. The Detransition Analysis, Representation and Exploration (DARE) study was a bi-national (US and Canada), SGM community-led study consisting of a cross-sectional online survey followed by a series of 42 semi-structured interviews with selected participants. York University's research ethics board approved the study, and all participants provided written informed consent to partake. This paper presents a concurrent mixed-methods analysis from survey items on participants' experiences seeking care after detransition, as well as their care needs and recommendations for improving care relating to detransition or retransition pathways.

Methods

Participants

The study aimed to explore heterogeneous experiences of people who self-identified with experiences of detransition/retransition. The term "detransition" was utilized on study flyers, the study website, the consent form, and in the survey along with alternative, related terms such as "retransition." The use of a broad conceptualization of detransition and retransition in the study was informed by previous research demonstrating the complexity of these experiences (Littman, 2021; MacKinnon et al., 2022a; Pullen Sansfaçon et al., 2023), as well as the lack of a consistent definition in the literature. This allowed us to capture a wide range of experiences reported among people who report detransition-related experiences. Following Vandenbussche (2022), individuals who were contemplating detransition but felt unable to take any steps were also invited to participate in the study.

To be eligible for the survey, participants provided written informed consent and confirmed that they: (1) were 16 years of age or older; (2) had ever stopped, shifted, or reversed an initial gender transition (or desired detransitioning but felt unable to take steps); (3) currently residing in the US or Canada; and (4) were able to complete the survey in English, French, or Spanish. A more detailed explanation of the study's sampling methodology, survey design, and bot/fraud/scam screening protocol has been published (MacKinnon et al., 2025).

Procedure

We developed three different recruitment flyers in English, French, and Spanish to ensure a large, socio-demographically diverse sample. Each flyer and its promotion were designed to appeal to individuals with different pathways to detransition, including a change in self-conceptualized gender identity or external stressors. Our strategy for promoting the survey was threefold. First, we used paid and unpaid online advertisements on eight major social media platforms (Facebook, Instagram, Reddit, Twitter/X, TikTok, Discord, Tumblr, and YouTube) that informed participants of the survey, and opportunity to enter a raffle to win a $50.00 gift card. Second, we distributed the survey through direct emails to over 615 TGD and LGBTQ2S+ organizations, gender service providers, and over 1,200 former SGM research participants in the US and Canada. Finally, we posted physical study flyers at various LGBTQ2S+-serving organizations, gender clinics, and universities.

Participants completed a cross-sectional online survey that included questions about their socio-demographic characteristics, current and lifetime gender identities/expressions, sexual orientation identities, history of and perspectives on gender transition and detransition, history of psychosocial stressors and mental health, support received during transition and detransition, and recommendations for transition and detransition-related care, among other areas of interest. The survey collected IP/geolocation to confirm participants' geographic eligibility. Given the significant issue of scam/malicious/automated responses in online sampling, particularly with regards to detransition research, our study employed rigorous participant screening protocols (See MacKinnon et al., 2025; Bowen et al., 2008; Caven et al., 2025; Pullen Sansfaçon et al., 2024b). After exclusions, 69% of completed surveys were deemed eligible and included in the final analytic sample.

For this analysis, we explored participants' perceptions, experiences, and needs related to care and support during the process of detransitioning and, if relevant, retransition (seeking access to gender-affirming healthcare after an interrupted gender transition). Using a Likert-type scale with three response options (*always*, *sometimes*, *never, not applicable*), participants ranked their degree of agreement with a series of statements. These included, "Please indicate if you have experienced the following events **after detransitioning,** or **stopping/reversing your initial transition,** and **how often** you have experienced them…": (1) "I needed healthcare but didn't receive it;" (2) "I avoided healthcare providers when I needed care;" (3) "My healthcare provider seemed knowledgeable about detransition;" and (4) "My healthcare provider seemed comfortable discussing detransition." One of the last items on the survey was an open-ended, write-in response, asking participants: "Were there any supports you wish you could have had during your detransition? Please list them in point form." Responses to this question were used for qualitative analysis.

Data analysis

Participants' responses to the quantitative survey items were analyzed descriptively using frequencies and percentages. For qualitative analysis of the 563 write-in, qualitative responses, we used interpretive description, developed by Thorne and colleagues (1997, 2004). Interpretive description focuses on developing practical knowledge that can be useful in real-world settings and is particularly appropriate for understudied human experiences (Thorne, 2016), such as detransition and retransition. Given the lack of formal resources for people experiencing detransition and retransition, we were interested in examining patterns and relationships of meaning that could lead to valuable insights for developing services and reforming current practices. In essence, interpretive description emphasizes knowledge mobilization to foster relevant and actionable knowledge (Thorne, 2016). Informed by interpretive description, we conducted an inductive applied thematic analysis following Guest et al. (2012). This is a rigorous and systematic approach to qualitative data analysis that integrates techniques from different methodologies into a single framework and is particularly suited to large datasets and team-based research. One distinctive aspect of this approach is the quantification of qualitative data by calculating theme frequencies, which increases transparency and rigor.

To this end, all participants' written responses to the open-ended survey question were first reviewed by a member of the research team, after which a coding framework was developed. The coding framework was then discussed with the rest of the research team. Seven members of the author team then reviewed and coded all participant responses (KR, PEC, DJK, WAG, MR, SR, KRMK)). A large majority of coders are gender diverse and/or LGBTQ2S+ and a minority have experience of detransition/retransition. A senior member of the research team reviewed the coding and facilitated the discussion to resolve disagreements. We also recorded the number of participants who referenced each theme to provide a descriptive indication of its relative prominence across the dataset.

Results

Of the 1,377 completed survey responses, 957 participant responses were included in the final sample after applying the bot/scam/nonsense protocol (see MacKinnon et al., 2025). There was a wide range of minoritized gender identities/expressions and sexual orientations among participants, particularly gender nonconforming (36.7%), detrans woman (22.5%), genderqueer (13%), bisexual (44.8%), queer (28.9%), and lesbian (26.5%), with an average of 4.2 gender identities/expression labels reported across the lifespan (Table 1). When asked about language used to describe themselves after detransitioning, 40.5% of participants were comfortable with describing themselves as being "detransitioned," 43.2% "transgender," 33.2% "nonbinary," and 19.6% "cisgender." However, between 10.8%-18% were "unsure" about these identity labels. These categories were not mutually exclusive, and participants could select multiple options. Regarding retransition experiences, 42% reported a history of discontinuing and later resuming transition. Tables 1 and 2 present complete sociodemographic data of the study sample. Table 3 presents participants' responses to the survey items about care seeking and receiving experiences.

Following analysis of the 563 open-ended responses, three key themes were identified: (1) *Accessing detransition-related care needs within the gender-affirming care system*; (2) *Detransition-related social/legal needs to navigate a second transition*; and (3) *Detransition preventative and retransition needs*. Each of these themes encompassed four subthemes (Table 4). Among the study participants, the most prevalent subthemes were: *Access to detrans-knowledgeable care providers* ($n = 162$; 28.8%), *Medical information* ($n = 62$; 11.0%), *Mental healthcare and supports* ($n = 92$; 16.3%), *Interpersonal supports* ($n = 124$; 22.0%), and *Community supports* ($n = 163$; 29%). Below, we explain the themes and subthemes and provide illustrative participant quotes (Table 5).

Accessing detransition-related care needs within the gender-affirming care system

Many participants mentioned or discussed challenges accessing adequate medical care within the mainstream gender-affirming healthcare system. Insufficient or difficult *access to detrans-knowledgeable care providers* and *medical information* were frequently highlighted, alongside a desire for *detransition procedures*. Some participants explicitly mentioned types of *mental healthcare and supports* that they would have liked to have access to during detransition.

Access to detrans-knowledgeable care providers

Participants overwhelmingly expressed a need for greater *access to detrans-knowledgeable care providers* relating to detransition. Specifically, there was a need for both mental and physical health practitioners who are knowledgeable and non-judgmental. Many participants reported direct experience with practitioners who provided insufficient care. For instance, one participant noted: "Providers had no idea what to do with me, although I managed to get screenings done in spite of their lack of knowledge" (P778). Another similarly reported: "Endocrinologists and surgeons […] kicked me back to these trauma filled medical spaces becuse [sic] they viewed me as trans and needing trans care. It was very hard to find healthcare" (P001). This suggests that they had encounters with providers who perhaps lacked experience with supporting someone through detransition.

Medical information

Participants' desire for accessible, knowledgeable practitioners intersected with a need for robust *medical information* on detransition. Participants

Table 1. Socio-demographic characteristics of the sample ($N = 957$).

	Total n	%
Age		
16-17	73	7.63%
18-24	416	43.47%
25-29	241	25.18%
30-39	178	18.60%
40-49	31	3.24%
50+	18	1.88%
Country		
United States	704	73.56%
Canada	253	26.44%
Sex assigned at birth		
Female	754	78.79%
Male	199	20.79%
No response	4	0.42%
Race/Ethnicity*		
White	823	86.00%
Mixed race	221	23.09%
Jewish	98	10.24%
Indigenous	76	7.94%
Latin American	70	7.31%
Black	50	5.22%
East Asian	36	3.76%
Middle Eastern	26	2.72%
Southeast Asian	14	1.46%
Other	6	0.63%
South Asian	4	0.42%
Mixed race combinations		
White + Non-Black	175	18.29%
Other combination	20	2.09%
White + Black	19	1.99%
Black + Non-White	7	0.73%
Education		
Some high school, no diploma or GED	95	9.93%
GED	23	2.40%
Some CÉGEP, no diploma	3	0.31%
CÉGEP graduate	4	0.42%
High school graduate	129	13.48%
Some college or trade school, no degree	152	15.88%
College or trade school graduate	74	7.73%
Some university, no degree	126	13.17%
Bachelor's degree	183	19.12%
Some graduate work, no degree	29	3.03%
Master's degree (e.g. MA, MS, MBA)	68	7.11%
Some doctoral or professional work, no degree	11	1.15%
Doctoral or professional degree (e.g. PhD, MD, JD)	20	2.09%
No response	42	4.39%
Household income		
Unsure	139	14.52%
Less than $10,000	59	6.17%
$10,000 to less than $15,000	48	5.02%
$15,000 to less than $20,000	56	5.85%
$20,000 to less than $30,000	67	7.00%
$30,000 to less than $40,000	71	7.42%
$40,000 to less than $50,000	65	6.79%
$50,000 to less than $60,000	56	5.85%
$60,000 to less than $80,000	89	9.30%
$80,000 to less than $100,000	67	7.00%
$100,000 to less than $150,000	97	10.14%
$150,000 or more	101	10.55%
No response	42	4.39%
Diagnosed intersex condition		
Yes	34	3.55%
No	844	88.19%
Unsure	64	6.69%
No response	15	1.57%
Gender identity/Expression*		
Woman	386	40.33%
Gender nonconforming woman	241	25.18%
Nonbinary	238	24.87%
Detrans woman	215	22.47%
Man	152	15.88%
Genderqueer	124	12.96%
Gender nonconforming man	110	11.49%

(*Continued*)

Table 1. Continued.

	Total n	%
Genderfluid	100	10.45%
Trans woman	84	8.78%
Agender	66	6.90%
Detrans man	46	4.81%
Two-spirit	23	2.40%
Trans man	17	1.78%
Sexual orientation identity*		
Bisexual	429	44.83%
Queer	277	28.94%
Lesbian/homosexual	254	26.54%
Pansexual	114	11.91%
Straight or heterosexual	108	11.29%
Asexual	101	10.55%
Gay/homosexual	94	9.82%
Not sure or questioning	73	7.63%
Two-Spirit	8	0.84%

*Indicates that participants could select more than one option.

Table 2. Distribution of cisgender, nonbinary, transgender, and detransitioned identities at the time of survey.

	Yes		No		Unsure		Did not respond	
Do you consider yourself…	n =	%	n =	%	n =	%	n =	%
Detransitioned	388	40.54	384	40.13	172	17.97	13	1.36
Transgender	413	43.16	403	42.11	128	13.38	14	1.46
Nonbinary	318	33.23	522	54.55	103	10.76	14	1.46
Cisgender	188	19.64	631	65.94	125	13.06	13	1.36

Note. Participants could select "Yes" for multiple categories.

Table 3. Participants' responses to questions relating to healthcare experiences."Please indicate if you have experienced the following events after detransitioning, or stopping/reversing your initial transition and how often you have experienced them…"

Item and response options		N (%)
I needed healthcare but didn't receive it	Always	122 (12.75%)
	Sometimes	318 (33.23%)
	Never	381 (39.81%)
	N/A	118 (12.33%)
I avoided healthcare providers when I needed care	Always	121 (13.06%)
	Sometimes	429 (44.83%)
	Never	313 (32.71%)
	N/A	74 (7.73%)
My healthcare provider seemed knowledgeable about detransition	Always	68 (7.11%)
	Sometimes	119 (12.43%)
	Never	410 (42.84%)
	N/A	342 (35.74%)
My healthcare provider seemed comfortable discussing detransition	Always	124 (12.96%)
	Sometimes	156 (16.30%)
	Never	289 (30.20%)
	N/A	369 (38.56%)

frequently mentioned a need for general information about detransition, including what to expect from the process and the potential medical consequences of detransitioning. For example, one participant noted wanting to access "accurate, easy to find information and statistics on detransition" (P522), while others recommended "medical/academic research regarding detransition that my providers could access" (P465).

Table 4. Qualitative themes.

Themes		Frequency (*N* = 563)
Detransition-related care needs within the gender-affirming care system	Access to detrans-knowledgeable care providers	162 (28.77%)
	Medical information	62 (11.01%)
	Detransition procedures	31 (5.51%)
	Mental healthcare and supports	92 (16.34%)
Detransition-related social/legal needs to navigate a second transition	Interpersonal supports	124 (22.02%)
	Community supports	163 (28.95%)
	Financial needs to cover detransition	25 (4.44%)
	Legal needs	15 (2.66%)
Detransition preventative and retransition needs	Access to gender-affirming healthcare	40 (7.10%)
	Financial needs related to retransition	32 (5.68%)
	Mental health supports	25 (4.44%)
	Social supports	53 (9.41%)

Endocrinological needs with regards to discontinuing hormonal therapy appeared frequently within this subtheme, with 46 responses specifically referring to hormonal care. Participants expressed a lack of access to detrans-knowledgeable endocrinologists and specialist services that could address physical health needs, as well as insufficient support, follow-up care, or information when discontinuing hormonal therapy. For example, one participant mentioned a need for a "knowledgeable doctor for going off testosterone" (P072). Therefore, while a general desire for thorough clinical data on all aspects of the detransition process was present, more information on the long-term effects of hormonal therapy and how to safely end or restart treatment after a period of discontinuation was particularly notable. For instance, one participant explicitly mentioned a need for a "protocol for safely stopping hormones without the ill health

Table 5. Illustrative quotes for themes and subthemes.

Theme	Subtheme	Illustrative quotes
1. Detransition-related care needs within the gender-affirming care system	Access to detrans-knowledgeable care providers	I wish there was a space I could have gone to, a doctor that would have talked to me about my detransition. […] I wish my current doctor was more knowledgeable and willing to discuss my detransition. (P411)
		Medical providers who are educated on detransition (I had no confidence in my providers when I stopped transitioning) (P015)
		I wish there were medical professionals who could help support people with their detransition instead of just ending up on your own. (P900)
	Medical information	Accurate easy to find information and statistics on detransition (P522)
		Any information at all about what to expect going off hormones (P219)
		More information about expected changes when I first started detransitioning (P963)
	Detransition procedures	Voice training by and for detrans cis women (P550)
		Health insurance coverage of electrolysis/ laser hair removal (P135)
		More support in my search for a surgeon for breast reconstruction (I was turned down by 4 surgeons and ghosted by the one who did the mastectomy) (P686)
	Mental healthcare and supports	Therapists who are trained to deal with the complex trauma detransitioners experience without shaming us for no longer trusting the trans medical establishment (P437)
		Therapy specializing in detransition and body image (P390)
		specifically lgbt aware therapy that's willing to say it's detrans-friendly (because I was still ""queer"" for lack of a better term, but worried I was no longer welcome due to my personal feelings and/or the general association [of detransition] with anti-lgbt rhetoric) (P042)
2. Detransition-related social/legal needs to navigate a second transition	Interpersonal supports	My friends. I feel so alienated now, and super isolated from the rest of the queer community. (P779)
		social support from family (I received negative feedback, hostility, and stigma from family members, ranging from shouting to relative estrangement) (P620)
		Any. I lost every adult and friend in my life when I chose to detransition […] I lost everything I had socially. (P682)
	Community supports	Community resources to speak with other detrans people in person (P397)
		Detransition support groups locally and online (P081)
		More understanding from my LGBTQIA+ community. (P623)
	Financial needs to cover detransition	Financial support for covering the cost of reconstructive and reversal surgeries (P963)
		Insurance coverage for detransition needs such as hair removal and breast reconstruction (P663)
		financial and logistical support in changing my documents back (P085)
	Legal needs	Legal aid (reversing gender marker, name, etc.) (P100)
		Legal resources to easily revert documents to original. (P397)
		financial and logistical support in changing my documents back […] petitioning for a malpractice suit (P085)
3. Detransition preventative and retransition needs	Access to gender-affirming healthcare	More regular visits with my doctor so that I wouldn't have medically detransitioned against my will (P136)
		Access to better transition care so that I wouldn't have detransitioned (P018)
		If the support of adequate transition related medical care had existed, I wouldn't have had to temporarily stop my transition. (P258)
	Financial needs related to retransition	No, I did not want to detransition, I had to because I temporarily ran out of money (P183)
		Universal healthcare. I didn't want to detransition, but access to care/cost of care forced the issue. (P140)
		I would have loved to be able to simply afford to continue my transition (P428)
	Mental health supports	Access to therapy. I would not have detransitioned if I'd had any support whatsoever (P181)
		I wish I had gotten help for my substance use. I believe that if I was sober and in recovery during that period of time I would not have detransitioned and had as difficult of a time as I did. (P293)
		Better mental health support and income support as being off hrt was difficult and made it hard to work (P846)
	Social supports	Support from my family (I detransitioned because I did not want to be disowned by them) (P138)
		[…] (I) had to stay with family & detransition temporarily to be safe around them (P852)
		The climate of fear arounds trans people is the only reason I am not going forward with my transition. (P324)

effects I believe I experienced due to going 'cold turkey'" (P465). It is worth noting that two participants who reported that there were relevant resources available to them considered these inappropriate or lacking applicability for detrans patients: "[research is] there but it's buried in cisnormative language about post-menopausal women" (P520); "I was handed an informed consent sheet for MTF HRT [male-to-female hormone replacement therapy] and told to ignore the bits about male genitalia and finasteride [and] *spiro*[nolactone]" (P918).

Detransition procedures

Some participants noted a need for specific *detransition procedures*, such as breast reconstruction or reduction surgeries, vocal training to address the vocal deepening from testosterone therapy, and hair removal or restoration: "More support in my search for a surgeon for breast reconstruction (I was turned down by 4 surgeons and ghosted by the one who did the mastectomy)" (P686); "Voice training by and for detrans cis women" (P550).

Mental healthcare and supports

Regarding *specific care provision*, consistent with the broader need for accessible practitioners, many participants expressed a desire for professional mental health support. Some were explicit about the type of care they would have liked to receive during detransition, mentioning practices such as counseling, psychotherapy, or grief or trauma-oriented support: "Grief counseling for losing a life I thought was gonna make me happy" (P700); "Therapy specializing in detransition and body image" (P390).

A need for communal spaces, particularly LGBTQ2S+-serving "support groups/group therapy for detransitioners" (P004) was also expressed by some participants, who wanted (among others) "More private support groups (the ones online feel too public and easily viewable by non-detrans or non-trans people)" (P100). Others specified an additional need for LGBTQ2S+/TGD-friendly therapists ("therapy from a therapist who is not transphobic" (P686), while others desired practitioners who do not immediately affirm a TGD identity ("I mentioned how I struggle with being a GNC [gender nonconforming] woman and she goes, 'why don't you just ID [identify] as nonbinary then?'" (P028). Some participants also expressed a wish for providers who are aware of and sympathetic to detransition experiences. For instance, one mentioned wanting access to "specifically LGBT aware therapy that's willing to say it's detrans-friendly (because I was still 'queer' for lack of a better term, but worried I was no longer welcome due to my personal feelings and/or the general association [of detransition] with anti-LGBT rhetoric)" (P042). A minority of participants discussed the need, based on prior negative experience within the gender-affirming care system, for non-judgmental therapists who would not shame or guilt patients for their feelings on detransition: "therapists who are trained to deal with the complex trauma detransitioners experience without shaming us for no longer trusting the trans medical establishment" (P437).

Detransition-related social/legal needs to navigate a second gender transition

Within this theme, participants referred explicitly to different sources of support they wished they had had during their detransition process to support them through a second gender transition. These included: *interpersonal supports*, *financial needs to cover detransition*, *LGBTQ2S+ community supports*, and *legal needs*.

Interpersonal supports

Within *interpersonal supports*, participants discussed the broad need for greater understanding of their experience of detransitioning from family members and friends. Some participants mentioned losing the support of their families in response to detransition ("I received negative feedback, hostility, and stigma from family members, ranging from shouting to relative estrangement" [P620]), while others mentioned losing all sources of support ("I lost every adult and friend in my life when I chose to detransition" [P682]).

References to loneliness, rejection, and isolation from previous LGBTQ2S+ connections were notable in many of the participants' accounts. For instance, one participant expressed: "I feel so alienated now, and super isolated from the rest of the queer community" (P779). Similar sentiments were echoed by respondents who wished for more *community supports* and discussed the loss of former social networks, wishing they had not been "shamed and excluded by LGBT people I used to be friends with" (P064). Others expressed not feeling able to talk about their experiences in LGBTQ2S+ spaces due to detrans-specific stigma.

By extension, there was a desire from many participants for support and recognition from TGD communities, which were primarily experienced as hostile to detrans people: "Support from within the trans community (I felt somewhat abandoned, and though I still identify under the trans umbrella, I do not share my history with stopping transition because there is still stigma and judgement)" (P015). This was concurrent with concerns surrounding the stigmatization of detransition and a general lack of public awareness for the needs of detrans people: "General understanding from society, lgbt spaces, health care providers" (P269); "less social stigma toward detransitioning from all sides of the political spectrum" (P390). Some participants also expressed concerns about the ways in which detransition is co-opted or misunderstood by political actors:

> More understanding and not using us as a "talking point." Conservatives want us to speak to them to "prove" that transitioning is "evil." Liberals want to silence us for fear that we'll somehow "influence" trans people to detransition. We're in a horrible space and it's nearly more painful detransitioning for me than it was just suffering through an identity that didn't fix my problems like everyone said it would. (P639)

This quote reflects the significant impact that widespread misunderstanding of detransition experiences can have on the social and mental wellbeing of detrans people, and the interpersonal impacts of the politicization of gender-affirming healthcare on LGBTQ2S+ communities.

Community supports

The most prevalent need within the subtheme of *community supports* was connection with other detransitioned people; specifically, the need for offline interactions, detrans support groups, and private detrans-focused spaces (e.g. "Community resources to speak with other detrans people in person" (P397)). The preferred nature of these, however, varied across participants, with neutral/apolitical, pro-trans, "non-transphobic," and lesbian/female-specific all discussed as potential needed resources. Participants also reported the need for detrans resources in the form of books, videos, or magazines, as well as more varied detransition representation in the media broadly: "Detransition information pamphlets that are peer reviewed, positive, and honest" (P081); "More media representation or like experiences from others who had similar experiences portrayal of detrans people in positive lights, especially detrans people who are still GNC" (P469).

Financial needs to cover detransition

The most commonly reported *financial need* was access to health insurance to cover detransition procedures and the cost of medical complications: "Insurance coverage for detransition needs such as hair removal and breast reconstruction" (P663).

Legal needs

Regarding *legal needs*, assistance with reverting or altering documents (e.g. changing name, sex, or gender markers in legal documents) was the most prevalent need mentioned by participants (e.g. "help navigating legal aspects of detransition" (P672). Only a few participants indicated a desire for support in pursuing legal action against previous practitioners: "suing my surgeon" (P047); "legal support in […] petitioning for a malpractice suit" (P085).

Detransition preventative and retransition needs

While our main study objective was to identify needs during the detransition process, many participants expressed that they would not have detransitioned if the necessary affirming supports had been present during their initial gender transition. Among these respondents, detransition was reported as involuntary, necessary for survival, and an overall undesirable experience: "I didn't want to detransition, just felt like I didn't have a choice" (P919). Within this broader theme, four subthemes were identified: *Access to gender-affirming healthcare*, *financial needs related to retransition*, *mental health supports*, and *social supports*.

Access to gender-affirming healthcare

For many of the participants within this theme, interrupted gender transitions were related to loss of *access to gender-affirming care*. They expressed that detransition would not have occurred had they been able to receive adequate medical care: "More regular visits with my doctor so that I wouldn't have medically detransitioned against my will" (P136); "If the support of adequate transition related medical care had existed, I wouldn't have had to temporarily stop my transition" (P258).

Financial needs related to retransition

Participants also discussed *financial needs* as a significant restricting factor when attempting to access gender-affirming medical care. In this subtheme, participants mentioned issues such as cost of care or loss of financial means as the drivers of detransition "I didn't want to detransition, but access to care/cost of care forced the issue" (P140).

Mental health supports

Among some respondents, there was an additional indication that the current model of gender-affirming medical care does not adequately support those with complications or atypical transition pathways. For example, some participants wished they had had access to *mental health supports* during their transition in order to avoid detransition (e.g. "doctors willing to help me navigate my health needs during transition so I could continue" (P201).

Social supports

Most prominent, however, were *social support* needs. A lack of acceptance for TGD identities within interpersonal relationships and from society broadly were the primary reported reasons for involuntary detransition. Within this subtheme, familial rejection or pressure were particularly prevalent: "[I] had to stay with family [and] detransition temporarily to be safe around them" (P852); "I detransitioned because I did not want to be disowned by [family members]" (P138). Detransitioning was also reported by some both as a precautionary safety measure in anticipation of future discrimination (e.g. "the climate of fear arounds trans people is the only reason I am not going forward with my transition" (P324)) or as a reaction to actively dangerous or abusive environments.

Discussion

This study explored detransition and retransition-related care experiences and needs of SGM individuals living in the US or Canada. Results indicate a need to expand care for detrans and retransitioned SGM people, and they also show how the broader socio-political and interpersonal LGBTQ2S + community dynamics compound minority stressors within/outside clinical contexts. The weaponization of detransition experiences against gender-affirming healthcare and sexual and gender diversity may be particularly difficult for SGM detrans people (Gelly et al., 2025). Findings also highlight the heterogeneity of detransition and retransition care needs: Some individuals who detransition do so due to external forces and may later seek access to a gender-affirming transition process, as shown by the present study. This is consistent with Walls et al.'s (2025) interrupted gender transitions concept. This is especially relevant given increasing restrictions on access to gender-affirming healthcare in the US, which may drive some to detransition temporarily due to safety concerns. Across all participants, however, many shared recommendations to improve care and supports. This echoes prior research indicating that detransitioned people can feel that they were insufficiently supported by providers or in interpersonal relationships during initial transition within the mainstream gender-affirming healthcare system (Haarer, 2022; MacKinnon et al., 2023b; Maragos et al., 2025; Pullen Sansfaçon et al., 2023; Turban et al., 2021).

Our findings also extend prior research on the limited availability of detransition-related care (Gelly et al., 2025; Vandenbussche, 2022) and detransphobia encountered in care settings, within LGBTQ2S + communities, and broader society (MacKinnon et al., 2022a).

Detransition-related care needs within the gender-affirming care system

The mainstream gender-affirming care system largely presumes that gender identity/expression is immutable and that TGD people will engage in only one gender transition. While this may be the reality for many TGD people, this presumption can create care environments in which multiple transitions, gender fluidity, and detransitions are misunderstood or even stigmatized, as identified by past research (Holloway & Walls, 2025; MacKinnon et al., 2023b). In our study, care-avoidant behaviors during detransition appeared prevalent, with 13.1% of respondents "always" avoiding providers and 44.8% "sometimes" doing so. Some care avoidance may be explained by anticipatory or perceived stigma or feeling shame or a fear of being judged for detransitioning, as found in previous research on the healthcare experiences of detransitioning individuals (Gelly et al., 2025; MacKinnon et al., 2022b). Nondisclosure of detransition poses a detransition-specific minority stressor emerging from detransphobic

contexts, with important implications for seeking and receiving care (MacKinnon et al., 2022a). Care access disparities may be explained by insufficient provider knowledge or comfort with detrans people due to stigma and politicization. Our results suggest detransitioned people retain a strong desire to engage with practitioners and to receive support and guidance, but face challenges accessing appropriately informed providers. With a majority of participants (42.8%) reporting that their healthcare provider "never" seemed knowledgeable when discussing detransition, it is unsurprising that written responses overwhelmingly detailed a desire for healthcare providers who are familiar with or specialize in detransition.

There was, however, diversity in the desired form of healthcare support, with TGD-affirming and neutral practitioners requested. Among participants who desired non-trans-affirming care providers, some expressed that previous therapists were too eager in encouraging them toward initial transition, or to retransition after detransition, despite no expressed desire to do so. It is worth noting that, as reported elsewhere (MacKinnon et al., 2025), a significant portion of the sample (41.2%) did not currently affirm a TGD identity, while others were unsure about their current identity. Many shifted from TGD to gender nonconforming lesbian, gay, or detrans identities and, in hindsight, wished they had access to providers who took a more neutral approach to care. This is consistent with previous research findings (e.g. Gelly et al., 2025; MacKinnon et al., 2023b; Maragos et al., 2024; Sanders et al., 2023); and carries implications for gender-affirming care delivery. It is essential that providers are aware of the diverse experiences of SGM people, and that shifting between trans and lesbian or gay identities may not be uncommon, emphasizing a need for non-judgmental, neutral, and individualized care regarding transition and detransition-related services (Gelly et al., 2025;; MacKinnon et al., 2023b; Pullen Sansfaçon et al., 2023).

Consistent with prior research, findings also emphasize the need for greater endocrinological support and access to surgical reconstructive procedures (Vandenbussche., 2022). There is currently limited knowledge about the endocrine consequences of detransitioning (Charlton & Bond, 2024), and no known published reports on outcomes or satisfaction with breast reconstruction following chest masculinization.

Detransition-related social/legal needs to navigate a second gender transition

Findings underscore the impact of detransition-related stigma on access to social supports (MacKinnon et al., 2022a; Sanders et al., 2023; Vandenbussche, 2022). The loss of friends, rejection from former LGBTQ2S+social networks, and a general lack of awareness from society contributed to feelings of isolation and alienation. Care providers must be aware of the unique minority stressors detransitioning people may face outside the clinical context, and their impact on well-being. Also consistent with prior studies, we observed a prevailing need for peer support, particularly in the form of detransition-specific spaces or support groups (Sanders et al., 2023; Vandenbussche, 2022). Although grassroots detrans communities have emerged over the last decade (Monroe, 2016; R/actual_detrans, 2020; R/detrans, 2017), care providers and organizations may be unaware of their existence. In addition, some detransitioning people have expressed the limitations of these spaces in meeting their needs (Sanders et al., 2023). Findings also suggest that some detransitioned people may not wish to engage with LGBTQ2S+/TGD-oriented services, which highlights the importance of organizing detransition-specific care and services. Combined with the broader need for more accessible information related to detransition, we believe there is additional scope for care providers to collaborate with detransitioned patients/communities to produce educational resources for various audiences, including intimate relations, friends, and the wider public to combat stigma.

Despite numerous high-profile detransition lawsuits in the US (Ryan, 2023), only a minority of respondents expressed a desire to pursue legal action against former providers. Instead, participants' primary legal concerns surrounded bureaucratic processes like reverting legal documents.

Detransition preventative needs and retransition

Finally, as with prior studies emphasizing the significant impact of external factors on detransition among TGD individuals (Turban et al., 2021; Walls et al., 2025), some respondents specifically highlighted restricted access to gender-affirming healthcare, financial issues, and lack of social support as significant factors in interrupted transitions and a need to retransition. While individual providers may have limited power to combat systemic obstacles, understanding the challenges that can cause TGD patients to unwillingly detransition or disengage from gender-affirming care could further advocacy efforts for appropriate care availability and support structures. Given the current socio-political climate inclusive of de-funding LGBTQ2S+ health research in the US, care debates and legal restrictions being placed on pediatric gender-affirming healthcare (Kinitz et al., 2025), more involuntary detransitions may have occurred since data collection.

Strengths, limitations, and conclusions

This study represents an effort to recruit from a wide range of detransition and retransition experiences in North America, resulting in the inclusion of different pathways, motivations and care needs. The use of multiple outreach strategies, obtaining a heterogeneous sample, and the development of a rigorous scam/bot removal protocol enhanced the quality of the data collected and are notable strengths of this study. Additionally, the use of a mixed methods approach provided deeper insights into the experiences and care needs of participants. However, as data collection took place from December 2023 to April 2024, it is likely that further restrictions on gender-affirming healthcare implemented in the US have increased the incidence of interrupted transitions/detransitions. It is also possible that some respondents currently identifying as detrans may experience a subsequent shift in their identity or feelings about initial transition, and will request retransition care later. Thus, providers should be prepared to facilitate ongoing identity exploration and individualized, compassionate, nonjudgmental care (Expósito-Campos et al., 2024). Future research, particularly prospective, longitudinal studies, are needed to explore the heterogeneous care needs of detransitioning individuals, including SGM identity development across the life course. Providers should be aware of the challenges detrans people face when accessing formal community supports due to detransition-related stigma, and that detrans non-disclosure in these settings may be occurring to negotiate access to LGBTQ2S+ peer supports and community settings.

The current study contributes to the limited body of work regarding the experiences and care needs of detrans people and other SGM people who report identity fluidity and detransition/retransition. Findings indicate that, like other SGM people, detransition may be inadequately understood by some LGBTQ2S+ serving and gender-affirming care practitioners. Future research and community-led research on detransition/retransition can ameliorate this knowledge gap. Importantly, given the potential for country-specific differences in detransition/retransition experiences, future research should be more sensitive to geopolitical and healthcare delivery dynamics.

Note

1. Throughout this paper, acronyms are used for brevity. These were chosen for their conciseness, simplicity or inclusivity, with an understanding that preferred terms differ widely across various demographics. Choice of acronym is not meant to convey adherence to any one worldview or paradigm. While "detransitioner" is often used to describe those with a detransition experience, there are many who do not self-identify with the term but nonetheless met the inclusion criteria for the current study. Consequently, this paper uses language like "gender minority," "detransitioning people," "detrans" person, and "retransition" to better encompass the sample population.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Informed consent

Written informed consent was obtained from all individual participants included in the study.

Statement of human rights

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Data availability

Research participants did not provide consent to have their data made publicly available. Requests to access the anonymized dataset are welcome and will be discussed by the research team.

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