



Detransition Analysis,
Representation,
and Exploration

RETHINKING DETRANSITION

IDENTITY, PATHWAYS, AND REGRET
IN GENDER-RELATED CARE

AN ANALYSIS OF EXPERIENCES,
TRAJECTORIES, AND CARE IMPLICATIONS

PREPARED BY
the DARE study team





Detransition Analysis, Representation, and Exploration

About the Study

The Detransition Analysis, Representation, and Exploration (DARE) Study is one of the first LGBTQ2S+ community-engaged research studies to examine detransition, gender fluidity, retransition, and regret. Funded by the Social Sciences and Humanities Research Council (Insight Grant), the DARE team includes an interdisciplinary team of majority LGBTQ2S+ researchers, clinicians, trainees, and community advisors. The study seeks to address important gaps in knowledge about the experiences, healthcare needs, and outcomes of people who stop, pause, reverse, or later resume a gender transition. Developed with input from individuals with lived experience of detransition and retransition, the study seeks to address important gaps in knowledge about neglected gender-related care outcomes.

Community engagement was central to the project with lived experience input informing study development. To gather community, academic, and care provider feedback, a Trans-Mad-Detrans Studies symposium and discussion was held to discuss findings and their implications. The study aims to generate evidence that can inform patient-centred care, care settings, and policy development.

Methods

Participants and Recruitment

A total of 957 participants from Canada and the United States completed an online survey. Participants were recruited through community networks, social media, advocacy organizations, gender care providers, and word-of-mouth referrals. Eligible participants were aged 16 years or older and had experienced stopping, pausing, reversing, or changing a previous gender transition.

Data Collection

The survey collected information on demographics, gender identity development, transition history, healthcare experiences, psychosocial factors, and reasons for detransition. Participants completed structured survey measures and had opportunities to provide open-ended responses.

Data Analysis

Three complementary approaches were used:

- **Descriptive Statistics** summarized participant characteristics, transition histories, healthcare experiences, and reported reasons for detransition.
- **Latent Class Analysis (LCA)** identified distinct subgroups of participants with similar patterns of experiences and reasons for detransition.
- **LASSO and Elastic Net Regression** identified factors most strongly associated with decisional regret regarding medical transition.

Limitations

DARE used a non-probability convenience sample and therefore may not be representative of all individuals who have experienced detransition/retransition. It did not include transgender, nonbinary, or other gender-diverse people without experiences of detransition, post-transition identity questioning, or retransition, and therefore does not reflect broader transgender experiences. Participants were recruited primarily through online and community-based networks,

which may have influenced who chose to participate. As with all survey research, findings rely on self-reported experiences and cannot establish causal relationships. Despite these limitations, the study provides one of the largest and most detailed examinations of detransition and retransition experiences available to date.

Key Message

Detransition, retransition, and gender fluidity are diverse experiences rather than a single phenomenon. Healthcare providers should use individualized, trauma-informed, and patient-centred experiences when working with transgender, nonbinary, and detransitioning people. LGBTQ2S+ advocacy organizations can better understand the contexts under which people detransition and identity evolutions may unfold, and offer needed supports.

Acknowledgements

DARE received ethics approval from York University Research Ethics Board (e2023-298). All 957 study participants provided written informed consent before participating. We greatly appreciate the time and input of all study participants. The study was supported by the Social Sciences and Humanities Research Council (Insight grant). *DARE* appreciates the expertise of the full research team, including co-investigators, collaborators, research assistants, volunteers, visiting research students, and community advisors. We especially thank Katherine Newman, Naail Khan, Madeline Rosen, Ari Para, and MacGregor Goodman for their efforts toward developing this document.

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For more information, please see www.thedarestudy.com

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The DARE study draws on research supported by the Social Sciences and Humanities Research Council of Canada. Full report available upon request.



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Rethinking Detransition: Identity, Pathways, and Regret in Gender-Related Care

An Analysis of Experiences, Trajectories, and Care
Implications

<https://doi.org/10.1080/30678935.2026.2653130>

Executive Summary

Detransition is often framed as a singular outcome—typically associated with unsuccessful care or regret. However, recent findings from a binational study suggest that detransition is better understood as a heterogeneous, non-linear set of trajectories shaped by identity development, psychosocial and cultural context, and timing of care decisions.

Across a large North American sample:

- Detransition is driven by multiple interacting factors, not a single cause
- Individuals follow distinct pathways, with different life experiences and needs
- Decisional regret is not universal and seems to be linked to identity and developmental factors more than to specific medical interventions

Together, these findings support longitudinal, identity-sensitive, and developmentally-informed care practices.

A Three-Part Framework for Understanding Detransition

1

**Detransition is
Multifactorial**

Detransition is most commonly associated with:

- Identity development and shifts in gender perceptions
- Mental health considerations (for some, but not all)
- Social and structural factors, including discrimination and lack of support
- These factors can co-occur
- No single factor explains all experiences
- Pathways differ in identity stability, psychosocial context, care satisfaction, and outcomes.

2

**Distinct
Subgroups with
Different Needs**

Latent Class Analysis identified four pathways:

- **A:** Early transition with strong regret and co-occurring mental health challenges
- **B:** Identity evolution with transition satisfaction
- **C:** Transition ambivalence and psychosocial challenges
- **D:** Interrupted or involuntary transitions due to gender minority stressors or lack of access to care (often followed by retransition)

3

**Regret is
Contextual, Not
Procedural**

**Decisional regret is most strongly
associated with:**

- Identity fluidity
- Shorter timelines to medical transition
- Younger age at transition
- Lower social support

Regret is less associated with:

- Specific medical interventions
- Type of treatment received

DETRANSITION IS NOT AN ENDPOINT.

The Challenge

- Gender care systems assume linear transitions
- Many patients experience:
 - Identity shifts
 - Pauses or reversals
 - A need to discontinue treatment
 - Uncertainty
 - Unexpected side effects from treatment
- Few detransition-related care resources are currently available

Top Reasons for Detransition

- 1 Identity shifts
- 2 Mental health
- 3 Trans-related discrimination
- 4 Lack of access to care

957 participants



76% under 29
79% AFAB

Average of
4.2
lifetime gender
identities/
expressions

42%

resumed
transition
(retransitioned)

- Identity is dynamic
- Detransition ≠ regret
- Community care needs are ongoing

What this means

- X Discontinuity of care
- X No detransition protocols
- X Lack of understanding gender fluidity
- X Care provider education

Current Gap

- Lifespan-based care
- Identity-flexible frameworks about gender development
- Integrated medical & mental health care
- Access to LGBTQ2S+ community supports

Recommendations

Action Steps

- Gender fluidity and detransition support from LGBTQ2S+ organizations
- Develop hormone discontinuation guidelines
- Maintain continuity of care across lifespan
- Access to mental health supports that include neurodiversity

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Detransition Analysis,
Representation,
and Exploration

Understanding Detransition and Retransition Pathways

A Latent Class Analysis

<https://doi.org/10.1007/s10508-025-03264-6>

Executive Summary

- Some transgender and gender-diverse (TGD) young people report experiences of stopping, shifting, or reversing an initial gender transition (e.g., “detransition”), sometimes temporarily, before re-engaging in transition (e.g., “retransitioning”).
- Gender identity, expression, and sexual orientation can be fluid, particularly among youth. Depending on study design and age group, recent longitudinal research found that 18% to over 50% of gender-diverse young people experience shifts in their gender identity over time.¹⁻⁴ These identity shifts are not necessarily signs of regret or pathology but may be an aspect of child or adolescent developmental processes. This developmental reality underscores the importance of care models that are responsive to evolving identities and the dynamic ways that LGBTQ2S+ young people can experience their gender.
- A recent bi-national study of 957 participants in Canada and the United States identified four distinct pathways to detransition and retransition using Latent Class Analysis (LCA).
- In this study, the average time between initial TGD identity realization and detransition ranged from several months to over 10 years, depending on the unique pathway.
- The field currently lacks robust evidence for long-term outcomes related to gender-related treatment and identity development; more longitudinal, prospective research is needed.
- Gender care providers and LGBTQ2S+ serving organizations are encouraged to adopt flexible, evidence-informed, and non-stigmatizing understandings that gender identity and treatment needs can evolve over time.

Background: Why this Brief Matters

As access to gender-related medical care has expanded, so too has awareness of complex and fluid gender trajectories, including detransition and retransition. Current care guidelines and public discourse often frames detransition narrowly.

The DARE study aimed to better understand the diverse pathways and contexts under which detransition/retransition can unfold, ensuring that all LGBTQ2S+ individuals are offered safer, non-stigmatizing, comprehensive, responsive, and appropriate care.

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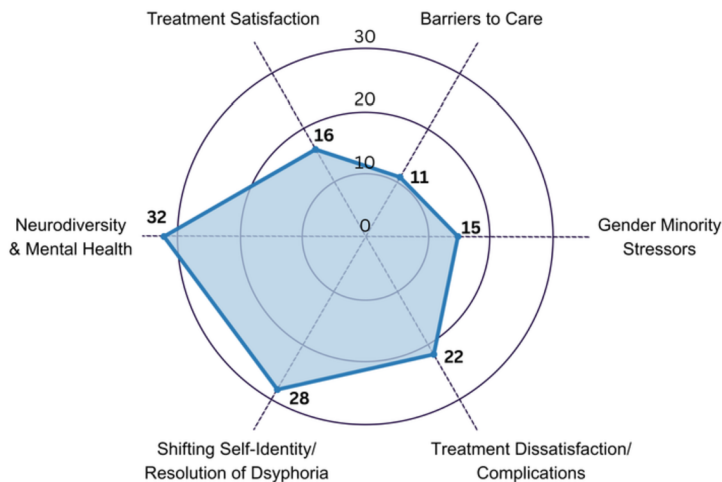
Overview: Four Pathways to Detransition

DARE (2023-2024) surveyed 957 participants aged 16-74 across the United States and Canada who had detransitioned and/or retransitioned after a social and/or medical gender transition. This comprehensive survey—available in English, French, and Spanish—collected demographic data, self-reports on gender identity, mental and physical health, transition/detransition history, and validated measures such as:

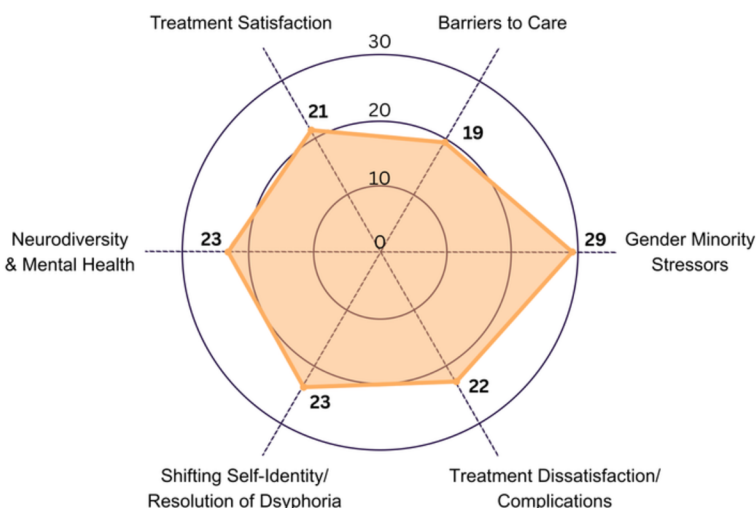
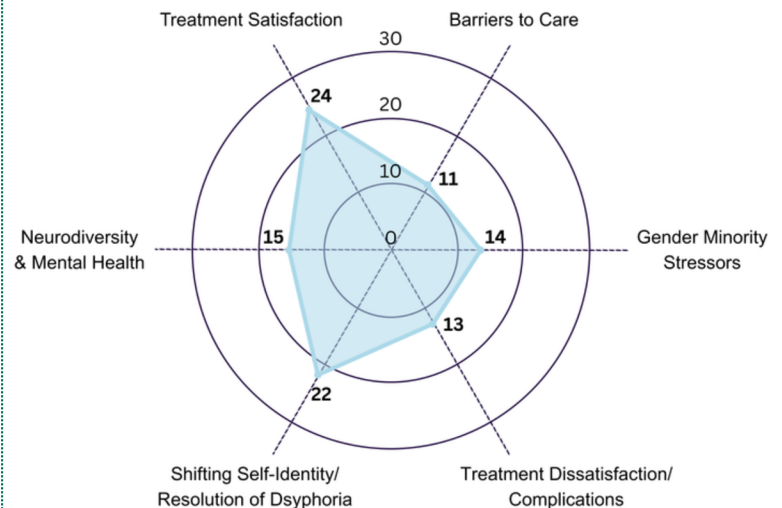
- Adapted Decision Regret Scale (DRS)⁵
- Adverse Childhood Experiences (ACEs)⁶
- Recalled Childhood Gender Identity (RCGI)⁷

Latent Class Analysis (LCA) was used to identify four distinct subgroups based on six thematic reasons endorsed by participants.

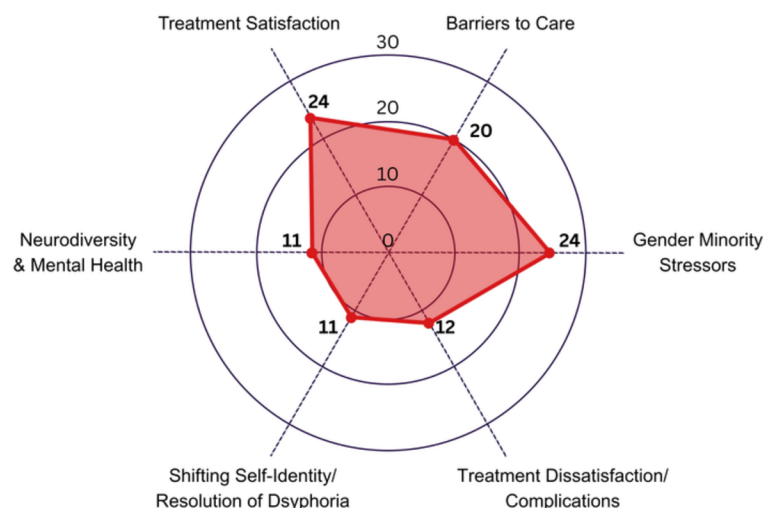
Class A
(33%)



Class B
(19.5%)



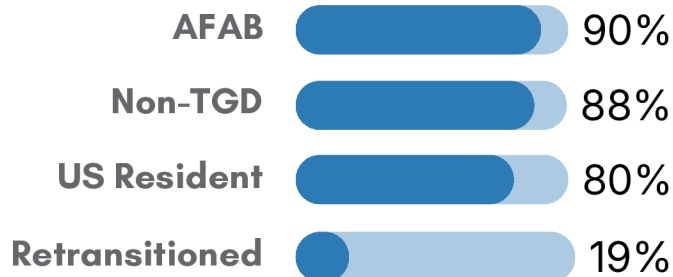
Class C
(19%)



Class D
(28.5%)

Class A

Pathway: Internally-motivated detransition due to treatment dissatisfaction, mental health factors, and gender identity/ expression changes.



- Highest reported regret of four classes
- Lowest rate of plurisexual identities (44%)
- More than half of participants who accessed surgery as minors in this group
- Majority no longer identified as TGD
- Approximately ¼ want to detransition but feel unable

Average Age at Survey **25** years



Age of realizing a TGD identity: 15.5 years

Identity & regret: Only class where majority no longer identify as TGD; strong social and medical transition regret. Highest average lifetime gender identities/ expressions (4.4).

Sexual orientation*: Most likely to identify as lesbian/gay (42%) or heterosexual (16%), with 6% reporting asexual and 8% reporting queer sexual orientations.

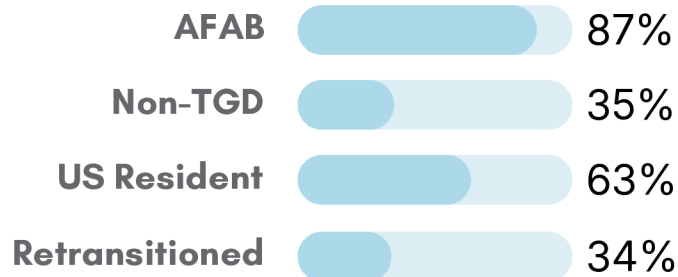
Outcomes: Lowest rate of retransition (19%); 26% expressed a desire to detransition but felt unable.

Care context: Fewer than half reported receiving decision-making supports: 38% had a mental health assessment; 49% attended talk therapy. Over half of those who had gender-related surgery as minors were in this group. 33% had gender-related surgery.

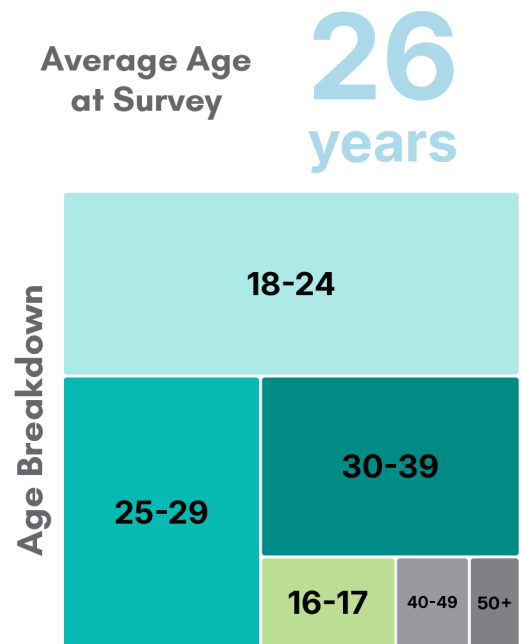
*Participants could choose multiple options

Class B

Pathway: Predominantly identity-evolution detransition, often with treatment satisfaction and little/no regret. External barriers were not prominent.



- Ongoing TGD identification common
- High satisfaction with treatment and care
- Longest period from medical transition to detransition in this group
- Lowest Adverse Childhood Experiences
- Detransition reflects identity development, not dissatisfaction



Age of realizing a TGD identity: 15.4 years

Identity & regret: 62% reported a current TGD identity; regret generally low.

Sexual orientation*: 50% identified as bisexual/pansexual, 39% identified as queer, 37% as gay/lesbian, 12% as heterosexual, and 9% as asexual.

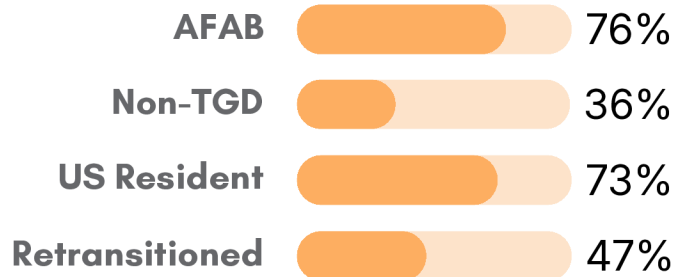
Outcomes: Retransition rate (34%); high treatment satisfaction and little/low regret. 16% wanted to detransition but felt unable.

Care context: A majority reported access to decision-making supports: 54% had a mental health assessment and 60% had talk therapy. 34% had gender-related surgery.

*Participants could choose multiple options

Class C

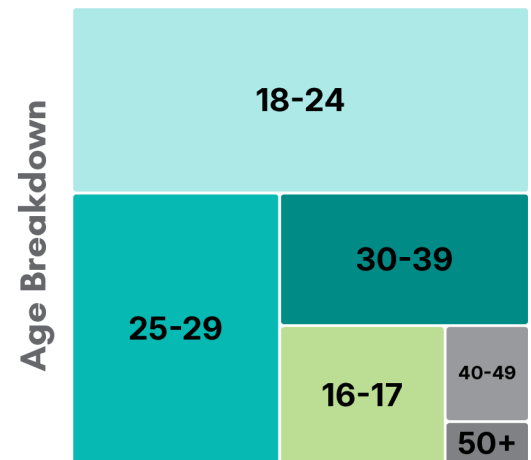
Pathway: Complicated/ambivalent detransition driven by both internal and external factors.



- Highest Adverse Childhood Experiences
- Mixed internal and external drivers
- Moderate regret and mental health complexity
- Some reported barriers to detransition

Average Age
at Survey

26 years



Age of realizing a TGD identity: 15.5 years

Identity & regret: 62% reported a TGD identity at the time of survey; second highest average number of lifetime gender identities/expressions (4.3); highest rates of Adverse Childhood Experiences.

Sexual orientation*: Most reported being bisexual/pansexual (65%). 33% identified as queer, 20% as lesbian/gay, 9% as asexual, and 10% as heterosexual.

Outcomes: Retransition rate 47%; 29% wanted to detransition but felt unable; moderate regret; mixed satisfaction with care.

Care context: Moderate transition regret; mixed satisfaction with treatment. 44% had a mental health assessment; 54% attended talk therapy. 34% had gender-related surgery.

*Participants could choose multiple options

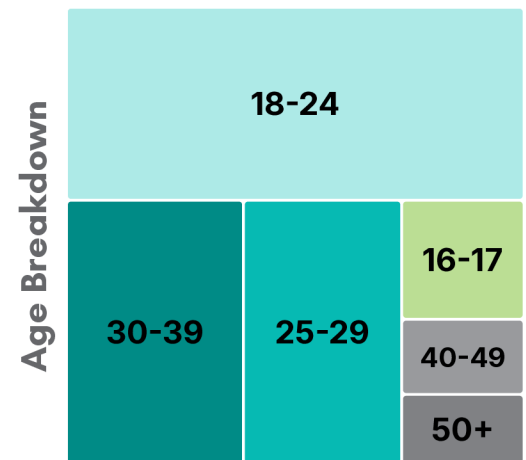
Class D

Pathway: Interrupted gender transition with pauses attributed to external factors, not to internal factors or identity shifts.



- Detransition driven by external constraints:
 - Discrimination
 - Cost
 - Lack of support
- Greater reported childhood gender non-conformity
- Lowest rate of gender-related surgeries

Average Age at Survey **27 years**



Age of realizing a TGD identity: 13.9 years

Identity & regret: 95% reported a current TGD identity. Trans women were likelier to be in this group. Little/no transition regret.

Sexual orientation*: Most likely to identify as bisexual/pansexual (66%) or asexual (18%). 43% identified as queer, 8% as heterosexual, and 17% as lesbian/gay.

Outcomes: Highest retransition rate (71%). Lowest decisional regret.

Care context: Highest access to decision-making supports: 58% had a mental health assessment; 64% attended talk therapy. Recognized TGD identity at a younger age than other groups, yet began medical transition later. 14% had transition-related surgery.

*Participants could choose multiple options

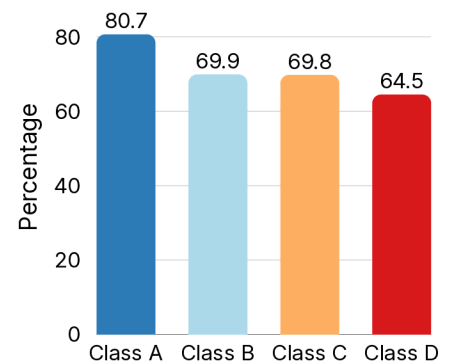
Key Findings for Healthcare Providers

Findings challenge reductive assumptions about detransition

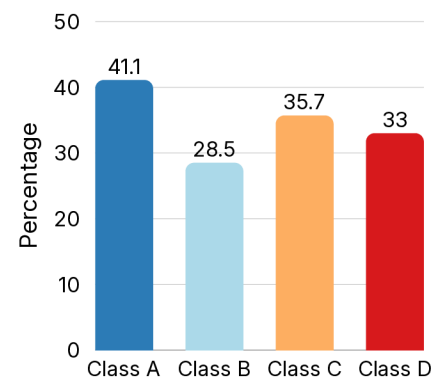
- **Many people who detransition are LGBTQ2S+.** The majority are young adults who were assigned female at birth.
- **Detransition can occur with or without decisional regret:** About half of the participants who accessed gender-related medical treatments reported decisional regret or ambivalence, but many reported ongoing satisfaction. Classes A and C reported relatively high regret, while Classes B and D reported being largely content with their decisions to transition.
- **Detransition is stigmatized:** Over a quarter of Classes A and C reported a desire to detransition but felt unable to take steps, signalling potential difficulties with pursuing a detransition process, stigma, and lack of support.
- **Young AFAB sexual minorities are overrepresented** in high-regret categories, particularly those who accessed medical treatments as minors. This highlights the need for enhanced developmental, contextual, and identity-sensitive care and support.
- **Mental health and neurodivergence can impact gender development:** Classes A and C reported disproportionately high rates of internalizing disorders (e.g., anxiety, eating disorders), obsessive disorders, and trauma histories. These groups reported mental health-related factors as being relevant to their transition and detransition trajectories.
- **Structural and social conditions matter:** Discrimination, lack of support, and healthcare access barriers were significant factors prompting detransition for some participants (especially in Classes C and D).
- **Retransition is common:** A majority (71%) of participants in Class D retransitioned, illustrating that discrimination and lack of access to treatment can drive temporary, interrupted gender transitions.

Findings support the expansion of individual, data-driven care models

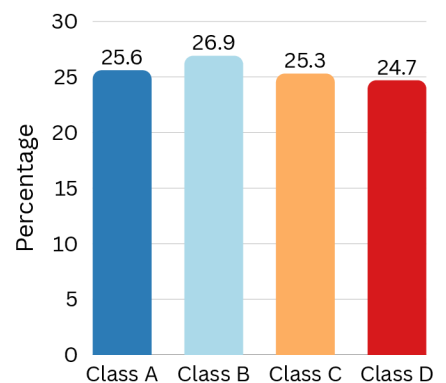
Anxiety Diagnosis*



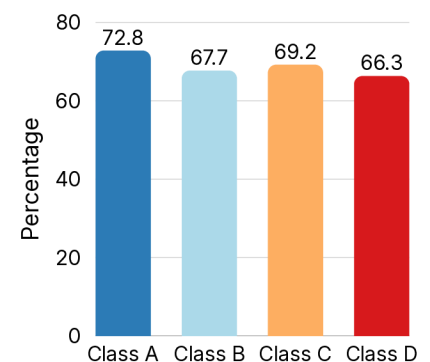
Trauma-Related Diagnosis*



Autism Diagnosis*



Mood Disorder Diagnosis*



*Diagnosed by healthcare provider

Policy and Care Recommendations

1

Integrate Gender Fluidity into Care Models

- Recognize that gender-related care is not always linear, and treatment plans should allow for identity exploration and recognize the possibility for identity/expression changes.
- Providers should avoid assuming transgender or cisgender identity outcomes are inherently preferred, and instead practice curious and nonjudgmental care.
- Normalize gender and sexuality exploration and detransition within LGBTQ2S+ youth community care, and gender care settings.

Support Voluntary Detransition/Retransition Pathways

- Establish protocols to support individuals seeking to detransition, or to restart transition-related care, ensuring access to medical, psychosocial, and peer support.
- Integrate peer-led support and shared decision-making tools into care settings to enhance trust, autonomy, and informed care across all stages of gender transition and detransition.

2

Address Interrupted Gender Transitions and Continuity of Care

- Implement system-level reforms to prevent care interruptions caused by discrimination, cost, or legal barriers.
- Remove stigma from returning to care or requesting help with retransition.

3

Expand Mental Health and Trauma-Informed Services

- Ensure concurrent access to gender care that meets care standards and provides mental health services throughout transition and detransition processes.
- Provide targeted, neurodiversity-inclusive psychosocial and community supports, especially for those with high Adverse Childhood Experiences and recent gender-based trauma histories.

4

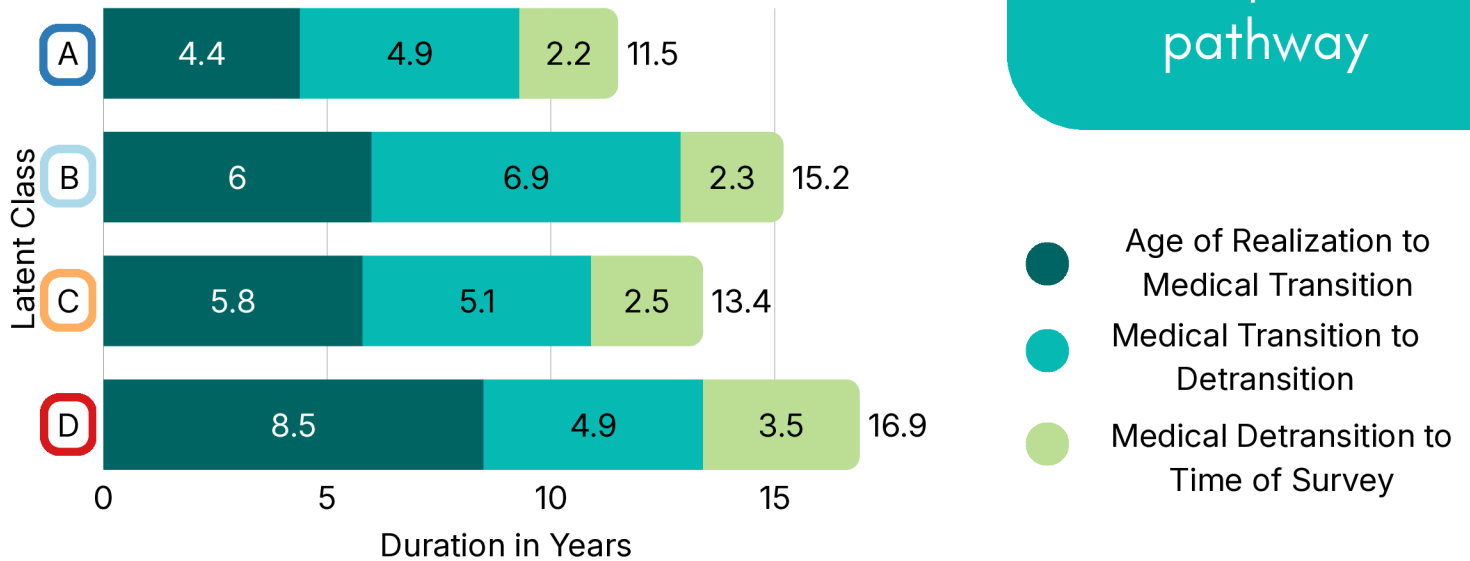
Train Providers and Update Clinical Guidelines

- Develop decision-making tools and curricula to support conversations about gender fluidity, detransition, and retransition within training and continuing education.
- Encourage providers to reflect on their own assumptions about detransition, recognizing that it has often been politically framed as opposing transition, rather than understood as part of a spectrum of gender and sexual diversity.

5

Transition Timelines by Latent Class

Detransition is a heterogenous, non-linear developmental pathway



Conclusion and Call to Action

Transition-related care must be grounded in flexibility, compassion, and evidence. By integrating research on gender fluidity and detransition into care models, healthcare providers and systems can maximize benefit, reduce harm, improve patient trust, and ensure that services remain inclusive across the full spectrum of LGBTQ2S+ experiences. We must evolve from static models of care to systems that welcome redefinition and return. Now is the time to expand our frameworks to ensure that LGBTQ2S+ inclusive care includes everyone, at every stage.

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2. Ocasio et al., 2024 (<https://doi.org/10.1016/j.pmedr.2024.102735>)
2. Katz-Wise, 2024 (<https://doi.org/10.1080/00224499.2023.2244926>)
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6. Zucker et al., 2006 (<https://doi.org/10.1007/s11199-006-9019-x>)

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Detransition Analysis,
Representation,
and Exploration

Understanding Decisional Regret Following Gender-Related Medical Transition

Findings from LASSO and Elastic Net Analyses

Paper currently in revision

Background

While gender-related medical care—including hormone therapies and surgery—address gender dysphoria/gender incongruence for many individuals, a subset may experience decisional regret. A cross-sectional study of 322 individuals who experienced detransition—stopping, shifting, or reversing an initial gender transition—identified key factors influencing decisional regret.

Regret and detransition are distinct experiences. Not all individuals who detransition experience regret, and not all who experience regret choose to detransition.

322 participants with detransition experience



23% Canada
77% U.S.

200+ candidate predictors

- Demographic characteristics
- Medical transition details & timing
- Psychosocial variables
- Mental health indicators
- Reasons prompting detransition

23% medically transitioned as minors

47% aged 16-24 at time of survey


47% current TGD identity

76% assigned female at birth

Methods


Participants who had stopped, shifted, or reversed a medically supported gender transition completed an adapted version of the Decision Regret Scale¹. Decision regret scores were analyzed using Elastic Net and LASSO regression models to identify key predictors from more than 200 candidate variables.

Factors associated with INCREASED regret*



- Greater identity fluidity
- Increased comfort with “detrans” label and/or sex assigned at birth
- Recent medical detransition
- Younger age at start of medical transition
- Lower parental support

Factors associated with DECREASED regret*



- Longer time between transition and detransition
- Current binary trans identity
- Longer time between TGD identity realization and transition
- Older at start of medical transition
- Greater lifetime mental health diagnoses
- Greater religiosity during childhood

* Variables are ordered from the strongest to weakest predictor identified by the penalized regression analyses

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“Decisional regret is shaped by personal, psychological, and social contexts — not solely by medical outcomes.”

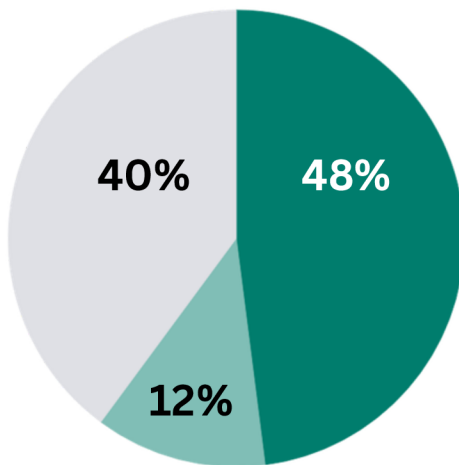
Key Findings

Shifts in identity and greater alignment or current comfort with sex assigned at birth were among the strongest predictors of regret. Timing also played a central role, with shorter timelines between realizing a transgender and gender diverse (TGD) identity and transitioning associated with higher regret. No specific diagnostic or neurodivergence profile (e.g., autism) emerged as predictive in this sample.

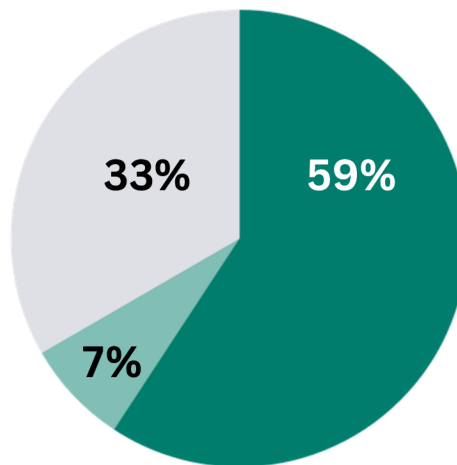
A large majority of the sample realized a TGD identity in adolescence (average age of 15 years). Therefore, these results may not be reflective of individuals who came to know their TGD identity as children or older adults, or those who do not experience gender fluidity. Participants reported an average of 4.2 lifetime gender identities/expressions, which may limit generalizability. Findings suggest the importance of community support and inclusion around gender fluidity and challenging transition experiences, rather than exclusion.

If you could go back in time...

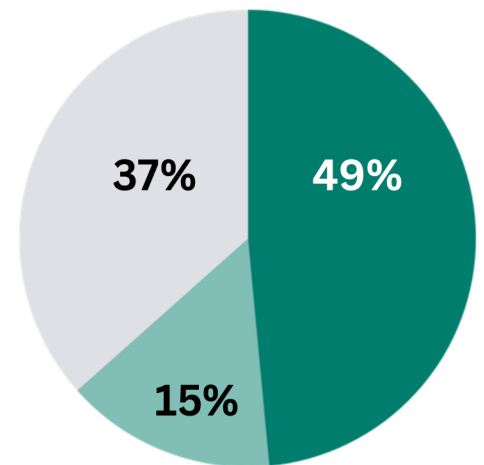
...would you still transition with **hormones**?



...would you still transition with **puberty blockers**?



...would you still transition with **surgery**?



Yes **No** **Unsure**

References:

1. Brehaut et al., 2003 (<https://doi.org/10.1177/0272989X03256005>)
2. Zou & Hastie, 2005 (<https://doi.org/10.1111/j.1467-9868.2005.00503.x>)
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