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Low detransition rates among 709 adult gender-affirming therapy recipients, motives and risk factors: Results from a systematic follow-up study

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ABSTRACT

Background: Despite growing research on transgender healthcare, detransition remains understudied, particularly among adults. Estimates of detransition rates vary widely, from <1% to 30%, due to definitions and methodological differences. This study aimed to determine detransition rates among adult recipients of gender-affirming therapy (GAT) at a major gender identity clinic in Israel and identify potential risk factors.

Methods: We conducted a retrospective cohort study of 709 adult transgender individuals who sought GAT at the Transgender Health Center at Tel Aviv Sourasky Medical Center between May 2014 and December 2022. We systematically contacted those who had discontinued clinic attendance to ascertain their transition status. Detransition was self-reported, and its rate was calculated as the proportion of confirmed detransitioners among patients with known outcomes. We compared sociodemographic and clinical characteristics between detransitioners and those who continued transition elsewhere.

Results: Over a median follow-up of 58.4 months, 239 subjects (33.7%) discontinued clinic attendance. Among the 694 individuals whose outcomes were known, only 13 had detransitioned, yielding a cumulative detransition rate of 1.87% (95% CI: 0.86%–2.88%). Detransitioners were more likely to have psychiatric comorbidities ($p=0.017$), lack family support ($p=0.013$), and reside outside the Tel Aviv area ($p=0.023$). The most frequently cited reasons for detransition were family/social pressure and realization that gender dysphoria stemmed from other psychological factors. Importantly, the high clinic discontinuation rate was not indicative of treatment abandonment, as 94.2% of those who left our clinic continued their transition through community-based healthcare providers, suggesting successful integration of transgender care into general practice.

Introduction

The past two decades have seen a dramatic global rise in the number of individuals identifying as transgender and seeking medical transition (Coleman et al., 2022; Wiepjes et al., 2018). With this surge, new issues are emerging, including that of detransition, which remains under-researched but highly contentious.

Across societies and historical periods, sex and gender have not always been viewed as strictly binary. The modern distinction between biological sex and gender identity emerged in the mid-twentieth century, contributing to the understanding of gender as a spectrum rather than a

rigid category (Mukhopadhyay et al., 2023). With growing acceptance of gender-affirming care and the depathologization of gender dysphoria (American Psychiatric Association, 2013), more individuals have sought transition-related care. Transition is usually viewed as aligning one's assigned birth sex with one's gender identity through social, legal, and, in many cases, medical changes, such as hormone therapy or gender-affirming surgery (Hembree et al., 2017),

In contrast, the concept of detransition is far less harmonized, as it is often referred to using different, conflated terms such as desistance and transition interruption, (events), or regret and

gender identity rescission (feelings). A very recent review underscored these inconsistencies and called for greater clarity in how detransition is defined and studied. Its suggested nuanced definitional framework, if widely adopted, could help bridge these semantic gaps (Walls, Call, et al., 2025; Walls, Restar, et al., 2025). Despite the lack of standardized terminology, and fully aware of these limitations, we will continue to use the term “detransition” as an umbrella term throughout this paper, as it remains familiar to the intended readership. Where possible, we will aim to contextualize our findings in light of the emerging classification framework.

Detransition rates vary widely in the literature, with estimates ranging from less than 1% to as high as 30% (Cocchetti et al., 2022; Feigerlova, 2025; Gupta et al., 2023; Hall et al., 2021; Roberts et al., 2022). In addition to the terminology and classification issues mentioned above, they are also the result of different study timeframes, and methodological approaches. Some studies are single-center retrospective evaluations based on medical charts (Davies et al., 2019), while others are anonymous internet-based surveys (James et al., 2016; Turban et al., 2021; Vandebussche, 2022). Target populations also differ, with some studies focusing exclusively on children or adolescents (Boskey et al., 2025; Butler et al., 2022; Olson et al., 2022; van der Loos et al., 2022), and others including both adults and minors (Glintborg et al., 2022; Kaltiala et al., 2024; Roberts et al., 2022; Wiepjes et al., 2018).

Methodological challenges are significant. The Amsterdam cohort, from the world’s oldest and largest transgender health center, reported regret rates of 0.6% for transwomen and 0.3% for transmen among those who underwent gonadectomy. However, 36% of patients were lost to follow-up in this four-decade study (Wiepjes et al., 2018). Additionally, a web-based survey found that 24% of detransitioners did not inform their physicians of their detransition (Littman, 2021). A recent U.S. Military Healthcare System study defined treatment discontinuation as failure to refill gender-affirming hormone prescriptions for over 90 days, yielding a four-year hormone discontinuation rate of 29.8%. Discontinuation was more

common among transmasculine individuals but less frequent in those who began treatment as minors (Roberts et al., 2022).

Beyond methodological challenges, public discourse on detransition has become increasingly polarized, shaped by media coverage and politically driven narratives (Montgomery, 2019; Schneible, 2022; Showalter, 2019). While current restrictions on gender-affirming care have largely targeted minors (Movement Advancement Project, 2025), a broader climate of scrutiny is emerging. The spread of unsubstantiated claims, despite scientific evidence to the contrary (Jackson, 2023), may influence policy decisions, especially when echoed by prominent public figures (Norton, 2023; Rahman, 2024). These developments highlight the need to study detransition in a systematic manner.

Despite Israel’s active role in transgender health research (Cocchetti et al., 2022; Even Zohar et al., 2021; Yaish et al., 2021, 2023), key demographic data remain scarce. There is virtually no systematic information on the prevalence of transgender individuals, the demand for gender-affirming care, or rates of detransition and regret in the local population.

The Transgender Health Center at Tel Aviv Sourasky Medical Center has served well over 1000 adult transgender patients seeking medical transition over the past two decades. In the last 10 years, referrals have increased steeply, with annual numbers reaching up to 300 new patients since 2020. Despite being the largest clinic of its kind in Israel, the center struggles to meet this growing demand, resulting in extended wait times and patient frustration. While several specialized clinics have opened in other hospitals in recent years, the persistent shortage of appointment slots has led some patients to discontinue follow-up visits. This group may include individuals who have detransitioned, but without a systematic assessment of those lost to follow-up, detransition rates remain uncertain.

The present study aimed to provide a comprehensive evaluation of detransition rates among adult patients receiving gender-affirming therapy (GAT) at our center since 2014, offering the first systematic data on this phenomenon in Israel. Additionally, we sought to identify potential risk

factors for detransition that could be recognized during initial patient evaluation, before treatment begins, allowing for additional support throughout their gender-affirming journey.

Study design, subjects and methods

Study design and aim

This was a retrospective single-center cohort study of all new adult (≥ 18 year) subjects who presented to the Transgender Health Center within the Institute of Endocrinology, Metabolism and Hypertension at Tel Aviv Sourasky Medical Center to seek GAT between May 1, 2014, and December 1, 2022. The study was complemented by a cross-sectional survey conducted between December 2023 and December 2024, systematically tracking and contacting subjects who had discontinued clinic attendance during this period to assess detransition rates and motives. We aimed to compare the demographics of persistent clinic attenders to those who had discontinued follow-up. Additionally, among those who discontinued clinic attendance, we sought to identify specific characteristics of subjects who detransitioned that could help flag individuals likely to detransition. Although this was an exploratory study, based on our clinical experience, we expected detransition rates to be low, most likely below 3%–4%.

Study population selection

We generated a list of all adult (aged 18 years or older) subjects who visited the Transgender Health Center at Tel Aviv Sourasky Medical Center for the first time between May 1, 2014, and December 1, 2022, by searching the outpatient electronic records using ICD-9 codes compatible with a diagnosis of gender dysphoria, primarily 302.6 and 302.85, but also including 302.50, 302.51, 302.52, and 302.53 (a detail of diagnoses covered by these codes is found in the [Supplementary material](#)).

From an initial list of 828 subjects, we excluded those who had visited the clinic only once, resulting in 709 eligible subjects with two or more visits, as an indication of the intent to pursue GAT.

We identified individuals who had discontinued clinic attendance. For subjects enrolled during the later period, we considered those who had not returned to the clinic between December 31, 2022 and December 31, 2023 as disengaged from care. To assess detransition rates, we then attempted to contact all individuals meeting these criteria. After excluding 15 subjects who could not be reached (due to changes in contact information or refusal to participate), 694 individuals formed the analytic cohort for detransition outcome assessment.

Data extraction and questionnaires

All relevant outpatient electronic charts were manually reviewed, and general demographic data were retrieved for all subjects. Persons who had discontinued clinic attendance were contacted by one investigator (GG) who introduced herself, explained the purpose of the call, and requested verbal consent to ask a few questions. Subjects who reported continuing to live in their affirmed gender were asked about their current care setting (primary care physician, a different hospital-based gender clinic, or other) and their reasons for transferring care.

No rigid a priori definition of detransition was imposed. Instead, classification was based on participants' own accounts. For the purposes of this study, individuals who self-identified as having detransitioned, whether by interrupting or actively reversing the transition process, were categorized accordingly. These individuals were invited to complete a more detailed semi-structured questionnaire (see [Supplementary material](#)) designed to explore their motives and experiences. If an individual could not be reached or declined to respond, their outcome was classified as unknown.

Statistics

The primary endpoint was the rate of detransition as broadly defined above. We calculated its cumulative proportion as the number of confirmed detransitioners divided by the total number of patients with known outcomes who received treatment at the clinic during the study period. For statistical analysis, we calculated the

standard error, and derived the 95% confidence intervals, expecting the true cumulative proportion of detransitioners in the population to be included within these boundaries.

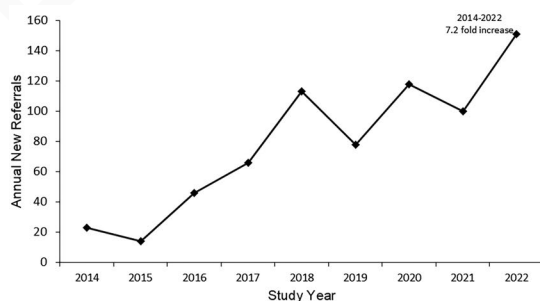
Continuous variables (demographic, clinical, etc.) are presented as mean \pm SD or median (IQR), according to their distribution, while categorical variables are expressed as frequencies and percentages.

Group comparisons were performed using t-tests for normally distributed continuous variables and Mann–Whitney tests for non-normally distributed data. Categorical variables were compared using the chi-square test, or the Fisher exact test with the Freeman–Halton extension when needed.

All statistical analyses were performed using IBM SPSS Statistics for Windows, Version 29.0 (IBM Corp., Armonk, NY), and R Version 4.4.3 (R Core Team, 2024). Statistical significance was defined as $p < 0.05$.

Ethics

The Ethics Committee of Tel Aviv Sourasky Medical Center approved this study protocol in accordance with the Declaration of Helsinki principles (approval number TLV-0755-22). For the retrospective component involving anonymized data extraction from electronic medical records, a waiver of informed consent was granted. The telephone interview portion was authorized following review of the questionnaire, with the stipulation that oral consent be obtained and documented from each contacted subject.



Results

Trends in new referrals over the study period

Consistent with global trends, new referrals to our center increased substantially, from 21 in 2014 to 151 in 2022, a 7.2-fold rise (Figure 1a).

To analyze temporal trends, we categorized the study period into three three-year intervals: 2014–2016, 2017–2019, and 2020–2022. Consistent with prior reports, we observed an increasing proportion of transmen among new referrals to our clinic, from 44.9% in the first period to 55.3% in the third. However, this shift did not reach statistical significance ($p = 0.116$, chi-square test), (Figure 1b). Age at presentation remained stable across all periods.

Comparison of subjects who continued vs. discontinued clinic attendance

Of the 709 subjects in the full cohort, 239 (33.7%) discontinued clinic attendance by the end of 2022. The primary difference between those who remained under our care and those who discontinued was the duration of follow-up in the clinic. Individuals who discontinued clinic attendance had a median follow-up of 56 months (IQR 43–71), compared to 22 months (IQR 8–43.3) among those who remained under our care ($p < 0.001$).

In line with the shift toward a larger representation of trans men in later years referrals, a higher proportion of trans men remained under regular clinic follow-up (52.1% vs. 43.1% among those who discontinued, $p = 0.023$). Age at presentation, however, was similar between groups,

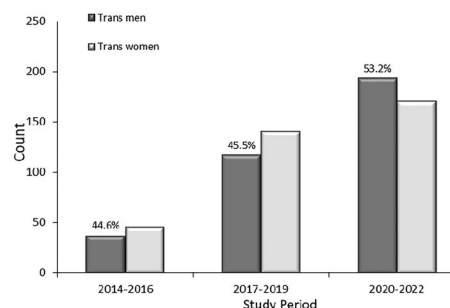


Figure 1. (a) Increase in annual new referrals to the transgender Health Center between May 2014 and December 2022. (b) Number of new referrals by study period, stratified by gender. The plot shows both the increase over time, but also the trend for a greater proportion of trans men in the later part of the study period.

with a median of 25 years (IQR 20–32) for those who discontinued attendance and 22.5 years (IQR 20–31) for those who remained under clinic care ($P=NS$). At the time of their last visit, the median age of subjects who discontinued attendance was 29.1 y (IQR 25.0–36.5).

Detransition rate and associated factors

To assess detransition rates, we attempted to contact all individuals who had discontinued clinic attendance to verify their status. As outlined in the Methods, we were unable to reach or retrieve information on 15 individuals. Among those who remained in clinic care ($n=470$), none reported discontinuing gender-affirming treatment (GAT).

Thus, detransition was analyzed in a slightly reduced cohort of 694 individuals. Of the 224 subjects successfully assessed, 211 (94.2%) reported continuing gender-affirming treatment elsewhere, while 13 (5.8%) stated they had detransitioned, yielding a cumulative detransition rate for the entire cohort of 1.87% (95% CI: 0.86%–2.88%) over a period of 58 (IQR 38.4–80.4) months. These 13 individuals were further questioned about their reasons for detransition, which will be presented in a following narrative section.

To identify factors associated with detransition, we compared socio-demographic and clinical characteristics between detransitioners ($n=13$) and those who continued treatment elsewhere ($n=211$) (Table 1). The two groups did not differ significantly in gender distribution, age at onset of dysphoria, age at presentation or at the time of the last clinic visit, referral period, marital status, birthplace, ethnic origin, education level, or employment status. Several other factors, including degree of religious observance, history of trauma or bullying, existing medical conditions, and substance abuse, were also assessed but did not reveal meaningful differences between the groups.

In contrast, detransitioners were less likely to reside in the Tel Aviv metropolitan area (38.5% vs. 61.1% among those continuing treatment, $p=0.023$). Psychiatric comorbidities were notably more prevalent among detransitioners, with virtually all individuals in this group having at least one psychiatric diagnosis at the time of referral, compared to 19.8% of those who continued treatment ($p=0.017$). Psychiatric diagnoses at presentation and follow-up, with group comparisons, are shown in Supplemental Table 1. Lack of family support was also significantly more common among those who detransitioned, with 55.5%

Table 1. Socio-demographic and clinical characteristics of subjects who discontinued clinic attendance, with breakdown between those who either persisted in their transgender identity or had detransitioned.

Variable	All $N=224$	Persevered $n=211$	Detransitioned $n=13$	P
Socio-demographic				
AFAB ^a n/N (%)	97/224 (43.3)	91/211 (43.1)	6/13 (46.2)	1.0
Age at 1st visit (y)	25 (20–32)	25 (20–32)	26 (19.5–34.5)	0.827
Referral period ^c 1/2/3 (n)	54/129/41	50/121/40	4/8/1	0.629
Israeli-born n/N (%)	199/224 (88.8)	194/211 (91.9)	12/13 (92.3)	0.963
Time since 1st visit (months) ^b	79.9 (67.4–95.1)	79.4 (67.4–94.4)	90.4 (76.9–110.4)	0.118
Single at presentation n/N (%)	179/224 (79.9)	180/211 (85.3)	11/13 (84.6)	1.0
Tel Aviv area resident n/N (%)	134/224 (59.8)	129/211 (61.1)	5/13 (38.5)	0.023
Family support none/some or full/ unknown ^c (n)	23/102/99	18/98/95	5/4/4	0.013
Clinical				
Duration of GAHT ^d (months)	79 (65–94)	79 (66–94)	12 (5.5–66)	<0.001
Gender-affirming surgeries non/any/ unknown ^c (n)	35/127/62	26/124/61	9/3/1	<0.001
Pre-existing psychiatric co-morbidity no/ yes/unknown ^b	22/99/103	22/89/100	0/11/2	0.017

Note: Comparisons between the 2 Sub-groups were done with the chi square or fisher exact tests for proportions. Continuous variables, given as median and IQR in parentheses, were compared with the Mann Whitney test.

^aAFAB: Assigned Female At Birth;

^bThis was computed between the first and the date of ascertainment;

^cThese data were retrieved both from the charts and from the subjects' accounts at the time of the interview. A sizable fraction of subjects chose not to answer these questions;

^dGAHT: Gender-Affirming Hormone Therapy duration was computed either until discontinuation, or until the time of the follow-up interview and includes subjects who had never received GAHT.

reporting no family support for their transition, compared to 16.9% of those who continued treatment ($p=0.013$). Detransitioners had notably larger intervals between clinic visits, and a significantly shorter duration of gender-affirming hormone therapy (GAHT) than those who continued treatment ($p<0.001$). Not surprisingly, detransitioners were also significantly less likely to have undergone gender-affirming surgeries, with only one-quarter having received any such procedure compared to 82.7% of those who continued treatment ($p<0.001$). A breakdown of the surgical procedures by type is shown in Figure 2.

However, there were two remarkable exceptions. One involved an assigned female at birth person who had already undergone bilateral

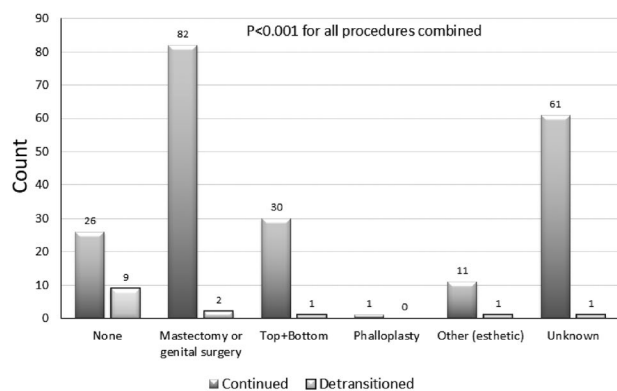
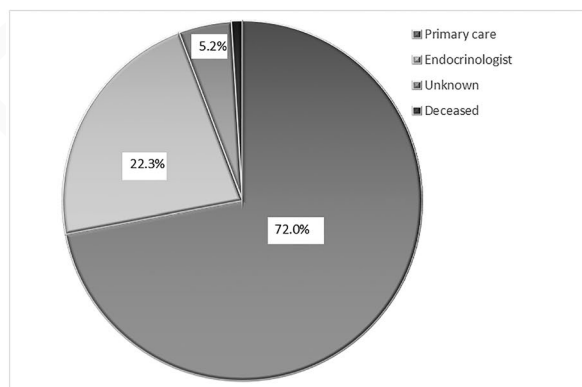


Figure 2. Number and detail of gender-affirming surgeries undergone by subjects who continued their gender transition treatment (dark grey bars), and by subjects who detransitioned (light grey bars). Persons who continued treatment underwent significantly more surgical procedures, $p<0.001$.



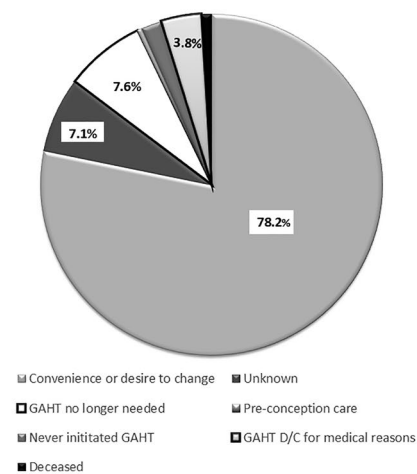
(a)

mastectomy before presenting to our clinic for initiation of GAHT at age 37. After 12 months of masculinizing hormone therapy, during which she also underwent a hysterectomy for a fibroid uterus and an oophorectomy, she decided to detransition. She subsequently underwent breast reconstruction surgery and started estrogen replacement therapy. The second case involved an assigned male at birth person who started GAHT at age 26. He underwent breast augmentation, orchiectomy and vaginoplasty at age 30, but detransitioned at age 32. He discontinued estrogen therapy and testosterone replacement therapy was initiated. He ultimately completed the detransition process by having breast implants removed at age 35.

While this univariate analysis identified three potential risk factors for detransition (lack of family support, psychiatric comorbidities, and residence far from our center), the small number of detransitioners prevented us from conducting a multivariate analysis to further assess their predictive value.

Alternative care settings and circumstances for discontinuing clinic follow-up

Most of the 211 patients who discontinued clinic attendance and did not detransition (72%) continued their treatment under the care of primary care physicians, family doctors, internists, or endocrinologists elsewhere (Figure 3a).



(b)

Figure 3. (a) Breakdown of alternative medical settings following subjects after they discontinued clinic attendance. (b) Reasons cited by subjects for discontinuing clinic attendance.

The overwhelming majority (78.2%) cited convenience as their main reason for seeking care elsewhere, mentioning a clinic closer to their residence, better appointment availability (especially in COVID times), or a desire to change physicians (Figure 3b).

Sixteen individuals (7.6%), most of whom had undergone some form of gender-affirming surgery, continued to live in their affirmed gender but no longer felt the need or desire to continue GAHT. In eight cases, GAHT was discontinued for medical reasons without prior consultation with our clinic. These included a myocardial infarction (in a 75-year-old trans woman), development of hydrocephalus requiring shunt placement, eradication of hepatitis C, or a psychiatrist's recommendation. Although these individuals maintained their transgender identity and continued to live accordingly, they felt that ongoing endocrine follow-up was no longer necessary. Four individuals had never initiated GAHT but continued to identify as transgender. One trans man stopped attending our clinic to start a family and planned to resume follow-up after giving birth.

For 15 individuals (7.1%), the specific reasons for discontinuing care at our clinic remained unclear, though we ascertained they were still receiving GAT elsewhere. Finally, two individuals (0.9%) died by suicide, but had lived in their transgender identity until their death.

Motives and circumstances for detransition: Personal narratives and framework comparison

Thirteen subjects (3 born as females and 10 as males) reported having detransitioned. Through structured interviews, we attempted to identify the primary reason for detransition and classify the cases according to the recently proposed framework by Walls, Call, et al. (2025) and Walls, Restar, et al. (2025), though in many cases, multiple factors were at work. In one instance, the individual declined to explain the circumstances that led to this decision.

The most commonly cited reason was family and social pressure (coercive regret, adaptive gender transition). Two subjects came from religious backgrounds and had no support, or worse,

could not openly identify as transgender. Four individuals reported realizing that what they had experienced was not gender dysphoria, but rather the result of trauma or confusion. These cases were typically accompanied by expressions of profound regret (identity-related regret). A couple of participants indicated that their transition had occurred too easily or without adequate psychological evaluation (intervention-related regret).

In one case, a subject reported that the knowledge of being unable to afford surgical procedures, and therefore never being able to "pass" as a man, was the driving force behind discontinuing transition, though he stated he still internally identified as a man but reverted to live as a woman (structural regret). In another case, the individual expressed the belief that, regardless of one's feelings, it is morally wrong to alter the body in which one is born (coercive regret). A more in-depth account of the motives, and some further details about these individuals are given in Supplemental Table 2. Among the 13 individuals, 3 continued to identify as transgender and 2 as non-binary, indicating that detransition did not necessarily involve a return to identifying with one's sex assigned at birth (adaptive gender transition).

Discussion

The goal of this study was to assess detransition rates in a large cohort of adult transgender individuals seen at our Transgender Health Center over the past decade. Based on prior literature and our experience (Butler et al., 2022; Davies et al., 2019; Feigerlova, 2025; Glintborg et al., 2022; Hall et al., 2021; Kaltiala et al., 2024; Olson et al., 2022; Wiepjes et al., 2018), we expected this rate to be under 10%, likely closer to 3%–4%. Over a median ascertainment period of 58.4 months, we found a detransition rate of 1.87% among 694 individuals, despite a 33.7% clinic attendance discontinuation rate.

Previous investigations in adults have relied on electronic health records or pharmacy data rather than direct patient follow-up. In contrast, our study systematically contacted individuals who had disengaged from care, allowing us to distinguish

between those who detransitioned and those who continued their transition in other settings. This approach is in line with recent calls for greater attention to patient-reported experience (Walls, Call, et al., 2025; Walls, Restar, et al., 2025).

Most studies define detransition by hormone discontinuation, a method that is practical in healthcare settings but may easily lead to overestimation, as some individuals cease hormone therapy while still identifying and living in their transgender identity (Walls, Call, et al., 2025; Walls, Restar, et al., 2025). Others use clinic disengagement as a proxy, but without follow-up, this too is unreliable. In our study, 33.7% of patients discontinued attendance, illustrating the difficulty in using this as a sole measure. The study by Gupta et al. (2023) attempted to follow up on 77 individuals who had stopped attending their clinic, but two-thirds of them could not be reached, significantly affecting the reliability of their detransition estimates.

Legal and social changes have also influenced transition and detransition patterns. Many countries now allow legal gender recognition without medical intervention, whereas before 2014, some Northern European countries required gonadectomy to change legal sex. This policy naturally led to low recorded detransition rates in studies relying on prescription databases or clinic records (Glintborg et al., 2022; Kaltiala et al., 2024; Wiepjes et al., 2018).

Research on detransition has focused mostly on children and adolescents, where follow-up is typically more complete, with rates reported between less than 1% and 6% (Boskey et al., 2025; Butler et al., 2022; Olson et al., 2022; van der Loos et al., 2022). Studies on adults are fewer and rely mostly on electronic medical records or centralized pharmacy systems rather than on direct patient follow-up. One study captured expressions of regret in electronic medical records, identifying a detransition rate of 0.47% among 3,398 adults attending National Health Service (NHS) gender identity clinics (Davies et al., 2019). Another, by Hall et al. (2021), reviewed notes from 175 adults discharged from NHS clinics and inferred a detransition rate of 6.9%, though again, this was based on chart reviews without direct patient confirmation. Studies

enrolling subjects before 2010 largely comprised adults, as medical transition was rarely available for minors prior to that (Glintborg et al., 2022; Gupta et al., 2023; Littman, 2021; Roberts et al., 2022; Wiepjes et al., 2018). Despite methodological differences, most studies report low detransition rates, typically between 0.5% and 10%, and consistent with our own 1.87% estimate.

One notable exception is the study by Roberts et al. (2022) on the U.S. military health system, which used pharmacy records to define treatment discontinuation as failure to fill a hormone prescription within 90 days. They found that 29.8% of individuals met this criterion after four years. While the authors refrained from labeling this as detransition and suggested alternative explanations, the lack of clinical context limits the insight that can be drawn from these findings.

Among the 224 subjects who discontinued clinic attendance and whose outcomes are known, the majority (211) continue to identify as transgender and receive care elsewhere. Notably, those who discontinued attendance had been under our care for more than twice as long as those who remained (median 56 months), indicating that many felt confident enough to transition to other providers after extended specialized care.

In contrast, 13 individuals reported having detransitioned, although at least 5 of them had not fully reidentified with their sex assigned at birth, and some continued to identify as transgender or non-binary. These findings are consistent with more recent research showing that detransition does not necessarily reflect regret or a reversal of gender identity (Walls, Call, et al., 2025; Walls, Restar, et al., 2025).

Their reasons given for detransition varied. The most common were family and social pressures, particularly in individuals from religious backgrounds. Others described financial barriers, regret, or a reassessment of their dysphoria as linked to trauma rather than to gender identity. These narratives suggest that in some cases, detransition may have resulted from external circumstances and might have been avoidable with better support.

We also observed some differences between those who detransitioned and those who did not. Detransitioners were more likely to lack family

support, have a psychiatric history, and reside outside the Tel Aviv area. The latter may reflect barriers in accessing specialized services. While two individuals had undergone advanced sex-reassignment surgeries while detransitioning, most had not, which is reassuring given the permanence of such procedures.

In view of the growing politicization of transgender healthcare in several countries (Aaron & Konnoth, 2025), our findings provide some empirical ground in a field often shaped by anecdote and polarized debate. The low rate of self-reported detransition in our cohort, taking into account the broad, participant-defined way in which we used the term, highlights the importance of distinguishing between leaving a particular treatment setting and the often personal and complex decisions that lead individuals to pause or adjust aspects of their transition. These findings point to the need for clearer definitions in future research and for clinical and policy decisions that are based on evidence and responsive to the diversity of experiences within trans care.

Strengths

This study is based on a large, well-defined adult cohort followed over a substantial period. We applied a structured, qualitative approach to understanding motivations for detransition, using a recently proposed framework (Walls, Call, et al., 2025; Walls, Restar, et al., 2025). The long follow-up period and the ability to assess both continuation of care and patient-reported outcomes add robustness to our findings.

Additionally, those who discontinued attendance had been under our care for more than twice as long as those who remained (median 56 months), suggesting that many felt confident enough to transition to other providers after extended specialized care.

Limitations

This study has several limitations. As a retrospective, single-center study, the findings may not be generalizable. Although our follow-up approach was more direct than studies relying on records alone, 15 individuals could not be

reached. The number of confirmed detransitioners was small, which limits subgroup analysis and statistical modeling. Finally, the classification of motives and experiences was based on self-report and mapped onto a relatively new framework that has not yet been widely adopted.

In conclusion, this study confirms that detransition is a rare outcome among adults receiving gender-affirming care, with a self-reported rate of only 1.87% over a median follow-up of nearly five years. Most individuals who discontinued clinic attendance continued their transition elsewhere, indicating that disengagement from specialized centers should not be equated with detransition. Our findings suggest that, with accessible protocols and adequate training, gender-affirming care can be delivered safely and effectively outside of specialized settings, helping meet the growing demand for inclusive, community-based care.

Authors contributions

GG: Investigation, data curation, draft review and editing. **YY:** Conceptualization, methodology, investigation, supervision, draft review and editing, project administration. **YG:** Draft review and editing, resources. **KT:** Conceptualization, methodology, supervision, formal analysis, original draft writing, draft review and editing, project administration. All authors have read and approved the final manuscript.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. For the retrospective part of the study, formal consent was not required. Telephone interviews were conducted after verbal consent was granted and documented.

AI usage statement

Artificial intelligence tools (ChatGPT, OpenAI) were used for language editing, formatting references to APA 7th style, and converting figures to the required image resolution. No AI tools were used for data analysis, interpretation, or drafting of scientific content.

Disclosure statement

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Data availability statement

The data supporting the findings of this study are not publicly available due to the sensitive nature of the material and to protect participant confidentiality. Data may be available in de-identified form from the corresponding author upon reasonable request and pending institutional and ethical approval.

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