Behind Gender Dysphoria – A Qualitative Study on Detransition

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Abstract

Despite increasing clinical attention, research on detransition remains in its early stages. This qualitative study aimed to explore clinicians' experiences of working with detransitioners, focusing on the most recurrent themes and psychological patterns encountered in therapy and the patients' emotional experience; and to examine aspects that may not be adequately addressed by the Gender-Affirming Care Model (GAMC) in light of the recent increase in detransition cases. Semi-structured interviews were conducted with five clinicians experienced in working with individuals who had detransitioned, and data was analyzed using Reflexive Thematic Analysis. Participants collectively reflected on 41 detransition cases. For the first objective, findings revealed that gender-related distress and core experiences of detransition are rooted in intersecting social (e.g. feelings of being different – 80%, relational patterns – 40%), psychological (e.g. negative emotional experiences – 100%, internalized rigid thinking patterns – 40%) and corporeal (e.g. same-sex attraction – 60%) dimensions. The results further suggest that, for some, adopting a transgender identity can serve as protective factor (80%) to manage psychic pain; and how medical transition can prove to be insufficient in addressing the underlying concerns resulting in the disintegration of the transgender identity (80%) over time. Still in relation to the first objective, the experience of detransition was described as not homogeneous (100%), encompassing emotional aspects (acceptance – 60%, experiences of grief and courage – 80%), reconnection with the natal sex (irreversibility of medical transition – 60%, well-being – 100%), and social impacts (80%). For the second objective, findings revealed two overarching themes: Gender Affirming Model of Care (e.g., profoundly flawed – 100%, disregards psychological dynamics – 80%, rigid – 60%, not prone to full consent – 20%, unethical and unregulated implementation – 20%) and Alternative approaches (e.g., exploration and individuality – 80%, relation and acceptance – 60%). Implications for clinical practice and future research are discussed, including the importance of integrating psychodynamic understanding into gender-related care and addressing the long-term impacts of medical transition.

Keywords: Gender detransition; Regret; Gender Dysphoria; Gender Identity; Qualitative Study

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Introduction

At a general level, sex can be distinguished as a biological category identifiable by sex chromosomes, sex hormones, gonads, and unambiguous internal and external reproductive organs (American Psychiatric Association [APA], 2013; Schiappa, 2022). Approximately 98% of the population can be accurately categorized within the binary of female or male sex, however, some individuals are born with variations in sexual development and are categorized as intersex (Schiappa, 2022).

While sex is primarily a biological construct, gender constitutes a social category linked to behaviors, attitudes and personality traits ascribed to each sex, reflecting the social role each individual assumes (Robertson, 1981; Withers, 2020; APA, 2013). This categorization is shaped by social norms, leading to variations in the meaning ascribed to each sex across distinct cultural and historical moments (Lindesmith et al., 1999). In this sense, gender is conventionally assigned at birth based on biological sex, thereby reflecting embedded social and behavioral expectations (Withers, 2020; APA, 2013).

Beyond its social categorization, gender also becomes an integral aspect of self-identity (APA, 2023). Emerging from a complex interplay of bio-psycho-social factors, gender identity reflects how individuals perceive and experience themselves – whether as a man, woman or in another category such as non-binary (APA, 2023). How individuals communicate their gender identity – through appearance, mannerisms, interests and language – constitutes what is known as gender expression, which tends to be dynamic throughout one's life (Hennekam & Ladge, 2023; Palmer & Francis, 2024). When these expressions challenge prevailing norms associated with each sex, they are described as gender nonconforming, a phenomenon frequently linked to both gender diversity and sexual minorities (Palmer & Francis, 2024).

Building on this conceptualization of gender identity, the term cisgender denotes individuals whose gender identity is congruent with their natal sex, whereas transgender serves as an umbrella term for those whose gender identity is incongruent with their biological sex (APA, 2013). This integrates transsexual, non-binary and gender diverse identities – the latter two describing individuals whose gender cannot be fully captured by the traditional male-female binary (World Professional Association for Transgender Health [WPATH], 2022).

Taken together, these conceptual distinctions between sex, gender, gender identity and gender expression underscore the complexity of human diversity beyond the binary model and establish the basis for exploring the diverse and sometimes shifting ways individuals experience, express and relate to their gender over the course of their lives.

Literature Review

Gender Dysphoria

Historical records show that individuals whose gender identity diverged from their biological sex have always existed across cultures and epochs (Marchand et al., 2019). However, the term transsexual first arose to describe those who not only felt they belonged to the other sex but also actively sought to appear and function as such (Marchand et al., 2019). These individuals experienced significant distress related to their anatomical sex and pursued medical interventions, including sex reassignment surgeries and cross-sex hormones, to align their physical characteristics with their gender identity (Marchand et al., 2019).

Over time, as understandings of gender expanded, the term transgender emerged to distinguish individuals who wished only to change their gender – adopting cross-gender roles and sometimes seeking cross-sex hormone treatment – without identifying as the opposite sex or pursuing genital reconstruction surgery (Marchand et al., 2019). In this sense, the defining difference between transgenderism and transsexualism concerns whether gender incongruence is experienced mainly as a psychological and social phenomenon or is accompanied by a complete rejection of one's anatomical sexual characteristics (Marchand et al., 2019). While transsexual individuals typically feel profound discomfort with their sexed body and seek to alter it, transgender individuals may not wholly reject their physical traits (Marchand et al., 2019).

Understanding these categories also requires considering the psychological distress that can accompany gender incongruence (APA, 2013). Gender Dysphoria (GD) refers to the affective and/or cognitive distress that can result from a pronounced and persistent incongruence between one's assigned gender at birth and experienced gender identity (APA, 2013). For a clinical diagnosis, this incongruence must significantly disrupt functioning in more than one area of life and persist for at least six months (APA,

2013). However, it is important to emphasize that not all transgender and gender diverse (TGD) individuals experience or meet diagnostic criteria for GD (APA, 2013).

In children, for a GD diagnosis one must experience a strong desire to be, or an insistence that one is, of another gender, accompanied by at least five additional indicators, such as a preference for cross-gender roles, toys, clothing or peers and a rejection of gender-typical activities (APA, 2013). Among adolescents and adults, diagnosis requires a marked incongruence between natal sex and experienced gender, significant distress or impairment, and at least two further features – such as discomfort with primary or secondary sex characteristics, a compelling desire to prevent or remove these characteristics and acquire those of the other gender, an intense yearning to be and be recognized as the other gender or that one has the typical felt experience of another gender (APA, 2013). Additional features supporting diagnosis include appropriating mannerisms, clothing or behaviors associated with another gender, feeling discomfort when addressed by one's assigned gender, concealing sexed anatomy and a tendency to not allow their partner to touch or see one's sexual organs, if sexually active (APA, 2013). While some individuals pursue medical transition to alleviate this distress, others find relief by living in the desired gender role or adopting a non-binary presentation (APA, 2013).

Over the past decade, the number of people, especially of younger age groups, being diagnosed with GD and seeking gender transition has drastically increased (WPATH, 2022). Currently, the estimated prevalence of GD and transgender identities vary depending on definitions and study methodologies (WPATH, 2022). To address this, the World Professional Association for Transgender Health (WPATH) Standards of Care - Eighth Edition (SOC-8) (2022) categorizes data into three types: health systems-based studies, survey-based studies of adults, and survey-based studies of children and adolescents. Health system-based studies report prevalence rates ranging from 0,02% to 0,1% and are usually limited to people with a GD diagnosis or who have requested or undergone gender related surgeries (WPATH, 2022). Survey-based studies rely on self-reported data concerning biological sex, gender identity, gender experience, comfort with one's sexed body, and desire to alter it, distinguishing between transgender identities and broader gender-diverse expressions (WPATH, 2022). These surveys estimate the prevalence of transgender identities at 0.3% to 0.5% in adults and 1.2% to 2.7% in

children and adolescents, with wider transgender and gender-diverse identities ranging from 0.5% to 4.5% in adults and 2.5% to 8.4% in younger populations (WPATH, 2022).

Historically, the sex ratio among individuals diagnosed with GD and who procure medical care predominantly consisted of natal males who began identifying as female either in childhood or middle age (Kaltiala-Heino et al., 2018; WPATH, 2022). In recent years, however, this pattern has changed with an increasing predominance of natal females who start to identify as males in adolescence despite no prior indicators of GD in childhood – a phenomenon previously infrequent (Kaltiala-Heino et al., 2018; WPATH, 2022; Clarke & Amos, 2024). This new presentation was termed as rapid-onset gender dysphoria (ROGD) contrasting with the early-onset GD typically manifested by natal males and that persisted or intensified during adolescence (Litman, 2018). Interestingly, Litman's (2018) study also found a co-occurrence of ROGD with psychological distress, leading to the hypothesis that, for some youth, the abrupt emergence of GD and urgency to transition might reflect a maladaptive coping mechanism. Similarly, Byne et al. (2012) reported that individuals with later-onset GD exhibited higher rates of psychopathology compared to those with early-onset GD. These findings highlight the need for further investigation, as much of the existing research on persistence and desistance rates and on the outcomes of medical transition is based on populations whose GD characteristics differ from the newer presentation (Litman, 2018). While the WPATH SOC-8 (2022) attributes the increased prevalence of GD among adolescents and natal females to a cohort effect, shaped by generational changes including social and medical advances and reduced stigma, several authors argue this explanation is insufficient, as it fails to adequately account for psychological and developmental context (Gray et al., 2012; Kaltiala-Heino et al., 2018; Litman, 2018).

GD has been associated with a high prevalence of psychiatric distress and mental health concerns with the most common comorbidities being anxiety, depression, emotional dysregulation, substance abuse, eating disorders, suicidal ideation, borderline personality disorder and autism spectrum disorder (APA, 2013; Cass, 2022; WPATH, 2022; Gould et al., 2024; Mirabella et al., 2024). In fact, some studies suggest that 40% to 45% of the adolescents referred to gender clinics present with significant pathology and are three to four times more likely to engage in self-harm and suicidal behaviors when compared to cisgendered peers – approximately the same as youth referred to mental health services (Kaltiala-Heino et al., 2018; Cass, 2022).

Some scholars argue these mental health difficulties primarily stem from minority stress – that is, external stressors such as societal stigma, discrimination, or violence experienced by individuals belonging to a minority group – and thus should not be viewed as barriers to accessing medical transition (Jorgensen, 2023; Gould, 2024). This perspective reinforces that access to gender-affirming medical interventions can have a significant impact on improving mental health (Gould, 2024). While minority stress and lack of social support are undoubtedly influential, more comprehensive perspectives also considers other contributing factors, including general identity confusion, complex trauma, internalized homophobia, social isolation, difficulties associated with puberty and symbolic processes related to body image and identity (Marchiano, 2017; Withers, 2020; Cass, 2022; WPATH, 2022; Jorgensen, 2023). Consistently, these factors have been shown to play a critical role in the emergence of body-related discomfort and the adoption of a transgender identity, suggesting that it is implausible that all mental health concerns would derive solely from gender incongruence or to assume these will resolve entirely through medical intervention (Kaltiala-Heino et al., 2018; Withers, 2020). Additionally, whilst medical transition has been associated with improvements in quality of life and body discomfort, there is limited evidence that it reliably reduces psychiatric distress as studies have indicate that the suicide risk among TGD individuals persists through to all stages of transitioning, only decreasing slightly over time in transgender women (WPATH, 2022; Gould, 2024). In this sense, exploring and addressing underlying psychological dimensions before pursuing irreversible medical treatments may be crucial to reduce future regret (Litman, 2018; Kaltiala-Heino et al, 2018).

Gender Affirming Model of Care: conceptualization and perspectives

The Gender-Affirming Model of Care (GAMC), recommended by the WPATH SOC-8 (2022), is positioned as a science-based framework supported by research indicating improvements in quality of life, mental health and body image satisfaction among TGD individuals (WPATH, 2022). Beyond its clinical scope, the GAMC has contributed significantly to the depathologization of gender diversity, advocating for transgender rights and addressing the social and healthcare discrimination this population faces (WPATH, 2022; Clark & Amos, 2024; Huit et al., 2024). Consequently, over the past two decades, its influence has expanded globally across political, clinical and social domains (Klein, 2023; Clark & Amos, 2024).

The GAMC bases itself on the premise that gender identity is shaped by biological, psychological and social factors, rather than being solely determined by biological sex (WPATH, 2022; Clark & Amos, 2024). It upholds individuals' rights to socially, legally and medically transition if desired, irrespective of age, and recognizes that diverse gender identities are neither pathological nor rare historically and culturally (WPATH, 2022; Clark & Amos, 2024). Although gender incongruence itself is not considered pathological it may cause significant distress, which the model addresses primarily through medical transition (WPATH, 2022). In accordance, the WPATH SOC-8 (2022) firmly encourages governments to consider transition-related care as a medical necessity and ensure that health care systems provide them accordingly. These treatments consist of hormone blockers that suppress the normal course of puberty to prevent the development of secondary sex characteristics, cross-sex hormone therapy that is referred to as hormone replacement therapy (HRT) and gender affirming surgeries (GAS) (WPATH, 2022). Access to this type of care generally requires a GD diagnosis and psychological/psychiatric evaluation to understand the individual's history and identify any mental health issues, often linked to minority stress (Huit et al., 2024; WPATH, 2022).

Early studies about gender affirming care and its longitudinal impact reported mainly on natal males whose GD started in childhood and found little regret and improved quality of life (WPATH, 2022). Recent findings confirm improvements in body satisfaction and quality of life but report ambiguous results on mental health improvement and regret (Gould, 2024). These earlier findings seem to support claims that adolescents, after careful assessment, can be deemed capable of providing informed consent for treatment (WPATH, 2022). However, the WPATH SOC-8 (2022) finds it important to notice that the current population presenting for gender-affirming care differs significantly from earlier cohorts with not enough time for longitudinal research to be conducted and to understand how the growing social visibility on transgender issues can impact the way gender identity is developed.

When it comes to assessing minors, the WPATH SOC-8 (2022) recommends involving caregivers and addressing mental health concerns before treatment, alongside evaluating whether the young person demonstrates cognitive and emotional capacity to understand treatment effects with its reversible and irreversible components (WPATH, 2022). This includes disclosing the possibility of sexual impairment and infertility,

explaining the options for its preservation prior to treatment initiation and managing expectations regarding medical care outcomes (WPATH, 2022). Lastly, it advocates for clinicians to acknowledge that there is a lack of clinical data about some of the impacts of puberty suppression hormones and advises a staged treatment approach so that treatment is provided from partially reversible to irreversible procedures (WPATH, 2022).

Perspectives on the GAMC are extremely polarized, following a sharp increase in transition rates and concerns that GD diagnosis and approval for medical care are being facilitated without adequate exploration of personal history, possible roots for the emergence of GD symptoms and mental health symptoms (Clarke, & Spiliadis, 2019; D'Angelo et al., 2021; Vandenbussche, 2022; Gerritse et al., 2024). Additionally, clinicians have noted a recurring pattern wherein TGD youth perceive clinicians as gatekeepers, sometimes presenting similar, seemingly pre-rehearsed narratives of GD history designed to minimize other psychological concerns and secure access to predetermined treatments (Withers, 2020; Gerritse et al., 2024).

Proponents of the GAMC argue that individuals possess privileged insight into their own corporeal (distress) experience and have a fundamental right to self-determination, asserting that questioning these experiences or delaying access to medically necessary care is both ethically problematic and inhumane (Clarke & Spiliadis, 2019; WPATH, 2022). This view typically relies on a predominantly neurobiological understanding of GD, often framed in narratives such as being "born in the wrong body" (Littman, 2018; Spiliadis, 2019). From this standpoint, the role of the clinicians in the decision-making process is perceived as an unjust barrier that undermines self-determination, reinforces pathologization and further erodes trust in healthcare providers (WPATH, 2022). Consequently, non-affirmative approaches are frequently equated with conversion therapy by gender-affirming supporters (Clarke & Spiliadis, 2019; WPATH, 2022).

Notwithstanding, the evidence for the biological basis of GD is scarce and critics caution that the GAMC postulates a one-size-fits-all approach that hinders individualized work and overlooks complex social, psychological and contextual factors (Spiliadis, 2019; D'Angelo et al., 2020; Gerritse et al., 2024). From this perspective, it can be argued that the principle of nonmaleficence is not being sufficiently safeguarded under an exclusively affirmative model (D'Angelo et al., 2020). This concern underscores the need

for more comprehensive psychological assessments and therapeutic approaches that move beyond the extremes of uncritical affirmation and the historical harms of conversion therapy (Spiliadis, 2019; D'Angelo et al., 2020; Gerritse et al., 2024). Instead, a balanced and exploratory stance is advocated, one that supports open-ended reflection and careful clinical judgment (Spiliadis, 2019; D'Angelo et al., 2020; Gerritse et al., 2024).

These views often have a base on developmental psychology as childhood and adolescence are crucial periods for identity development and, as such, it is natural for children to explore and display diverse gendered behaviors in an attempt to figure out their own identity (Kaltiala-Heino et al., 2018). Evidence also attests that for approximately 80% of children who experience GD, these feelings tend to recede with puberty with many identifying as non-heterosexual (Kaltiala-Heino et al., 2018). Such findings align with research indicating that many homosexual adults exhibited cross-sex behaviors in childhood, prompting concerns that early transition decisions might be premature and risk masking emerging same-sex attraction (D'Angelo et al., 2020). Some authors argue it may be psychologically easier for certain individuals to identify as transgender, aligning themselves with heteronormative expectations, than to accept a homosexual identity, which remains more socially stigmatized (Lemma, 2018). This gives rise to ethical concerns that immediate gender affirmation, without careful exploration of underlying struggles with gender nonconformity or same-sex attraction, could inadvertently function as a contemporary form of gay conversion therapy (D'Angelo et al., 2020).

Adolescence itself is marked by profound cognitive, emotional and social changes, often accompanied by heightened urgency, emotional volatility and identity reconfiguration (Branje et al., 2021; WPATH, 2022). A central developmental task during this phase involves the consolidation of self-identity, including sexual identity, and the acceptance of one's body and social gender role, which does not need to be binary (Kaltiala-Heino et al., 2018). This period of uncertainty and fluidity provides space for subjective exploration across the spectrum of gender and sexuality until a more cohesive sense of self emerges (Lemma, 2018). Yet, this process has proven to be especially challenging for some youth, with many who present with GD also displaying signals of broader identity confusion, i.e., having an incoherent, fragile and contradictory sense of self, which often results in psychological distress (Leonhardt et al., 2024). In this context, adopting a transgender identity can offer an immediate, concrete explanation for diffuse

bodily unease and identity uncertainty, helping adolescents feel less isolated and misunderstood once the source of distress is named (Lemma, 2018; D'Angelo, 2020). Similarly, it may feel more manageable for families and clinicians to perceive the young person's suffering as biologically rooted and thus potentially resolved through medical intervention, rather than confronting more complex psychological dimensions (Withers, 2020). Furthermore, research suggests that youth presenting with GD and an avid desire to transition often display rigid thinking patterns, making it difficult to reflect on internal conflicts and to ponder these life-changing decisions, thus turning to concretization as a more straightforward route to relieve distress (D'Angelo, 2020; Sanders, 2025).

For these reasons, some clinicians advocate for exploratory therapeutic approaches that adopt a neutral, open stance, seeking to understand who the person is and what the transgender identity signifies and functions as in their life (D'Angelo et al., 2020; Sanders, 2025). Such approaches are often mischaracterized publicly and in some literature as transphobic or akin to conversion therapy (Lemma 2018; Spiliadis, 2019; D'Angelo et al., 2020). Nonetheless, it means only that the therapist presents with a curious unbiased stance without any preconceived notions of a right or healthy path to follow, i.e. not wanting to either confirm nor convert but to work with the individual to deepen their own understanding of themselves, their discomfort and desire to transition (Spiliadis, 2019; D'Angelo et al., 2020). As such, this process supports informed decision-making about medical transition, taking into account its underlying motivations, psychic investment and the emotional and physical benefits and risks for each individual specifically (Lemma, 2018; Spiliadis, 2019; D'Angelo et al., 2020). This therapeutic stance does not pathologize gender diversity but instead embraces it, while also being mindful of how it translates (or not) into body-related distress (Spiliadis, 2019). From this perspective, medical intervention can be a viable and meaningful outcome, but only after an in-depth assessment, as for some, GD can resolve without medicalization (Spiliadis, 2019; Cohn, 2023).

In summary, whereas affirmation and conversion-based approaches risk constraining autonomy by steering individuals towards a predetermined outcome, exploratory therapy seeks to empower them to arrive at a decision grounded in a deeper, more nuanced understanding of themselves (D'Angelo et al., 2020).

Detransition

The term detransition generally refers to individuals who cease or reverse an initial gender transition (Cohn, 2023). While this may involve reidentifying with one's natal sex, it can also include discontinuing medical treatment while continuing to identify as TGD (Chon, 2023). Reported prevalence rates vary from 1% to 13%, depending on study design and definitions, yet recent literature suggests detransition is an increasingly observed phenomenon (Marchiano, 2021 Expósito-Campos, 2021; Cohn, 2023; Expósito-Campos et al., 2024).

Expósito-Campos (2021) proposed two main typologies of detransition: core and non-core detransition. Non-core detransition refers to the cessation of the transition process without abandoning a transgender identity – often due to external factors such as lack of social support, financial barriers, discrimination, dissatisfaction with surgical outcomes, or health complications (Expósito-Campos, 2021). Such detransition may be temporary, with a higher likelihood of retransitioning once external barriers are resolved (Expósito-Campos, 2021). For this group, detransition can be temporary, with a higher probability of retransition than core detransitioners since the transgender identity remains and the reasons for the detransition might be external to the individual (Expósito-Campos, 2021). In contrast, core detransition refers to people who cease or reverse their transition due to no longer identifying as transgender and possibly reidentifying with their natal sex (Expósito-Campos, 2021). This can result from GD remission over time, recognition that transition did not alleviate all or some aspects of GD or an evolving understanding of underlying emotional and psychological contributors to GD (Expósito-Campos, 2021). Additionally, it can also be related to a change in one's worldviews, leading the individual to question their transgender identity and/or a reconciliation with one's sexuality and natal sexed body (Expósito-Campos, 2021). Given this shift in self-identification, the probability of retransition is lower, although possible (Expósito-Campos, 2021).

A second typology proposed by Janssen (2021) distinguishes detransition based on whether they experience regret, which is clinically relevant since regretful detransitioners often require specialized psychological or medical support (MacKinnon et al., 2023). Studies on detransition report that 30% to 60% of detransitioners feel ambivalent or regretful towards their initial transition, with many stating that, in retrospect, they would not have medically transitioned (Cohn, 2023; MacKinnon et al., 2023).

Vandenbussche (2022) realized a survey-based study on detransition, which included a sample of 237 participants, from which 92% were natal females and 65% had socially and medically transitioned before detransitioning. The sample showed high rates of comorbid mental health conditions (54%), primarily depression, anxiety, and post traumatic stress disorder (PTSD) (Vandenbussche, 2022). When asked about reasons for detransition, the most common response (70%) was realizing that GD symptoms stemmed from other issues (Vandenbussche, 2022). Other frequently cited reasons included health concerns (62%), recognition that transition did not alleviate GD (50%), finding alternative coping strategies (45%) and discontentment with social consequences (44%) (Vandenbussche, 2022). Conversely, external reasons such as discrimination, lack of support, and financial concerns were less commonly reported (10% to 13%) (Vandenbussche, 2022). The study also emphasized the psychological needs of detransitioned individuals, with 60% reported needing help to cope with regret, 53% with physical and social changes from transition, and 52% with feelings of internalized homophobia (Vandenbussche, 2022).

Litman (2021) conducted a survey-based study focusing specifically on individuals who underwent medical transition prior to detransitioning, aiming to understand their narratives and motives. The most frequently reported reason for detransition (60%) was a change in personal understanding of what it means to be male or female, resulting in a re-identification with the natal sex (Litman, 2021). Additionally, 58% attributed their GD to underlying trauma or mental health conditions, with over half believing that transition delayed the process of addressing these issues (Litman, 2021). While a minority (34%) viewed transitioning as an important part of their personal journey, regret was substantial (79,8%), with nearly two-thirds reporting that given their current knowledge, they would not have chosen medical transition (Litman, 2021).

Qualitative studies further illustrate the complex experiences of detransitioners, noting that many initially expected medical transition to alleviate GD and general psychological distress, and experienced a temporary sense of relief or euphoria (MacKinnon et al., 2023; Sanders et al., 2023). However, over time, a growing sense of unease and self-alienation emerged, with individuals describing feelings of inauthenticity or of concealing their true selves – experiences that often gave rise to shame (Sanders et al., 2023). Congruently, several detransitioners have retrospectively interpreted their transition as an attempt to be someone different from themselves in an effort to escape

their past, hypothesizing that what they perceived as GD could have been influenced by broader psychological and external factors (MacKinnon et al., 2023; Sanders et al., 2023; Sansfaçon et al., 2024).

Gould et al. (2023) studied detransitioners with co-occurring mental health conditions and found that participants did not discredit their GD symptoms by attributing them to underlying mental health conditions. Instead, many expressed that even if their GD was rooted in past trauma and consequent patterns of thinking/feeling, the experience of dysphoria and corporeal discomfort was real and deeply distressful (Gould et al., 2023). Participants also reflected on how their distress was a valid response to extreme circumstances and suggested that care pathways should include broader, more holistic options beyond exclusively gender-affirming interventions (Gould et al., 2023). For many, detransition followed therapeutic work that fostered greater self-awareness, leading to the realization that medical transition did not fully resolve their underlying distress (Gould et al., 2023; MacKinnon et al., 2023) For these individuals, detransition represented a return to authenticity (Gould et al., 2023).

Detransitioners have also voiced how societal norms about gender and a medical system oriented towards binary, transnormative transitions shaped their decision to transition (MacKinnon et al., 2023; Sansfaçon et al., 2024). Some of them later experienced reverse dysphoria from HRT and came to feel that transitioning constrained, rather than liberated, their authentic expression of masculinity and femininity (MacKinnon et al., 2023; Sanders et al., 2023). This highlights how transition can shift the pressure from conforming to the gender social norms of the natal sex to the opposite sex (Sanders et al., 2023; Sansfaçon et al., 2024). Sexuality also emerged as a key theme in these narratives with some detransitioners reporting that internalized homophobia and normative beliefs about heterosexual relationships influenced their identification as transgender (Sansfaçon et al., 2024). For instance, some equated same-sex attraction with being of the “other” gender or found that behaving like the opposite gender enhanced romantic prospects (Sansfaçon et al., 2024). However, after transitioning, the adoption of a heterosexual identity felt disconnected from their true sense of self (Sansfaçon et al., 2024). As such, after a continued struggle with authentic gender and sexual expression, many began a process of deconstructing and redefining gender, sexuality and self-expression away from society's constraints (Sansfaçon et al., 2024). This process contributed to a reduction in feelings of GD and facilitated a greater sense of ease in self-

expression, with some individuals describing detransition as a form of liberation from societal expectations (Sanders et al., 2023; Sansfaçon et al., 2024). Together, these findings highlight how heteronormativity continues to shape identity development, the medical system and the care provided for TGD individuals (MacKinnon et al., 2023).

Studies have shown that these insights often emerged retrospectively, with many detransitioners expressing a wish that their motivations and underlying psychological concerns had been more thoroughly explored prior to initiating medical gender-affirming interventions (Jorgensen, 2023; MacKinnon et al., 2023; Sanders et al., 2023; Expósito-Campos et al., 2024). Interestingly, however, several also acknowledged that even if such support had been offered, it might have been difficult to dissuade them from pursuing transition, even if ultimately it wasn't the right decision (Expósito-Campos et al., 2024).

The process of detransitioning and the experience of regret following medical transition carry significant traumatic potential, with profound implications for mental, emotional, social, and bodily well-being (Cohn, 2023; Sanders et al., 2023). On a social level, detransitioners frequently report feelings of isolation, stigma, and the loss of friendships and community support, including from healthcare professionals and the broader LGBTQ+ community (Expósito-Campos et al., 2024; Sanders et al., 2023). A notable concern is that many do not return to the clinics where they initially transitioned, citing shame, fear of judgment, or a perceived lack of openness from clinicians to engage with experiences of regret or reversal (Jorgensen, 2023; MacKinnon, 2023; Withers, 2020). As a result, individuals often resort to informal online support groups and may discontinue HRT without medical supervision (Jorgensen, 2023).

In terms of physical consequences, detransitioners may face enduring challenges related to the irreversible effects of HRT and gender-affirming surgeries, such as infertility, loss or alteration of sexual function, changes to primary and secondary sex characteristics (e.g., voice, hair distribution), and long-term hormone dependency (Cohn, 2023). These bodily changes often serve as painful reminders of past decisions, complicating the grieving process for one's pre-transition self (Sanders et al., 2023). Many detransitioners express concerns about their future capacity for romantic relationships, and report deep fears of being undesirable or unlovable in their altered bodies (Sanders et al., 2023). Moreover, disruptions to physical embodiment can undermine feelings of gendered belonging and contribute to severe emotional distress, including anxiety, social withdrawal, and despair (Sanders et al., 2023).

Detransition associated with regret often brings together a complex array of emotions, including anger, confusion, shame and grief – even when detransition proves to be the right decision (Cohn, 2023; MacKinnon et al., 2023; Expósito-Campos et al., 2024). This experience is accompanied by specific psychological, social, legal and medical support needs that remain significantly understudied (Vandenbussche, 2022). As such, the potential risk of regret should be given careful consideration when making decisions that may be irreversible (Gribble et al., 2023). Even so, case studies of detransition often report that alternative options to medical care and the possibility of future regret were not explored as a possibility (Marchiano, 2017; Guerra et al., 2020; Gribble et al., 2023).

Present study

In recent years, there has been increasing awareness of gender detransition; however, research in this area remains limited and many aspects are still poorly understood (Guerra et al., 2020; MacKinnon et al., 2023). Existing studies often rely on small sample sizes due to the challenges of reaching this low-visibility and highly stigmatized group (Expósito-Campos et al., 2024). As such, researchers frequently employ snowball and convenience sampling strategies and recruit participants through online platforms such as Reddit (MacKinnon et al., 2023). Given these methodological constraints, qualitative approaches are commonly adopted, as they prioritize rich, in-depth narratives and do not require large sample sizes (Expósito-Campos et al., 2024).

Although individual case studies have been published, there remains a lack of qualitative research that systematically collects and analyzes multiple clinicians' perspectives on their therapeutic work with individuals who have detransitioned. As such, this study seeks to address this gap and to identify the most relevant themes that emerge during clinical practice; to examine whether GD is perceived to serve a psychological function; to explore the emotional experiences and challenges encountered throughout the detransition process; and to capture clinicians' reflections on the GACM after working directly with this population.

Starting from the research question "What factors underlie core gender detransition and does the Gender-Affirming Model of Care account for them in its practices?", the present study strives to deepen our understanding of the nuanced and

multifaceted phenomenon of core and regretful detransition by exploring psychologists' experiences of working with this population.

From a theoretical perspective, this study contributes to a better understanding of core and regret-related detransition, as well as the psychological processes that may accompany them. Clinically, it offers valuable insights into the specific dynamics, thematic patterns, and therapeutic strategies that can be relevant to supporting individuals who detransition. More broadly, it may also help challenge social and medical stigma surrounding detransition, foster greater trust in mental health professionals among this population, and provide a sense of hope and understanding to those questioning their transition.

Moreover, the study aims to identify underlying factors that may contribute to distress related to gender identity, embodiment, and social presentation. Gaining insight into these dynamics is particularly relevant for informing clinical assessment and support practices, as it may enable clinicians to engage in more comprehensive psychological explorations. In doing so, the study aspires not only to enhance the quality of care provided to individuals experiencing gender-related distress, but also to potentially reduce the incidence of regret and detransition.

In this context, the study has two main objectives: (1) to explore clinicians' experiences of working with detransitioners, focusing on the most recurrent themes and psychological patterns encountered in therapy and the patients' emotional experience; and (2) to examine aspects that may not be adequately addressed by the GACM in light of the recent increase in detransition cases.

Methods

Study design

The present study adopts an exploratory qualitative design (Braun & Clarke, 2006), aiming to investigate participants' nuanced clinical experiences with detransitioned individuals and to examine their professional perspectives on the GAMC as informed by their therapeutic work with this population.

Participants

Given the specificity of its research focus and the narrow participant profile required, this study employed a convenience and snowball sampling strategy (Expósito-Campos et al., 2024; MacKinnon et al., 2023).

The inclusion criteria for participants were as follows: 1) holding a professional license as a psychologist; 2) being proficient in either Portuguese or English; 3) having provided clinical care to at least one detransition case in which the individual had previously undergone both social and medical transition; 4) the patient's detransition must have been associated with regret or desistance from the transgender identity.

The exclusion criteria were: 1) clinicians whose experience was limited to patients who only socially transitioned and then detransitioned; 2) clinicians whose patients were merely questioning their transition; 3) clinicians whose patients detransitioned solely due to external circumstances (e.g., family pressure, social stigma).

The final sample comprised five clinical psychologists based in the United Kingdom and Portugal. All participants work in private practice settings, have completed degrees in clinical psychology and have undertaken additional training in psychotherapy. Each reported on their professional experience working with individuals who detransitioned. Participants reported on clinical cases from their professional practice and, together, they accompanied 41 individuals who underwent detransition. Of these, 32 were natal females and 9 were natal males.

Table 1 represents participants main characteristics – names have been altered to preserve anonymity.

Table 1

Participant Demographic and Professional Characteristics

Participant	Age	Nationality	Relationship Status	Socioeconomic Status	Employment Site	Degree and Training
Emily	45	British	Single	€25,000–€50,000	Private practice	PhD; CBT, Systemic and Psychodynamic
Catherine	47	British	Married	€25,000–€50,000	Private practice	PhD; Group Analytic

George	37	Greek and British	Single	€50,000+	Private practice	PhD; Systemic & Family Psychotherapy
Jane	47	British	Married	€50,000+	Private practice	PhD; CBT, Systemic and Psychodynamic
Teresa	53	Portuguese	Married	€25,000–€50,000	Private practice	MSc; Relational Psychoanalysis and Psychogerontology

Table 2 shows a characterization of the cases participants reported on.

Table 2

Participants' cases characterization

Participant name	Number of detransition cases	Natal sex	Age range	Diagnoses
Emily	8	All female	16–20 (4); 21–45 (4)	Gender dysphoria (8); Substance abuse (1); Body dysphoria (1); Depressive disorders (5); Anxiety (7); Eating disorders (3)
Catherine	4	All male	16–20 (1); 21–45 (2); 45–65+ (1)	Gender dysphoria (3); Substance abuse (1); Autism (2); Anxiety (2); Personality disorder (1)
George	20	15 females; 5 males	10–65+	Gender dysphoria (20); Substance abuse (1); Body dysmorphia (2); PTSD (4); Depressive disorders (14); Anxiety (14); Personality disorders (5); Eating disorders (8); Autism (14); Bipolar disorder (3)
Jane	8	All female	21–45 (8)	Gender dysphoria (8); Substance abuse (2); Body dysphoria (1); PTSD (1); Depressive disorders (3); Anxiety (3); Eating disorder (1); Autism (2)
Inês	1	Female	21–45	Gender dysphoria; Depression

Material

A sociodemographic questionnaire was administered via Google Forms, in which participants provided information on their age, nationality, country of residence, sex, socioeconomic status, health status, marital status, academic background, theoretical orientation, and employment setting. Additional questions focused on the characteristics of the detransitioned individuals they had accompanied, including natal sex, age range, and any relevant diagnoses.

Following this, a semi-structured interview was conducted. This method was selected given the exploratory nature of the research and the limited existing literature on the topic. The semi-structured format also allowed for follow-up questions, which helped to deepen understanding of participants' professional perspectives and clinical experiences.

The interview questions were designed to address the research question and its objectives by capturing participants' clinical insights and lived-in experiences with detransition cases, as well as their perspectives on the Gender-Affirming Model of Care (GAMC) informed by this practice. Accordingly, the interview comprised six core questions: 1) "Which themes do you consider to be the most relevant on the detransition cases you worked on?"; 2) "Do you consider the identification with the opposite gender and the experience of GD, if present, had a function? If so, in what way?"; 3) "What were the main challenges in the detransitioning process for your patients?"; 4) "How would you describe your patient's emotional experience throughout the process of detransitioning?"; 5) "Considering your clinical experience with these cases, what's your opinion on the Gender Affirming Care Model and the way it's being implemented?" and 6) "Do you believe there to be crucial points that aren't being considered in the GACM? If so, what are they and what suggestions would you make based on them?".

Procedure

Sample recruitment took place between November and February 2025 through online platforms, including LinkedIn, Reddit, and email. All participants signed an informed consent form that ensured confidentiality, anonymity, and their right to withdraw from the study at any point during the interview or within ten days afterward (see Attachment 1). To facilitate deeper reflection, the interview questions were shared

with participants in advance, and the beginning of each interview was reserved for addressing any questions or concerns they might have.

The interviews were conducted online via the Zoom Meetings platform and lasted up to 45 minutes. Each interview was audio recorded, manually transcribed by the researcher, and subsequently deleted to protect participant privacy. To ensure anonymity, each transcript was labeled with a randomly assigned participant number.

Data Analysis

Reflexive Thematic Analysis (RTA) is a qualitative methodology that aims to identify and analyze patterns within the dataset (Braun & Clarke, 2006). Themes, in RTA, are thought of as sharing meanings organized around a central subject (Braun & Clarke, 2006). What distinguishes RTA from other forms of thematic analysis is its theoretical flexibility, allowing it to be applied across various theoretical frameworks, and its emphasis on reflexivity, which acknowledges the active role of the researcher, including their subjectivity and interpretative role (Braun & Clarke, 2006).

After the interviews were transcribed *in verbatim*, the analysis was conducted inductively, meaning that codes and themes were driven by the data itself. Both semantic and latent coding approaches were used: descriptive codes reflected the explicit content of participants' statements, while interpretative codes explored underlying meanings. When identifying themes relevant to the research, consideration was given not only to their recurrence but also to their significance in addressing the research question (Braun & Clarke, 2006).

Braun and Clarke (2006) outline a six-step process for thematic analysis: (1) familiarization with the data; (2) coding; (3) generating initial themes; (4) developing and reviewing themes; (5) refining, defining, and naming themes; and (6) writing up. This study followed these steps carefully to capture the key patterns and meanings related to the research question.

Given that the researcher conducted both the interview design and the interviews themselves, immersion in the data began early. Repeated listening to recordings during transcription further enhanced familiarity prior to formal analysis.

Coding was performed line-by-line throughout the transcripts and revised multiple times to ensure that codes were meaningful and captured both explicit statements and implicit meanings. Due to the psychological complexity of the subject, codes often took the form of full sentences to encompass the nuances within the data (Braun & Clarke, 2006).

The codes were then aggregated in themes through their commonalities and shared patterns of thought, in an iterative process that involved revisiting the raw data, codes, and emerging patterns. Thematic maps were used to visualize and organize the researchers' understanding of the data and the relationship between ideas. Through this process emerged overarching themes, themes, and sub-themes until theoretical saturation was reached (Braun & Clarke, 2006).. These were reviewed and discussed with two researchers until agreement upon the themes was reached.

The last step involved writing detailed descriptions of each theme, illustrating them with quotes from the data, which were transcribed *in verbatim*, to ensure fidelity to participants' original ideas.

Results

Three different analyses were conducted on data gathered. The first analysis concerned the most relevant thematics and psychological dynamics present in the therapeutic process with the detransitioners. The second analysis focused on encapsulating the experience of detransition, having in consideration its emotional, physical and social aspects and well-being perspectives. Lastly, the third analysis regarded participants' perspectives on the GAMC after having worked with detransitioners and their recommendations based on such work.

Objective 1: To explore clinicians' experiences of working with detransitioners, focusing on the most recurrent themes and psychological patterns encountered in therapy and the patients' emotional experience

Three overarching themes emerged from the first analyses: 1) Social Dimensions; 2) Psychological Dimensions; and 3) Sexuality and Body.

Social Dimensions include three themes: 1.1) Feeling different; 1.2) Relational Patterns; and 1.3) Online community integration.

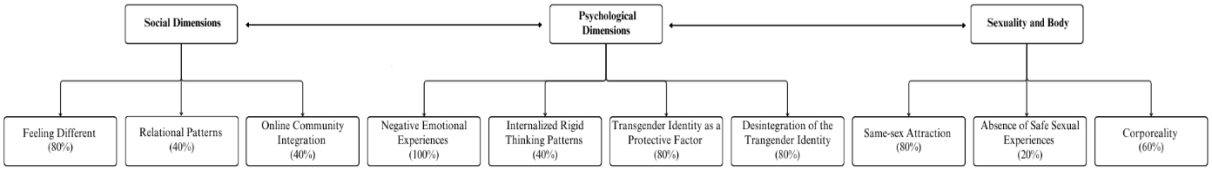
Psychological Dimensions include four themes: 2.1) Negative emotional experiences; 2.2) Internalized rigid thinking patterns; 2.3) Transgender identity as a protective factor; and 2.4) Disintegration of the transgender identity.

Sexuality and body include three themes: 3.1) Same-sex attraction; 3.2) Absence of safe sexual experiences; and 3.3) Corporeality.

A thematic map was elaborated (Figure 1) for a clearer view of the interconnectedness of the themes.

Figure 1

Conceptual Map of the Themes and Psychological Dynamics of the Transition/Detransition Process



1. **Social Dimensions**

1.1 Feeling different (80% of occurrence)

This theme regards how one of the most relevant and present thematics in the therapeutic process with detransitioners was their experience of not fitting into society's gender stereotypes, feeling different from others of the same sex prior to their transition:

> "Something about feeling very different and having a very different experience of people of the same sex, so feeling very different from other girls, having a very different experience of themselves and of life" (Emily, 8 cases);

> "these are really bright women who wouldn't have fitted into normal sexed stereotypes in adolescents" (Jane, 8 cases).

Participants also expressed how there were significant experiences of and of social isolation bullying in their patients' stories:

> “All of them had been bullied” (Jane, 8 cases);
>
> “I think maybe something about feeling quite alienated and finding it different to fit in at school or into a peer group” (Emily, 8 cases).

Some participants hypothesized that the sense of being different, along with the social rejection, may have served as a contributing factor to their patients’ experiences of gender and corporeal distress. This perceived difference could have shaped the patients’ self-conceptualization and understanding of their identities: “growing up when you don't have an alternative narrative and people telling you it's okay not to fit in a box and it's okay not to really be like the other girls or other boys often people get this narrative that there's something faulty in their body” (George, 20 cases).

1.2 Relational patterns (40% of occurrence)

This theme explores how people’s expectations of an individual, together with the relational patterns present in their personal life, can shape self-perception and the sense of embodiment. Catherine conveyed how for the detransitioners she accompanied the expectation from others and their social relations were a terrifying and castrating place, where they had to submit themselves to the mind of others: “for the other person, I don't think they ever experienced gender dysphoria, but in a way they became aware they were preferred socially and in the family unit when they expressed themselves as female” and “I would say a theme is people don't trust themselves (...) people trust the minds of others more than themselves, so part of the therapeutic process is okay how do you trust yourself better”.

On the other hand, Emily highlights how social relationships can also function as a safe and nurturing space in which individuals may explore and discover themselves, thereby serving as a protective factor: “I do think one of the things I've notice is that it tends to be friendships or romantic relationships that seem to be something that really help my clients feel good about themselves and feel comfortable in themselves, it seems to be friendships, relationships that are something that can really make a big difference, I don’t think that's something I really appreciated before I started working with this group”.

1.3 Online community integration (40% occurrence)

This theme encapsulates how participation in online communities constituted an important aspect of early adolescence for some detransitioners, as these spaces offered the validation and understanding of their identities that they were unable to find in their everyday offline lives:

> "finding stuff online about gender dysphoria and connecting with that and kind of seeing a way to make sense of their experiences of feeling so different from girls their age" (Emily, 8 cases).

2. Psychological Dimensions

2.1 Negative emotional experiences (100% of occurrence)

According to the participants, one of the most prominent psychological characteristics observed among detransitioners during the therapeutic process was the baseline of pervasive negative emotional experiences. These included feelings of being unloved, as well as shame, guilt, sadness, invisibility, and confusion:

> "there's a kind of depressive sadness, a dissatisfaction with life and something that seems to be pervasive is a certain confusion, confusion about who they are, explicitly who I am and how I did I get here" (Luísa, 1 case);

> "in everybody eventually there has been specific incidents that they feel deeply ashamed about whether its sexual assault or an experience of abandonment but I would say there is a more general predisposition for shame and there's definitely a kind of an experience of the world not being very interested in what it feels like to be them and that being experienced as shameful" (Catherine, 4 cases).

Furthermore, all participants reported the presence of complex trauma in the cases they accompanied. These experiences ranged from the absence of a stable home during childhood, an unstable, unhealthy, and unsafe family environment and disruptive emotional heritage to experiences of sexual abuse:

> "I maintain that the issue is a lack of love, everything stems from that first absence: unbalanced and unsafe family relationships and poorly developed emotional ties" (Luísa, 1 case);

> “Sexual abuse, not in all of them but in two of them it was very very striking. One of the detransitioners I've worked with had been sexually abused by a medical professional and I felt that was really significant given the whole story of medicalization and how they made sense of that medicalization, so the trauma was sexual abuse” (Jane, 8 cases).

These experiences were understood to have contributed to the distress individuals felt toward their sexed bodies and to have influenced their desire to transition into a different bodily form:

> “So one person I think they were moving away from childhood and sexual abuse, there was a lot of shame around the body and sex and desire but also a real wish to not remember, transition it made things worse not better, there was a period where things better and then it got worse again.” (Catherine, 4 cases)

2.2 Internalized rigid thinking patterns (40% of occurrence)

This theme concerns participants’ observations that their patients exhibited rigid patterns of thinking as a common psychological characteristic, which they hypothesized might originate from past traumas and relational patterns. As Catherine explained “there is often a quite kind of all or nothing way of thinking, which for me links to shame to be honest, it's like a fear response there, so something it's gonna be or has to feel completely fine or it's gonna be overwhelming and terrible.”.

Although this rigidity was observed consistently across various aspects of their patients' lives, participants noted that it appeared particularly prominent when it came to social gender stereotypes: “what they have in common is, you know, societies stereotyping about how a female bodied person should be and a male bodied person should be so, I think through my work with detransitioners I’ve realized that for different reasons people have really struggled with that” (George, 20 cases).

Participants conceptualized this rigidity as a key factor in the development of the transgender identities: “It’s gender roles, but it's in a specific way. Sometimes it's okay for women to be angry, it's men that are dangerous when they're angry. So there's a kind of an identification with the female body, also it's not okay for maybe men to have libido, to have sex drive, that's something that is acceptable in women”; “I think it’s almost like there's two incompatible truths going on for the person and that solves the problem. So

being the opposite sex solves the problem, I'm male and I have feelings and that's incompatible so I will be female" (Catherine, 4 cases).

2.3 Transgender identity as a protective factor (80% of occurrence)

This theme explores how participants conceptualized the transgender identity to function as a way of meeting psychological emotional needs, for individuals to feel safe or, perhaps, to claim traits they possessed that are culturally associated with the opposite sex:

> "So I believe it played these two roles, first a defensive response of hope, of resolving the agitation, the emptiness, the internal chaos"; "An attempt to find a safe place and depositing onto gender or gender difference the hope of finding that safe place" (Luísa, 1 case).

> "In terms of how the cross-sex gender identity functioned, firstly for the women who had been sexually abused, identifying out of their sex I think was highly functional and actually presenting to the world as male perhaps is quite a legitimate way to avoid sexualized violence"; and "Like I said these women were bright and mocked for it and I wonder if it functioned to allow them to claim their strengths in a way that didn't lead to being belittled or seen as less than as women" (Jane, 8 cases).

Participants further explained that this process was not a rational or deliberate strategy but rather operated at a subconscious level. They noted that some detransitioners, reflecting retrospectively, expressed they felt compelled to take these actions as necessary means to survive and navigate the world around them at that time:

> "so, in a sense of kind of trying to escape male violence, subconsciously you know not logically, unconsciously potentially were trying to escape the male gaze (...)" (Jane, 8 cases).

2.4 Desintegration of the transgender identity (80% of occurrence)

This theme focuses on how, over time, the transgender identity appeared to cease fulfilling the patients' psychological and emotional needs, leading the participants' patients to begin questioning their transition and address underlying vulnerabilities:

> "After being there, the realization that that wasn't a safe place either and experiencing that place with the disappointment of after all, everything is still the same, after all, I still feel the same way" (Luísa, 1 case).

> "then, let's assume the identity stopped functioning that way, they had to find new ways to deal with the underlying vulnerabilities that had land them there, they were having to deal with maybe the underlying trauma that had been not processes whilst they were living in this way I think" (Jane, 8 cases).

This is not to say the gender and corporeal distress these people experienced was not real, as George reminds us: "Of course some of the people I worked with, they did suffer from gender dysphoria, whatever this clinically means they met all the criteria, but there were many different reasons why they suffered from that".

3. Sexuality and Body

3.1 Same-sex attraction (80% of occurrence)

Participants considered sexuality to be a key theme in the therapeutic process, for instance George explained: "how it intersects with attraction in many complex ways, how it connects with pleasure and sex".

Additionally, same-sex attraction was identified as a common characteristic among the participants' detransitioned patients and was hypothesized as a potential contributing factor to transition, particularly when considered in the context of societal gender norms:

> "I think sexuality is key (...) Most of the cases I have worked with of detransitioners have been people who are same sex attracted" (Emily, 8 cases);

> "So, just one detransitioner I have that is in their 80's, it's a male detransitioner who in the seventies was put in prison because he was caught having sex with another man in San Francisco and he enjoyed wearing dresses and being very feminine and he went down that pathway as the only way of being with men." (George, 20 cases).

3.2 Absence of safe sexual experiences (20% of occurrence)

Participants considered the absence of positive sexual experiences and the lack of opportunities for safe bodily exploration prior to undergoing gender-affirming surgeries to be a significant and meaningful factor in the therapeutic process with detransitioners who subsequently experienced regret regarding their previous surgeries. This is important as individuals' can feel differently in their bodies depending on the sexual partner and circumstances in which they engage in sexual relations; such experiences can subsequently influence the distress around the natal sexed body:

> "many people I work with who have had surgeries and then regretted it, either hadn't had any sexual experiences initially or hadn't had safe sexual experiences with people that they felt safe with their bodies. I've worked with people who felt really really uneasy with their breasts and chest in the past with certain partners and then with other partners they felt more at ease" (George, 20 cases).

3.3 Corporeality (60% of occurrence)

Participants identified body-related challenges as a central theme in the therapeutic process. These challenges encompassed difficulties with sensory processing and touch, as well as issues related to puberty and eating. Furthermore, they noted that such corporeal challenges can induce distress experiences analogous to the symptoms of GD:

> "there is something quite complicated about feeling uncomfortable in ones body when going through puberty and it can make sense to think about that through a lens of gender dysphoria and if you understand that discomfort and that hatred and those really intense feelings to your body as being gender dysphoria and then you start to feel like - well, if I can take hormones, if I can get surgery, I'd feel so much better" (Emily, 8 cases);

> "Some of the people I have worked with that have detransitioned, they had eating difficulties that gradually we know also affects people's relationship with their bodies (...) body uneasiness as a phenomenon is very common in eating disorders, it's common in trans people and it's common in people on the autistic spectrum and I think that some of the people I've worked with that are detransitioners they thought that oh I felt uneasy in my body that's a proof I'm trans - yes, that's to do with self identification but no one had spent time to think how it connects to your eating, how it connects to you sensory challenges" (George, 20 cases).

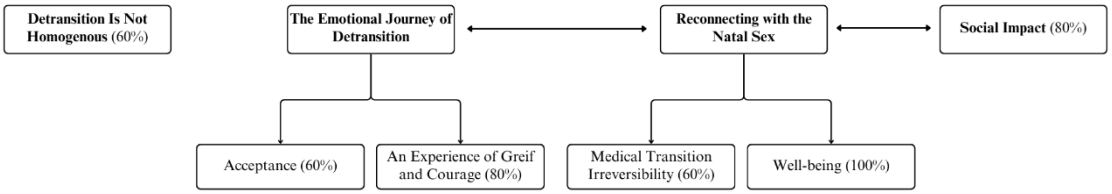
Four themes emerged from the second analysis regarding the experience of detransitioning: 1) Detransition is not homogeneous; 2) The journey of detransition; 3) Reconnecting with the natal sex; and 4) Social impact.

The emotional journey of detransition includes two sub-themes: 2.1) Acceptance; and 2.2) An experience of grief and courage.

Reconnecting with the natal sex includes two sub-themes: 3.1) Medical transition irreversibility and 3.2) Well-being.

Figure 2

Conceptual Map of the Detransition Experience



1. **Detransition is not homogenous** (60% of occurrence)

Regarding detransition, participants emphasized that it is not a homogeneous experience but rather one aspect of an individual's broader life narrative. They viewed detransitioning as the outcome of complex and highly variable circumstances unique to each person. Consequently, participants stressed the paramount importance of approaching each detransitioner as an individual with distinct experiences and needs. George explains this very clearly as he says:

> "I think it's a very diverse group of people and we also run the risk as clinicians to treat them as homogeneous, so I think as every trans person is different and every non-binary person is different but there's some commonalities, it's the same with detrans people, different experiences and different feelings for different detrans people" and "you know I would find it so problematic for me to try to tease out one subject because I think it would be very reductionist, almost like feeling like they're very simple stories for people and I think we're all very complex (...) what I see is that different things come together for different people

that has affected their relationship with their bodies and how they make sense of gender and sex and sexuality and all of that".

2. The emotional journey of detransition

2.1 Acceptance (60% of occurrence)

Participants conveyed that the decision to detransition, while often the result of an extended and introspective process, was not experienced as linear. They described it as an emotionally challenging and confusing journey, marked by the difficulty of accepting that reversing a previously strongly held belief could represent the necessary path move forward:

> "These things are always difficult because they entail going forward and backwards, forward and backwards, over and over again and there's always this feeling that somehow the advances might actually be a step back - and vice versa. So, it's hard for a person to understand exactly what's what and to make peace with it, to make peace with the idea that going backwards can now actually be a step forward. That is not an easy thing to grasp and so, above all else, I think that it is difficult in the sense that it's an experience that's hard to come to terms with, to accept it and to feel at ease with it. It's almost like the sunk cost fallacy. So much has been staked on this one card, so much has been invested in it, so many things have been placed here and now, is it really true that the positive thing to do and the way to move forward is to go back again" (Luísa, 1 case);

> "So I think it goes like in waves, sometimes things are going well and then it's a really painful time, so usually it's a long process for some of them and they might need time and they go through the waves" (George, 20 cases).

2.2 An experience of grief and courage (80% of occurrence)

Participants described detransitioning as a traumatic and profoundly painful experience for their patients. Regarding the emotional experience of their patients, they very candidly spoke about the overwhelming emotional experience their patients endured – marked by intense sadness, horror, confusion, anger, and profound regret. Bearing witness to and supporting patients through such raw and distressing emotions within the

therapeutic space led participants to recognize detransition as an extraordinary act of courage on the part of their patients:

> "It's really painful… it's really painful, it's an experience I think of grief. People have to be quite courageous, they have to learn to be self accepting and let go of any kind of perfectionism" (Catherine, 4 cases);

> "Clearly difficult, painful too, but above all it seemed to me like a very brave thing. It was frightening for them, there was doubt, courage and loneliness… I always felt that in some way, even though I tried to be present, I think the person often felt alone and ended up isolating themselves" (Luísa, 1 case).

Furthermore, participants observed that many individuals experienced significant shame in socially re-identifying with their natal sex:

> "I think there was a lot of shame having to come out as re-identifying with their birth sex and guilt because so many people had made the effort to celebrate their transness" (Jane, 8 cases);

> "the fear, the shame, the confusion of having to show up now and say it wasn't any of that" (Luísa, 1 case);

> "Some of them to come out for a second time to their peers or family, you know and I don't mean this in a bad way, some of them have really used the idea - I was born that way - to convince other people that they were trans and this had worked really well and then when they detransitioned, they feel like they need to go back and tell them oh this was not the case. So, to undo what they had said and this is a very complex process and we need to reassure them that it's okay, things change and ideas change and it's not your fault, most of the cases I tell people that it was not their fault, the whole system around them had failed them because they didn't do good enough exploration or assessment." (George, 20 cases).

3. Reconnecting with the natal sex

3.1 Medical transition irreversibility (60% of occurrence)

One of the primary challenges in the therapeutic process with detransitioners involved their re-identification with their natal sex following gender-affirming treatments

that were not fully reversible. Participants described this as an experience marked by profound regret and suffering, as detransitioners could never fully experience themselves and their bodies as they had before:

> "The other thing is the physical aspect, some people I've worked with they wish they could get back the part of their bodies they have taken away or have had surgery, sometimes bottom surgery that cannot really be undone or it can only be undone aesthetically, some people I've worked with who have been on testosterone have struggled with clitoris growth for instance" (George, 20 cases);

> "there were physical challenges, one of the young people I worked with was living in a body that was uncomfortable because of the medical transition and wanted to present as female again and was having to consider breast reconstructive surgery so, there are physical things sort of signaling to the world something that felt more like their felt identity at that point" (Jane, 8 cases).

This experience appeared to be a particularly disorienting and painful when the prior transition involved genital surgery, specially for natal men:

> "for the male detransitioners who have had bottom surgery things were really really complex because even sexual pleasure, they can never get again sexual pleasure as a male if you get what I mean, they can never do this and how do we support them to come to terms with that (...)"; "(...) they can never get a penis again, they can never get a functioning penis and so (...) it was really really hard, I mean the pain was really really strong and they didn't know who they were, so it's almost like trying to find a completely new identity, not a male one, not a fully female but being themselves and who they are away from this gender binary and stereotyping was quite tricky" (George, 20 cases).

3.2 Well-being (100% of occurrence)

Regarding their patients' well-being following detransition, participants acknowledged the process as challenging and marked by fluctuations; however, they also noted that, for some individuals, an improved state of well-being was attainable:

> "Everybody that I've worked with has arrived at a point of what I would say is integration but there's definitely suicidality drops, social life improves, sort of like

meaningful relationships are kind of re-established, people seem to be much more connected to life" (Catherine, 4 cases);

"In the immediate, relief and gradually, over time, a sense of well-being associated, it seems to me, with living something real, something more genuine" (Luísa, 1 case);

"for some people yes things have improved and for some other people they might go through a period of feeling better and then they might collapse or feel that they miss a community they had (...) So, again, sometimes yes, sometimes no and equally with trans people who transition, sometimes they do better, sometimes they do worse and so it's the same with detransitioners" (George, 20 cases).

4. **Social impacts** (80% of occurrence)

The process of detransitioning entailed significant social consequences for detransitioners, including experiences of rejection from the communities in which they were integrated and difficulties within their personal relationships:

"There's often real struggles in kind of social groups because of what you become to represent to different people, so people feel really guilty for detransitioning like they're really betraying others, so it's really complicated" (Catherine, 4 cases);

"sometimes they face a lot of ostracization from the community" (George, 20 cases);

"One of them was in a relationship with a trans woman so that had massive implications for their personal relationship because they essentially identified as a straight couple and then it was hugely complicated as you can imagine" (Jane, 8 cases).

Once more, Emily reminds us how a good support network can be especially important in cases like this: **"**I've found interestingly that having a really good friend or girlfriend can be something that can really help for a person going through detransition".

Lastly, participants noted that detransitioners frequently encounter medical stigma and that previous negative experiences with medical transition may lead them to disengage from necessary healthcare services:

"Some detransitioners have been so scared of connecting with clinicians and quite often they might reach out and they might never come to therapy because they're really really scared and I think there's something about the relationship with health authorities that has let them down" (George, 20 cases);

"so, it's issues like that or - I wanna have a reconstruction surgery but a surgeon won't take my referral because I'm a detransitioner" (Emily, 8 cases).

Objective 2: To examine aspects that may not be adequately addressed by the GACM in light of the recent increase in detransition cases

The third analysis addresses participants' perspectives of the GACM and its implementation, drawing on their clinical experiences with detransitioners. Additionally, it presents the approaches employed by participants in their practice, along with their recommendations for improving clinical care for this population.

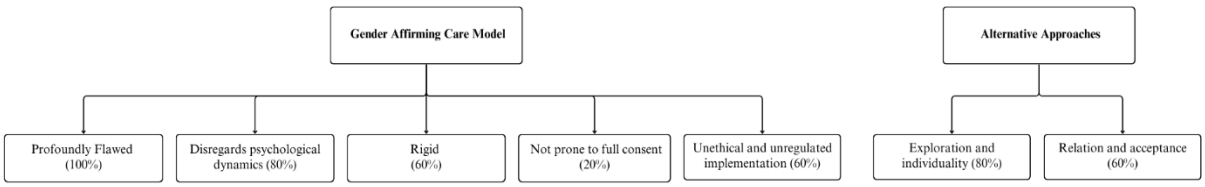
This includes two overarching themes: 1) Gender Affirming Model of Care and 2) Alternative approaches.

Gender Affirming Care Model includes five themes: 1.1) "profoundly flawed all the way through"; 1.2) Disregards psychological dynamics; 1.3) Rigid; 1.4) Not prone to full consent; and 1.5) Unethical and unregulated implementation.

Alternative approaches include two themes: 2.2) Exploration and individuality; and 2.3) Relation and acceptance.

Figure 3

Conceptual Map of the Care Models



1. Gender Affirming Model of Care

1.1 profoundly flawed (100% of occurrence)

This theme reflects participants' views that the GACM is an inappropriate framework: "I think it's naive and I think it's a sort of immature therapy model" (Catherine, 4 cases). They considered the model to lack rigorous development and to be insufficiently grounded in scientific evidence:

> "in the gender affirmative model, they have this very biological explanation that this is the only way of curing it because they were born this way but in terms of the evidence this is not really well supported by evidence." (George, 20 cases);

> "So from the very start the treatment model has been flawed essentially and not developed in a rigorous way as you would hope for a medical and psychological intervention that is so profound (...) the whole thing is incoherent and as you know, every single systematic review has been unable to find really good quality evidence or certainty, so we're still working in a world where medically it's hard to justify it" (Jane, 8 cases).

And viewed it to be taking grave risks with individuals' lives, without adequately considering the potential consequences and suffering it may cause:

> "And through working with a small group of detransitioners it makes me realize how profound the risks are that we're taking with these people and their lives. I guess I just think it makes me feel like the GACM isn't set up in a way to take care of everyone, some people are being sacrificed in order to view the model as THE right one, we're denying or haven't even looked at these peoples experiences and the significant life long impacts in order to continue to allow the model to continue to be thought of as the golden standard but I think the existence of these people and the suffering that they go through for life, it deconstructs the model. It deconstructs the idea that anybody who identifies as trans will be trans for life. Carl Popper, he says you can't prove anything you can only falsify it, so to prove that anybody who identifies as trans in childhood was gonna be trans you'd have to find every single person who'd ever identify as trans and you'd have to get 100% participation, however to falsify that you only need one who doesn't. So, it

falsifies that simple idea that is at the heart of gender affirmative treatment" (Jane, 8 cases).

1.2 Disregards Psychological Dynamics (80% of occurrence)

Participants expressed that the GACM does not provide adequate space and time for reflection on underlying issues that may contribute to individuals' body and gender distress, thereby overlooking important psychological dynamics:

> "it does not allow for reflection, profound reflection about the underlying issues the person might be living through" (Luísa, 1 case);
>
> "it also is a model that doesn't allow for sort of what I would call the unconscious experiences either, which just means that sometimes you don't know yourself very well and there's no room for error for the clinician or the person going through the experience"; "That, again is really dangerous as a part of this work, some people believe in true trans or whatever and I don't know about any of that I don't concern myself with it too much, it's somebody else's life, it's not my life I'm not gonna dictate their world view, but I certainly know that so much stuff can hide behind other things you know, you think you're working with grief and actually you're working with assault and that's normal for therapy" (Catherine, 4 cases).

Additionally, participants also felt that the model dismisses the universal human experience of reconsideration, as Catherine put it: "The other reason is there is a fantasy that people don't change their mind about things"; "people change their minds, people aren't fixed and I think it denies people that, I mean I've worked in sexual health my whole career and it's got nothing to do with being born this way or anything, people's sexuality does change. Now, I think it's all beautiful, I've just learned that actually the world is a strange place and things happen and things shift sometimes and you can be absolutely certain of something for decades and then you know, it's just not like that and so affirmation I think it's dehumanizing it's imagining that some people aren't quite human that they don't need the grace to change their minds, to make mistakes and to try something and that a gift we're all entitled to".

1.3 Rigid (60% of occurrence)

This theme addresses participants' perceptions of the GAMC model as rigid, directive and overly linear in its hypothesis, categorizing individuals based on the false

premise that experiencing gender dysphoria necessarily entails the need to transition to alleviate distress.

> "I think it is very biased and it has something very undemocratic and rigid about it because it puts people into boxes, into categories and it has to be that (...) I think it is a directive model built with a purpose." (Luísa, 1 case);
>
> "it's not helpful to start from a place of assuming that if a young person is experiencing gender dysphoria that definitely means that they're trans and that they probably should transition"; "Maybe thinking more holistically about body distress during adolescence may be more helpful than thinking about it only as potentially gender dysphoria and that if it's gender dysphoria you can only resolve that through surgeries" (Emily, 8 cases).

1.4 Not Prone to Full Consent (20% of occurrence)

Participants expressed concerns that currently the GACM lacks transparency regarding the extent of uncertainty surrounding medical interventions and their outcomes. They also consider it to be challenging both for adults and children to fully comprehend the complexities of medical care. This, along with the possibility of underlying contributors to gender and body distress, participants questioned whether the GACM facilitates truly informed consent:

> "a bit more exploration I think it's very much needed and also information that for some people medication and surgery doesn't really cure the dysphoria because we do have evidence that it doesn't cure it for everyone" (George, 20 cases);
>
> "With children I don't think there is enough evidence at all to justify the medical intervention and I don't think they have the ability, so in evidence based medical interventions values and preferences, I think a child's values and preferences has to be caveated, in that they're immature. So, if you take out values and preferences out of evidence-based medicine and you look at just the clinical consensus which is… not there and evidence base which is not there, you cannot justify this with children. With adults I think you then get into really meaty thorny debates about. Is it enough to tell them the truth? Not always, not always because if people are hooked and profoundly invested in it, they may not be in a place to truly make

balanced decisions from the information but then you can't be telling adults…" (Jane, 8 cases).

1.5 Unethical and unregulated implementation (60% of occurrences)

Regarding the systemic implementation of the GACM, participants expressed concerns about the rapid pace at which approvals for medical interventions are granted:

> "gender affirmation, even though it started from a really positive position, you know, to help people who are in distress, I think it has ended up being very unprofessional and quite unethical in terms of people using it in a really fast way, not allowing time to ask and ask again questions to help people think about really big decisions" (George, 20 cases);

> "there's obviously a lot of different pressures in clinicians working in different contexts, for example, in the clinic I worked at there was this huge waiting list, you had to get through the clients very quickly so there was a pressure to just get the people through in 4 to 6 sessions, but in privacy practice I don't have the same pressure from above as in an NHS clinic" (Emily, 8 cases).

Additionally, Catherine expressed concerns regarding the lack of consideration for clinicians' competencies and personal perspectives within the model: "lots of people work in a preformulated way, so they wanna know what the problem is and then they will offer you a solution"; "And also the affirmation model it makes no account for therapists skill, I got no doubt, like all therapies, I got no doubt that someone practicing it somewhere is gonna have a certain skill level that is just off the scale (...) but I said it sincerely before, I've been working on this area a long time and I think it's something you have to have an incredible high skill level for, you have to be in a relationship where you're really are comfortable with someone hating you full force out loud and a lot of therapist that's not even in their awareness of an experience, let alone something necessary as a therapeutic skill and lots of people are working, I sound so rude, but in sort of a shallow ways, they just wanna challenge thought and beliefs".

Lastly, participants also noted that some of their patients had been assured by the affirming clinicians involved in their transition that they would never end up detransitioners:

> “Thinking about my patients I think most of them, if not all, have said some kind of variation that they were a textbook case so they were under the impression and had the validation from the medical team that they were not people who this was not gonna work out for. I think that is really interesting, because (...) I know that most clinicians, in my experience, are not sure that the cases their working are all gonna be fine, in the gender clinic I worked in, there was much more of a conflict, the clinicians who were doing the fastest assessments were clinicians who were more of the mindset that you have the freedom to make mistakes. Obviously, the detransitioners I worked with did not go through the clinic I used to work at so it is interesting how they were given this message that they were textbox cases who would never end up in the situation they ended up with” (Emily, 8 cases).

2. Alternative approaches

2.1 Exploration and Individuality (80% of occurrence)

This theme highlights the importance participants placed on initiating the therapeutic process from a neutral and curious stance, seeking to understand each individual’s identity, emotions, and personal narrative, thereby adopting a holistic perspective on body distress. In this framework, the clinician’s role is to assist the individual in making sense of their experiences and collaboratively considering future decisions. Furthermore, participants emphasized that affirmation and medical interventions should be considered only as a last step, if deemed necessary:

> “The suggestion would be a model focused on self-discovery, personal development, and therapy, with the issue of gender being a consequence of that. I feel like gender right now is treated as a starting point rather than an endpoint, when I think it should be an endpoint… or not." (Luísa, 1 case);

> “I think you should start from a neutral space which is what I do in my private practice. I think it's possible, working one to one, I don't need to use pronouns or names, we just start with what is this young person feeling” (Emily, 8 cases)

Although exploration was regarded as an essential starting point in addressing body and gender related distress, participants also cautioned that some patients might

perceive this exploratory approach as an attempt to dissuade them from pursuing affirming care:

> "even exploration needs to happen with consent, I cannot explore without the young person or the older person joining with me and consenting so, yes many people don't come to me because they say oh he doesn't give medication straight away and he wants us to think, that's okay, its sad though (...) they think that thinking and asking them to think would be an attempt to change their mind."; "So exploration and how did they come to that realization, I tell them look my point is not to change your mind but if you were to take better decisions and to take well informed decisions I want to understand how did you come to the realization that doing this to your body, not about how you identify, I'm not getting into that now, but in terms of what you want to do with your body, how did you come to that point so, let's explore what happened there." (George, 20 cases).

2.3 Relation and Acceptance (60% of occurrence)

Building on the theme above, participants emphasized that establishing a trusting therapeutic relationship is of paramount importance, as it enables individuals to feel genuinely accepted and connected to another person, something that often appeared to be missing in these cases. This safe relational space was viewed as essential for allowing subjective experiences and narratives to unfold, thereby offering individuals the opportunity to fully explore and understand themselves, which could ultimately lead to an improved state of well-being over time.

> "(...) just trying to build trust, build a relationship and all kinds of interesting things unfold"; "What I've learnt is young people can start in a state of intense distress but with support and with containment we can get to a place where they can sort of be functional, feel okay" (Emily, 8 cases);

> "my experience of this is you go in, you start a relationship with someone and then you see what comes up in the material and then you help someone make sense of themselves" (Catherine, 4 cases).

Discussion

The current study aimed to examine what factors can underlie core gender detransition and regret from gender-affirming medical care, and whether those factors are being taken into account by the GAMC. For that purpose, five clinicians, who together have worked with 41 detransitioners, were interviewed regarding their overview of the cases they accompanied and their clinical opinion on the GACM. RTA was used to analyze the interviews, following Braun & Clarke's (2006) six step process.

Objective 1: To explore clinicians' experiences of working with detransitioners, focusing on the most recurrent themes and psychological patterns encountered in therapy and the patients' emotional experience

In terms of the most relevant thematics and psychological dynamics present in the therapeutic process with detransitioners three overarching themes emerged: Social Dimensions, Psychological Dimensions and Sexuality and Body (Figure 1). Although presented as three distinct categories, each congregating different sub-themes, these are interconnected and were conceptualized by participants as contributing to the initial gender-related distress experienced by their patients and their transition/detransition journey.

Early experiences of feeling different from others of the same sex were identified as a common theme in detransition cases. Congruently, studies have shown that people experiencing gender-related distress often feel apart from peers of the same sex and do not fit into typical gender norms (MacKinnon et al., 2023; Sanders et al., 2023). In this sense, social and cultural expectations around masculinity and femininity can foster an outsider identity early on and lead to isolation or confusion (Lemma, 2018; Marchiano, 2017; Withers, 2020).

Social isolation, peer rejection and bullying during adolescence are significant psychosocial stressors that can disrupt typical developmental processes and impair mental health (Kaltiala-Heino et al., 2018). These experiences may arise in response to gender nonconformity or simply from being perceived as different, reflecting the social enforcement of gender norms and having the potential to deepen the distress associated with being perceived as different (Kaltiala-Heino et al., 2018; Lemma, 2018; Marchiano, 2017; Withers, 2020). For some young people, particularly those struggling to find a

coherent sense of self, these difficulties may play a role in identity formation (Kaltiala-Heino et al., 2018; Lemma, 2018; Marchiano, 2017; Withers, 2020).

In this context, interpreting “being different” as GD and adopting a transgender identity can emerge as a way to make sense of one’s distress, gain access to community and affirmation, and create a more tolerable or empowered self-narrative (Kaltiala-Heino et al., 2018). Peer groups are crucial environments for identity exploration during adolescence, supporting typical development but also carrying the risk of encouraging conformity at the expense of individual growth (Spiliadis, 2019).

Moreover, social media platforms can play a significant role in shaping young people's experiences of gender identity (Marchiano, 2017). Online platforms have become spaces where personal journeys of medical transition are widely shared, often met with enthusiastic support and affirmation from virtual communities which fosters a strong sense of belonging and validation (Marchiano, 2017; Sanders et al., 2023). These platforms often reinforce self-diagnoses of gender dysphoria, with peers interpreting common adolescent experiences, such as preferring opposite-sex fashion, as signs of being transgender (Marchiano, 2017). In this digital environment, integration into trans-affirming online spaces can strongly influence how young users interpret and solidify their identities (Marchiano, 2017; Sanders et al., 2023). While supportive, these spaces sometimes reinforce rigid transition stories and discourage exploration of underlying mental health struggles, leading some individuals to present highly similar narratives when seeking care (Sanders et al., 2023).

Participants observed that their patients often grappled with internalized homophobia and restrictive gender norms linked to same-sex attraction. Research similarly indicates that discomfort with same-sex attraction may, in some cases, motivate identification with the opposite sex in an effort to manage distress rooted in internalized homophobia (D’Angelo et al., 2020; Withers, 2020). In heteronormative environments where same-sex attraction is stigmatized or misunderstood, adopting a transgender identity may offer a socially legible alternative, functioning as a coping mechanism to manage shame, confusion, or a desire for safety (D’Angelo et al., 2020; Lemma, 2018; Sansfaçon et al., 2024; Withers, 2020).

Similarly, Sansfaçon et al. (2024) found that societies pressure to conform to heteronormative and binary gender roles shaped individuals’ decisions around transition;

as for some, questioning their gender was intertwined with exploring same-sex attraction, while others reported post-transition discomfort from being perceived as cisgender and heterosexual (Sansfaçon et al., 2024). These findings underscore the importance of early clinical conversations with gender diverse youth about heteronormativity, helping individuals understand how transition may impact their sexual identity, including potential experiences of loss or invisibility (D'Angelo et al., 2020; Sansfaçon et al., 2024). Withers (2020) cautions that without these reflective conversations, clinicians risk reinforcing identities shaped by unresolved psychological struggles, potentially enacting a form of conversion through medicalization.

Participants also observed that the absence of safe and affirming sexual experiences could intensify feelings of bodily discomfort, while having a supportive partner who fostered a sense of ease sometimes facilitated greater self-understanding or alleviated distress. Delayed sexual development in adolescence may reflect underlying difficulties (Kaltiala-Heino et al., 2018). Congruently Kaltiala-Heino et al. (2018) study found that adolescents with GD typically report fewer intimate experiences and place less value on sex compared to their peers. Body-related distress and social challenges often limit opportunities for romantic and sexual experiences, with some individuals engaging in risky sexual behavior as a form of identity exploration or due to emotional vulnerability (Kaltiala-Heino et al., 2018). Experiences of sexual harassment are also more common in this group and may reinforce feelings of bodily discomfort and alienation (Kaltiala-Heino et al., 2018).

Family relational dynamics can also deeply influence gender identity formation (D'Angelo, 2024, Lemma, 2018). Participants described cases involving critical or emotionally distant parents, abusive relational patterns and rigid gender expectations. This has also been observed in current literature, for instance, D'Angelo (2024) describes a clinical case where his patient, who was transitioning from male to female, revealed a history of emotional and physical abuse from her caregivers, which occurred mostly in response to her expressions of fear, need, and vulnerability. During the therapeutic process, she began to articulate a connection between her gender identification and her developmental history, expressing the belief that had she been born a girl, her emotional sensitivity might have been accepted by her family rather than punished (D'Angelo, 2024). This reflection suggested that her identification with the opposite gender may have served as a way to manage dissociated parts of the self linked to unbearable affect and

unmet relational needs, distancing from internal states associated with shame and rejection (D'Angelo, 2024). This case, one of many in current literature (see D'Angelo, 2020; Lemma, 2018; Marchiano, 2021 for more examples), illustrates how deeply ingrained relational dynamics can contribute to the shaping of gender identity, particularly when these dynamics are infused with unresolved trauma and affective dislocation (D'Angelo, 2024).

Consistent with prior research, the present findings suggest that gender-related distress can stem from complex psychological factors, including early trauma (such as sexual abuse or neglect), emotional dysregulation, disruptive emotional heritage, attachment issues and rigid cognitive patterns (D'Angelo et al., 2020; Marchiano, 2017). Individuals facing such distress may attempt to manage internal conflict by displacing it onto the body, resulting in profound discomfort with their physical form and a belief that medical transition is necessary to alleviate psychological suffering (D'Angelo et al., 2020; Lemma, 2018). Withers (2020) illustrates this dynamic through a case in which a patient, after undergoing genital surgery, initially experienced a sense of relief as if all his anger had been cut off, only to later recognize that the procedure had not addressed the deeper emotional wounds. Here, transition was interlinked to early relational trauma, parental rejection, and autogynephilic fantasies – factors that shaped gender identification in the absence of a securely embodied sense of self (Withers, 2020). This is similar to Clarke & Spiliadis' (2019) account of a patient who came to associate her female identity with painful experiences she wished to distance herself from and who, through careful assessment, was beginning to confront and process these underlying issues.

Clinical observations suggest that many individuals with GD present with rigid psychological defenses, often struggling to reflect on their internal emotional experiences (Evans, 2025). This is congruent with this study's findings, where participants hypothesized that these rigid thinking patterns could steer from previous relational dynamics and trauma. Experiencing doubt or concern when considering a serious, life-altering decision is a hallmark of ordinary good mental health (D'Angelo et al., 2020). The absence of such reflective anxiety can be clinically significant, as psychological curiosity and the capacity for introspection are indicative of mental well-being (D'Angelo et al., 2020). If individuals are not supported in developing this capacity, their psychological distress may become externalized and channeled into a desire for concrete bodily changes, as if altering the body could resolve deeper emotional issues (Evans,

2025). This aligns with concerns that some individuals presenting with GD may resist exploration of identity formation or bodily distress, at times reacting with anger or accusations of transphobia - which can function as a defense mechanism against affective material that is not yet tolerable to confront (D'Angelo, 2024). Additionally, the participants' patients presented with several mental health concerns, possibly reflecting the underlying issues that influenced bodily and gender distress. Interestingly, 18 out of the 41 detransitioners accompanied by this study's participants were diagnosed with Autism Spectrum Disorder (ASD), a trend also observed in current research, where GD appears to be overrepresented in people with ASD (Walker & Walton, 2024).

Participants' conceptualization of the transgender identity as having a protective and organizing psychological function aligns with findings from recent case studies (Marchiano, 2021). However, the process through which this identity ceases to serve its function and begins to disintegrate has been given limited attention. Participants described how, over time, some of their patients began to question their transition due to various factors, such as disillusionment with the outcomes of medical transition, persistent mental health challenges, or a growing incongruence between internal experiences and the adopted gender identity. For some, this questioning facilitated a deeper engagement with underlying psychological vulnerabilities, leading to the decision to detransition. In other cases, the decision to detransition preceded therapeutic insight, with reflection and meaning-making emerging only afterward (Marchiano, 2021). These accounts highlight the non-linear and varied pathways of detransition, even within the typology of core gender detransition, and underscore how processes of self-understanding and decision-making unfold in complex interaction.

This study' second analysis (Figure 2), regarding the experience of detransition, offers a more nuanced perspective on the complexity and heterogeneity of the detransition process and its emotional, social and physical impacts. Participants consistently emphasized that detransition is not a uniform experience but rather the outcome of a multifaceted interplay of factors, which results in a wide range of emotional responses and personal trajectories, underscoring that no singular narrative can adequately encompass the realities of detransition (Expósito-Campos et al., 2024; Jorgensen, 2023). These findings align with existing literature, which highlights the need to approach detransition through a multifaceted and individualized lens (Expósito-Campos et al., 2024; Jorgensen, 2023).

Participants described detransition as profoundly painful and, for many of their patients, a traumatic experience. Detransition is often marked by complex and intense emotions, including regret, anger, shame, guilt and grief, as individuals begin to confront the consequences of earlier decisions (Clarke & Spiliadis, 2019; Marchiano, 2017; Gelly et al., 2024). These findings align with prior research documenting the psychological toll of irreversible medical interventions, particularly when these are later regretted (Marchiano, 2017).

Several studies have shown that there are individuals who come to recognize the psychological harm of their medical transition, leading to a deep sense of irreversible loss and mourning for aspects of their former selves that can no longer be reclaimed (Marchiano, 2017; Expósito-Campos et al., 2024). A recurring theme, both of this study and current literature, is the longing for reconciliation with one's former body or self, accompanied by the painful acknowledgment that such reconciliation is no longer possible (Marchiano, 2017). This is compounded by the psychological burden of accepting what has been done and the enduring challenge of living in an altered body that serves as a permanent reminder of such loss (Marchiano, 2017).

For instance, Gribble et al. (2023) case study of a woman who had undergone a double mastectomy as a part of transition and later detransitioned, perfectly describes the immense impact medical transition can have on future motherhood. For this woman, not being able to breastfeed was a disheartening consequence of gender transition, which led to feelings of guilt, anguish, grief and fear – especially when witnessing her infant instinctively looking for breasts she no longer had (Gribble et al., 2023). This loss of a meaningful relational and embodied aspect of motherhood compounded an already complex grieving process, which was further complicated by healthcare systems ill-equipped to recognize or address her specific needs (Gribble et al., 2023).

Even though reconstructive procedures may be available, they are often insufficient to recover what was lost, either emotionally or physically (Marchiano, 2017). To illustrate, reconstructive breast surgery cannot restore breastfeeding function, as the removal of breast tissue results in a permanent loss of biological capability (Gribble et al., 2023). These narratives highlight the long-term psychological challenges that can follow gender-affirming medical interventions (Cohn, 2023; Marchiano, 2017). Notably, participants described their patients' decision to detransition as an act of significant

courage, echoing assertions in the literature that detransitioners should be recognized as survivors (Jorgensen, 2023).

The social consequences of detransition emerged as a prominent theme in this study, reflecting patterns already identified in the existing literature that highlight how detransitioners often feel invisible, instrumentalized, silenced, or rejected, particularly within social and institutional environments that tended to minimize, dismiss, or delegitimize their experiences (Gelly et al., 2024). Such marginalization can significantly intensify emotional distress, contributing to heightened feelings of isolation and confusion during what is often a period of considerable psychological vulnerability (Gelly et al., 2024). Persistent external perceptions of being transgender – even after detransition – alongside enduring stigma and a lack of social understanding or support, can further complicate the grieving process and hinder psychological recovery (Expósito-Campos et al., 2024). Especially, when one can already experience difficulties forming a coherent gender identity or feel stuck in an in-between of genders due to the prior transition (D'Angelo et al., 2020)

A particularly distressing dimension of this social alienation is the exclusion many detransitioners experience from trans communities which previously served as critical sources of support, identity affirmation, and belonging (Gelly et al., 2024; Withers, 2020). Loss of access to these networks can result in the erosion of social foundations, leaving individuals without reliable emotional or relational support, giving rise to feelings of being alone and misunderstood (Gelly et al., 2024; Withers, 2020). Interestingly, individuals who strongly reject the existence of detransitioners can be projecting their own unacknowledged doubts, attempting to suppress in others what they cannot face themselves (Withers, 2020). When a person's identity and social connections are deeply tied to being transgender, engaging with regret or uncertainty can feel profoundly threatening (Withers, 2020).

Additionally, detransitioners have expressed significant anxiety and uncertainty about how family members, friends, and peers would react to their detransition, exacerbating the challenges of social reintegration and reinforcing feelings of alienation (Gelly et al., 2024). In this sense, some may experience shame or fear related to speaking out, either due to concerns about appearing ungrateful to medical professionals or apprehension about further rejection or criticism (Withers, 2020). As a result, many

detransitioners avoid participating in follow-up research, which can contribute to the low estimation rates of detransition (Withers, 2020).

Beyond social marginalization, participants also described how their patients experienced medical marginalization. This is consistent with existing literature indicating that detransitioners can feel betrayed and disappointed with healthcare providers who previously assured them that medical transition would alleviate their distress (D'Angelo, 2024; Evans, 2025). Reporting emotions such as fear, guilt, and shame when seeking further medical assistance and often perceiving clinicians as ill-equipped or unavailable to address their complex and evolving needs (Evans, 2025). This is understandable given that detransitioners are frequently excluded from medical discourse and clinical care frameworks, reflecting a broader institutional reluctance to acknowledge and respond to the nuanced experiences and needs of this population (D'Angelo, 2024).

In terms of well-being after detransition literature suggests that detransitioning and accepting one's biological reality can lead to reduced emotional distress and a greater sense of internal stability (Marchiano, 2021). Although this process may continue to present psychological challenges, with a lot of doubtful moments, re-engagement with reality – particularly within the context of personal relationships – combined with a clearer understanding of one's emotional truth, appears to foster a renewed sense of psychological coherence and resilience (Marchiano, 2021). Similarly, Sansfaçon et al., (2024) found that participants described detransition as a liberation from conventional gender norms, involving a rejection or redefinition of gender and the pursuit of a life beyond socially imposed expectations. This resonates with this study's observations that detransition can be experienced as a return to a more authentic way of living.

Objective 2: To examine aspects that may not be adequately addressed by the GACM in light of the recent increase in detransition cases

This study' third analysis (Figure 3) regarding clinicians' critical reflections on the GACM after having worked with detransitioners, provides new qualitative insights into what may be unaccounted for in the model. Participants were unanimous in their view that the GACM is "profoundly flawed all the way through", questioning its scientific foundation and cautioning against the potentially irreversible risks associated with

gender-affirming interventions – a perspective that aligns with concerns raised in recent systematic reviews (Cass, 2022; Ludvigsson & Ludvigsson, 2023).

The limited availability of rigorous comparative studies and the presence of possible funding biases undermine the scientific and ethical credibility of the GACM (Withers, 2020). Moreover, there remains a lack of sufficient long-term data regarding both the efficacy and potential harms of gender-affirming interventions, particularly concerning psychological well-being, cognitive development, reproductive and sexual functioning, and overall health (Jorgensen, 2023; McDeavitt et al., 2025; Withers, 2020). Congruently, several health authorities that previously endorsed medical transition for youth have shifted toward prioritizing psychotherapeutic approaches and treatment of comorbid mental health or developmental issues (Clark & Amos, 2024; Jorgensen, 2023).

Participants also viewed the GACM as overly rigid, particularly in its presumption that GD inevitably necessitates medical transition – an assumption they felt could inadvertently promote premature decisions without thorough psychological assessment. This reflects broader concerns in the literature that current clinical pathways risk becoming overly linear and protocol-driven, rather than individualized and context-sensitive (D'Angelo et al., 2020; Marchiano, 2021). Prevailing discourse on transgender identity often reinforces traditional gender stereotypes rather than challenging them, thereby perpetuating rigid gender norms under the disguise of affirmation (Marchiano, 2017). The use of gender nonconforming behavior as a justification for irreversible medical interventions raises significant ethical concerns, especially given that these same restrictive gender norms are deeply embedded within the diagnostic criteria for GD and frequently fall within the range of typical development of diverse sexualities (Marchiano, 2017). Indeed, research shows that many individuals who later identify as homosexual report experiencing GD in childhood that subsided once their sexual identity was integrated (Marchiano, 2017). Thus, a more constructive clinical framework would involve comprehensive assessment of emerging sexual orientation, critical exploration of internalized rigid gender norms, and support diverse expressions of gender while also recognizing the significance of bodily reality - prioritizing societal transformation over physical modification (Marchiano, 2017).

Another significant critique regarded informed consent, especially for minors. Participants emphasized the ethical complexities of ensuring that young people understand the lifelong implications of medical transition amidst ongoing uncertainty

about outcomes, evolving diagnostic patterns, and high rates of co-occurring conditions (Cass, 2022; Ludvigsson & Ludvigsson, 2023; Jorgensen, 2023; McDeavitt et al., 2025). They also questioned whether consent can be truly informed when unconscious psychological processes may drive the wish to transition (D'Angelo, 2024). Research shows that even among adults, emotional investment can impair balanced decision-making (D'Angelo, 2024). This aligns with testimonies from detransitioners who, in retrospect, wish they had been supported in exploring their motivations more thoroughly, even though they acknowledge they may not have been receptive to such conversations at the time (Expósito-Campos et al., 2024; Gribble et al., 2023). This critique further highlights how the current model tends to overlook the potentially life-altering and, in some cases, traumatic consequences of medical transition (D'Angelo, 2024). While future outcomes remain uncertain, it is essential to support thoughtful, reflective decision-making, including a candid exploration of the risks, unknowns, and irreversibility of medical gender-affirming interventions (D'Angelo, 2024).

Participants expressed concerns about the unregulated implementation of the GACM, particularly when shaped by systemic pressures to accelerate access to medical transition. This concern is supported by evidence that clinicians operating within high-demand services may feel pressured to abbreviate assessment processes, thereby limiting opportunities for in-depth exploration (Evans, 2025). Establishing a meaningful therapeutic alliance and gaining a comprehensive understanding of the individual's psychological and familial context often requires extended engagement over months or even years (Evans, 2025). When this is truncated, clinicians may overlook key factors, leading to inappropriate interventions and substandard care (Evans, 2025).

Participants characterized the GACM as disregarding psychological dynamics, echoing critiques that rapid affirmation protocols often overlook complex psychological and social dimensions underlying gender-related distress (Clark & Amos, 2024; D'Angelo, 2024; Marchiano, 2021). The model's limited attention to unconscious processes and the psychological complexity of identity formation, particularly how these dynamics influence experiences of bodily distress, may contribute to premature medical interventions that overlook underlying issues such as trauma, grief, anxiety, or depression (Clark & Amos, 2024; Marchiano, 2021). This tendency to misattribute psychological distress to GD is often described as diagnostic overshadowing and was also identified by

The Cass Review (2022) as a significant limitation of the GACM (Clark & Amos, 2024; Marchiano, 2021).

Many detransitioners have reported that their decision to transition was driven by internal factors, including deteriorating mental health or the recognition that their GD may have functioned as a maladaptive coping strategy in response to trauma, internalized homophobia or misogyny (Jorgensen, 2023). The model's emphasis on affirming a patient's self-declared gender identity often reduces the clinician's role to validation, a stance that stands in stark contrast to core principles of psychotherapeutic practice, which prioritize reflective engagement, symbolic exploration of distress, and the development of deeper self-understanding (D'Angelo, 2024; Marchiano, 2021). By offering a seemingly concrete solution to what may be a multifaceted and evolving psychological experience, the GACM risks foreclosing opportunities for meaningful engagement with suffering that could otherwise lead to transformative insight and personal growth (D'Angelo, 2024; Marchiano, 2021).

Clinicians working with gender-distressed individuals must remain vigilant to the role of unconscious dynamics and countertransference in their practice (Withers, 2020). As Withers (2020) notes, history offers cautionary examples of professionals endorsing invasive physical interventions to alleviate their own discomfort in the face of patient suffering (Withers, 2020). A similar dynamic may be at play in gender care today, where some clinicians may prematurely affirm or challenge a patient's wish to transition in an effort to manage their own discomfort, rather than engage in reflective therapeutic practice (Withers, 2020). Uncritical affirmation without first investigating psychological contributors risks misattributing the source of distress and offering medical interventions that may not resolve, and could exacerbate, underlying issues (D'Angelo et al., 2020).

Evidence suggests that for some individuals, GD may diminish through psychotherapeutic work addressing underlying trauma or identity struggles (D'Angelo et al., 2020). So, as an alternative to the GACM, participants advocated for a psychotherapeutic approach grounded in exploration rather than affirmation. This approach examines whether the desire to transition may be shaped by broader dynamics, consistent with established clinical models for conceptualizing and addressing psychological suffering (Blass, 2020; Clark & Amos, 2024; Evans, 2025; Spiliadis, 2019; Withers, 2020). This does not serve to pathologize transgender identities and medical transition remains an appropriate outcome for some; there is simply a recognition that GD

may sometimes hide underlying issues and so a thorough and reflective assessment process is deemed essential (Clark & Amos, 2024; Evans, 2025). Central to this approach are principles such as individuality, neutrality, relational depth and curiosity – which align with contemporary calls for nuanced, patient-centered care (Blass, 2020; Evans, 2025; Marchiano, 2021; Withers, 2020). Participants emphasized that establishing a trusting therapeutic relationship is fundamental to this process, as it fosters connection, acceptance, and safety. Such a foundation not only enables meaningful exploration but also promotes psychological well-being, integration and acceptance (Marchiano, 2021).

Regret and detransition are often minimized within the GACM, as acknowledging these outcomes challenges its core assumption that young people inherently "know who they are" and should be affirmed without question (Jorgensen, 2023). However, this premise has demonstrably failed some individuals, underscoring the need for a more nuanced, psychologically informed framework (Jorgensen, 2023). Participants emphasized that gender-related distress should be situated within the broader context of psychological medicine, as it may reflect unconscious attempts to manage internal conflict, trauma, or social pressures (Lemma, 2018; D'Angelo et al., 2020; Spiliadis, 2019). From this perspective, exploring unconscious meaning, interpersonal dynamics, sexuality, and familial or sociocultural narratives can deepen self-understanding and help clarify motivations for transition (Lemma, 2018; D'Angelo et al., 2020; Spiliadis, 2019). Clinicians thus bear an ethical responsibility to support such reflection, not to dissuade transition, but to facilitate informed, thoughtful decisions, particularly in light of the irreversible nature of medical interventions (Blass, 2020; Evans, 2025; Withers, 2020). This is especially critical prior to undertaking irreversible medical interventions, as it aligns with the ethical principle of non-maleficence or "do no harm" (D'Angelo et al., 2020; Evans, 2025). Even so, participants emphasized that this process must remain consensual, respectful of patient autonomy and avoiding coercion, in order to uphold the ethical integrity of clinical care.

Therapeutic work with detransitioners underscores the importance of sensitivity, respect and openness to complex and often contradictory emotional states such as grief, shame, sadness, anger, and confusion (Expósito-Campos et al., 2024). Helping patients process their experience, acknowledge that life may not return to a previous state and that some uncertainties may persist, identifying areas of continuity, and reestablish meaning can foster psychological healing and resilience (Expósito-Campos et al.,

2024). Acknowledging transition as part of a broader search for identity and well-being, rather than as a mistake, may also reduce shame and facilitate reintegration (Expósito-Campos et al., 2024).

Limitations

A primary limitation of the present study lies in the relatively small sample size, with only five clinicians participating in the interviews. Although these participants collectively reported on forty-one detransition cases, the sampling is not representative of the population, which constrains the generalizability of the findings. This narrow sampling scope may restrict the diversity of clinical experiences, theoretical conceptualizations of detransition, and critical perspectives on the GACM that could have emerged from a broader and more heterogeneous participant pool. Additionally, of the forty-one detransitioners discussed, only nine were natal males. Although this distribution appears to reflect the notable increase in natal females presenting with GD in recent years, the relatively small number of natal males limits the study's capacity to capture the complexity and specificity of male detransition experiences. Consequently, the findings should be interpreted with caution, particularly with regard to their applicability across different sex-based trajectories of gender identity development and detransition.

Furthermore, the geographic distribution of participants was relatively narrow with four of the five participants being based in (or primarily working with clients from) the United Kingdom, and one clinician being from Portugal. While both countries share certain healthcare practices and socio-political influences surrounding gender-affirming care, the findings are inevitably shaped by the particularities of these national contexts. As such, they may not be fully representative of clinical practices or gender-related healthcare experiences in other cultural or healthcare settings.

This study captures clinicians' interpretations of detransition experiences rather than the voices of detransitioners themselves. This feature of the study can be considered both a strength and a limitation. On one hand, it offers valuable insight into how clinicians conceptualize and respond to detransition, providing a clinical perspective that detransitioners themselves may not articulate or prioritize. On the other hand, the reliance on secondhand accounts inherently limits access to the subjective experiences, agency, and meaning-making processes of detransitioners. Furthermore, the reliance on retrospective accounts introduces the possibility of recall bias or selective emphasis, as

some clinical details or nuances may have been unintentionally omitted or shaped by the clinician's evolving theoretical orientation or reflective hindsight.

Implications of this study

This study aims to fill a gap in the literature by providing qualitative research providing insight into clinical work with detransitioners. The study examines the diverse factors that can influence the decision to detransition, explores the emotional and physical results of this process and provides clinical perspectives on the GACM after having worked with this population.

Future research should explore the experiences of detransition across diverse cultural and healthcare contexts, addressing the geographic limitations of current studies. Comparative cross-cultural investigations could elucidate how differing national policies, medical practices, and socio-political environments influence both gender identity development and detransition pathways. Given the academic formation of the participants and their rich insights, additional research on the application of psychotherapeutic models who prioritize in depth exploration, mean-making and relational aspects is deemed necessary, as it could better our understanding of identity formation and the complex psychological dynamics involved in gender-related distress and detransition.

Moreover, given the small sampling of the study and the predominance of natal females, further research is necessary to validate the findings of this study. Lastly, targeted studies on natal male detransitioners are needed to capture the potential sex-specific developmental and detransition aspects of this population.

Conclusions

This study explored the research question: "What factors underlie core gender detransition and does the Gender-Affirming Model of Care account for them in its practices?". The findings indicate that core gender detransition often emerges within a context of considerable psychological complexity, where early life experiences, unformulated emotional distress and unconscious conflicts significantly shape gender and bodily distress. These dynamics, though central to understanding the phenomenon, remain largely unaddressed within current GACM practices.

The affirmation-focused, protocol-driven structure of the GACM limits opportunities for meaningful psychological exploration and fails to engage with unconscious and developmental processes that are vital to identity formation. In doing so, it risks bypassing the very suffering it seeks to alleviate, foreclosing the possibility for individuals to understand and integrate their distress in a more enduring way. A more relational, exploratory, and psychodynamically informed model – one that allows time, tolerates uncertainty and prioritizes integration – appears far better placed to meet the needs of those navigating gender-related distress.

The understanding that gender identity and dysphoria can function as adaptive or defensive psychological strategies is not new, yet it acquires renewed urgency in light of the distress expressed by those who detransition. When medical transition becomes a concrete solution to what can potentially be a symbolic or emotional conflict, the relief it offers may prove short-lived. For some, the realization that transition has not resolved underlying distress or has become misaligned with the individuals' sense of self brings renewed and often intensified psychological struggle. In this context, detransition appears not as failure, but as a painful reengagement with unresolved psychic material.

The consequences of regret, when present, can be profound. While not universal, such experiences are rarely minor: they often carry the weight of grief, loss, shame, and anger, with far-reaching emotional, physical, and relational implications. These accounts must not be dismissed as anomalies. They highlight the necessity of clinical models that privilege meaning-making and psychological depth over rapid affirmation, particularly when irreversible interventions are at stake.

In conclusion, this research strengthens a growing body of critique against affirmation-only approaches, emphasizing the ethical and clinical importance of addressing unconscious, relational and symbolic dimensions of gender distress. Without such depth, gender care risks becoming a process that accelerates decisions without understanding their meaning, thereby compounding rather than alleviating suffering. A slower, more reflective and relationally attuned model is not only preferable but essential for ensuring that care supports individuals in building an integrated and enduring sense of self.

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Attachments

Attachment 1: Informed Consent

Instituto Universitário de Ciências Psicológicas, Sociais e da Vida

Informed consent

The present study **"*Clinicians perspectives on their detransitioning patients and the Gender Affirming Care Model – A Qualitative Study*"** incorporates the dissertation project for the Master´s Degree in Clinical Psychology, taking place at ISPA – Instituto Universitário, by the student Noah Lobão Ribeiro Soares. The scientific supervision of the study will be ensured by professor Sofia Von Humbolt.

The study aims to explore the experience of psychologists and psychotherapists with patients who have gone through the process of gender detransition. In this sense, your participation will consist of an online interview via *Zoom Meetings* with an expected duration of up to 45 minutes. In it, we will address your overview on the gender detransition cases that you have followed, in a way that the confidentiality and anonymity of the cases is never jeopardized. The interview will be audio recorded and after its transcription, it will be deleted immediately. In the transcription process, the interview will be associated with a participant number and not with your name, so that anonymity and confidentiality will be guaranteed. Only the researcher and professor Sofia will have access to the interviews transcription. Note that direct quotes from the interview may be used, but they will not be associated with you in any way. The data from this study may also be used for publishing.

Your participation is completely voluntary and you can withdraw from the study at any time during the interview and up to two weeks after it without having to give any justification. Your participation in this study has no foreseeable risks or adverse effects. Thank you for your availability and collaboration, if you have any other questions that need clarification, you can do so via email: lobaosoares@icloud.com

I declare that I have been properly informed of the studies conditions and voluntarily accept to participate:

Signature: _____ Date: _____ / _____ / 2024