

Levels of Satisfaction and Regret With Gender-Affirming Medical Care in Adolescence

Kristina R. Olson, PhD; G. F. Raber, BA; Natalie M. Gallagher, PhD

[+ Supplemental content](#)

IMPORTANCE There is a need to improve the evidence base for gender-affirming medical care provided to adolescents, including the experiences of those who have received this care.

OBJECTIVE To examine rates of satisfaction, regret, and continuity of care in adolescents who received puberty blockers and/or gender-affirming hormones as part of gender-affirming medical care.

DESIGN, SETTING, AND PARTICIPANTS This survey study used the 2023 online survey wave of an ongoing longitudinal study, the Trans Youth Project, among a community-based sample of transgender youth and their parents initially recruited throughout the US and Canada between 2013 and 2017. The satisfaction and regret data include responses from a youth or their parent representing 87% of the youth aged 12 years or older in the cohort who have received gender-affirming medical care (235 of 269 youths). Of these, 220 completed the 2023 survey (main sample); information about continuity of care was available for all youth. Data analysis was performed from April to August 2024.

EXPOSURE Satisfaction, regret, and continuity of care following puberty blockers or suppression and/or gender-affirming hormones.

MAIN OUTCOMES AND MEASURES Self- or parent-reported satisfaction or regret with gender-affirming care and continuation of care.

RESULTS Among the 220 youths in the main sample (mean [SD] age, 16.07 [2.40] years; 30 [14%] multiracial, non-Hispanic; 18 [8%] White, Hispanic; 155 [70%] White, non-Hispanic; 17 [8%] other race and ethnicity, including Asian, Black [Hispanic and non-Hispanic], Hispanic with unknown race, multiracial Hispanic, or Native American; gender at last interaction: 68 [31%] boys, 132 [60%] girls, 20 [9%] gender diverse, eg, nonbinary) and their parents, very high levels of satisfaction and low levels of regret with puberty blockers and gender-affirming hormones as well as high levels of continuation of care were reported. Of these 220 respondents in the main sample, 9 were regretful of having received blockers ($n = 8$) and/or hormones ($n = 3$; 2 of these individuals reported regret with both), of whom 4 have stopped all gender-affirming medical care and 1 has continued to receive blockers but plans to stop. The 4 others have continued care, suggesting that regret is not synonymous with stopping care.

CONCLUSIONS AND RELEVANCE The findings suggest that youth accessing puberty blockers and hormones as part of gender-affirming care tend to be satisfied with and not regretful of that care several years later. While regret was rare, these experiences need to be better understood.

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Author Affiliations: Department of Psychology, Princeton University, Princeton, New Jersey.

Corresponding Author: Kristina R. Olson, PhD, Princeton University, Peretsman Scully Hall, 40 Woodlands Way, Princeton, NJ 08544 (krolson@princeton.edu).

Gender-affirming medical care, which can include the use of puberty blockers, gender-affirming hormones, and/or surgery, can be an important aspect of health care for some transgender and nonbinary minors according to the American Association of Pediatrics, Endocrine Society, and American Medical Association.¹ While these youth often show elevated rates of mental health challenges before beginning gender-affirming medical care, receiving these interventions is often associated with improvements in anxiety, depression, and body image.²⁻⁵ Less is known about how satisfied or regretful youth are about the gender-affirming medical care received while they were minors. The primary objectives of the current study were to examine rates of satisfaction and regret following the administration of puberty blockers and/or gender-affirming hormones received before youth reached the age of majority.

To date, research on puberty blockers and gender-affirming hormones has primarily examined indirect assessments of satisfaction or regret. Commonly, studies report on rates of continuity or discontinuity of care. These studies typically find very low rates of early removal or stopping of puberty blockers (for example, 1.6%⁶) and low rates of discontinuation of gender-affirming hormones (for example, 2%-3%^{3,7}). However, continuation is not synonymous with satisfaction. Someone could wish they had never started treatment but feel that, given they had started, they should continue. Similarly, stopping treatment is not synonymous with regret, as in the case of someone who stops after achieving a desired effect, eg, lower voice,⁸ or someone who loses the ability to pay for care.⁹ Studies have also suggested that few individuals who receive gender-affirming medical care go on to later identify as cisgender, another potentially indirect measure of satisfaction or regret.¹⁰

Nonetheless, there are reports of individuals who regret the gender-affirming care they received.^{11,12} Complications of interpreting this literature include that (1) the majority of people in these studies received gender-affirming medical care as adults, not as adolescents, and (2) these data cannot be used to calculate how common these experiences are because the size of the broader pool from which these cases were selected is unknown. Nevertheless, this literature makes clear that there are at least some individuals accessing gender-affirming medical care who later regret it.

In the present research, our objectives were to assess satisfaction, regret, and continuity of care in an ongoing longitudinal, community-based study of youth aged 12 years and older who accessed puberty blockers and/or hormones during adolescence as part of their gender-affirming medical care.

Methods

Participants

Participants were recruited from the Trans Youth Project (TYP), a longitudinal study with an initial cohort of 317 youths. These participants were recruited into the ongoing longitudinal, community-based study between 2013 and 2017 when they were 3 to 12 years of age, at which time they had socially transi-

Key Points

Question How satisfied and/or regretful are youth after receiving puberty blockers and/or hormones provided as part of their gender-affirming medical care?

Findings In this survey study, the experiences of 220 youths who had accessed puberty blockers or hormones were detailed by the youth and/or their parents as part of an ongoing decade-long study of transgender youth. At a mean of 4.86 years after beginning blockers and 3.40 years after beginning hormones, they reported very high levels of satisfaction and low levels of regret; the overwhelming majority (97%) continued to access gender-affirming medical care.

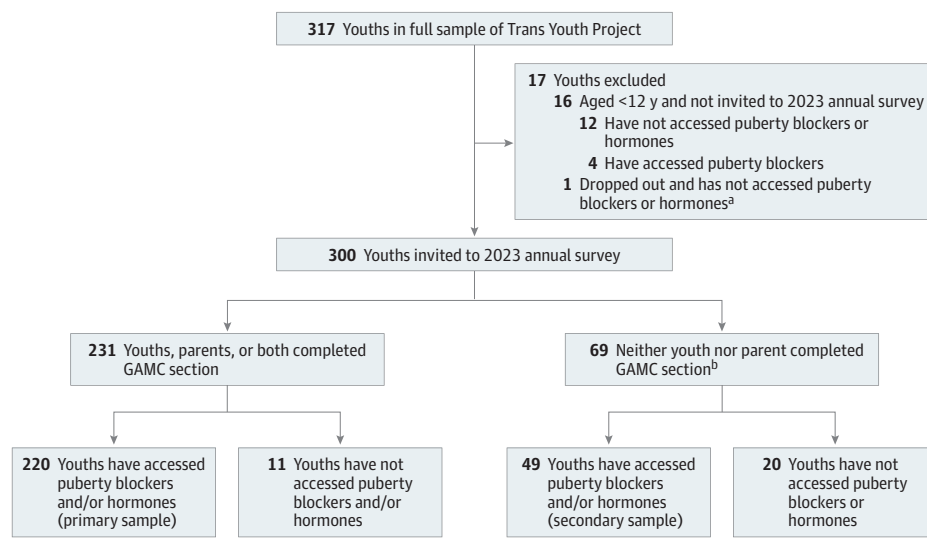
Meaning The findings suggest that most youth accessing gender-affirming medical care in adolescence are highly satisfied.

tioned. Their first participation in the study was in person so identities could be verified by the research team. Only 37 participants (12%) had begun any aspect of gender-affirming medical care prior to joining the study (1 had begun hormones and blockers; all others had begun only blockers). Participants were initially recruited through online and in-person support groups, conferences, and camps for families with gender-diverse youth, via word of mouth, and/or by finding our research via their own online searches. When participants began the study, they lived in the United States (98%) or Canada (2%). The current report used the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines for reporting observational studies.¹³

With 1 exception that occurred in March 2024, all participants completed this study between September and November 2023. All youth from the TYP who were at least 12 years old and 1 parent of each youth were invited to participate in an online survey that could be completed on their cellular phone or home computer. The minimum age of 12 years was selected because these youth were old enough to complete a 1-hour survey without a parent or researcher present. The main sample for this report includes 163 youths who have started blockers and/or hormones and reported on their own gender-affirming medical care in this wave and 57 parents who reported on the gender-affirming care of youth who did not participate in this wave and have started blockers and/or hormones ($n = 220$ unique youths; 82% of the TYP youth aged ≥ 12 years known to have started blockers and/or hormones). These youth had begun blockers a mean (SD) of 4.86 (2.42) years prior (range, 0-11 years) and had begun receiving hormones a mean (SD) of 3.40 (1.96) years prior (range, 0-8 years).

For youth aged 12 years and older who have accessed either blockers or hormones and are not in the main sample (secondary sample, $n = 49$), we relied on information from previous waves of data collection and/or contact with families (eg, email updates) until February 6, 2024, to report what is known about their satisfaction with treatment they had begun by the time of that contact. The **Figure** shows how our main and secondary samples relate to the TYP cohort overall. Demographic characteristics of both samples are displayed in **Table 1**. Race and ethnicity were determined by earliest parent report for each

Figure. Flowchart of Participant Inclusion



Information about whether a cohort member has accessed blockers and/or hormones is based on their most recent contact with the research team.

^aBoth the parents and youth in this family had dropped out of the study prior to 2023, at an age well before GAMC would be relevant.

^bThis group includes those who did not do the survey at all and those who did a partial survey but none of the gender-affirming medical care (GAMC) items.

youth; these are reported as multiracial, non-Hispanic; White, Hispanic; White, non-Hispanic; or other racial or ethnic background (groups with <10 individuals; including Asian, Black [Hispanic and non-Hispanic], Hispanic with unknown race, multiracial Hispanic, or Native American). This information was collected to allow us to understand any potential biases in the sample compared with the general US population.

In the main analyses, we include only 1 reporter per youth (youth, if they participated; parent, if the youth did not participate). This omits data from participating parents whose youth also participated. For maximal transparency, we include results from these parents in eTable 1 in [Supplement 1](#); all conclusions hold regardless of their inclusion or not in analyses.

This ongoing study is approved by the institutional review board at Princeton University. All participants—youth and parents—completed a consent form or an assent form before beginning the survey and were given the contact information of researchers if they had any questions. They were reminded they could choose to not participate at all, stop early, and/or skip any questions they did not wish to answer. Data analysis was performed from April to August 2024.

Measures

Here, we describe the questions as they were asked to youth in the main sample. Parents were asked parallel questions about their children (see eAppendix 1 in [Supplement 1](#) for exact wording). As participants were able to skip questions in the survey, not every participant in the main sample is included in every analysis (numbers are reported throughout). Further, some parents and youth did not opt in to relevant portions of the gender-affirming medical care section regarding the youth's experiences with blockers and hormones; these were considered nonresponses.

Satisfaction and Regret

Youth were asked the extent to which they were or were not happy with the intervention (1 indicated not at all happy; 7, extremely happy; we considered scores of 1-3, ie, below midpoint responses, to indicate dissatisfaction when reporting the number of participants who reported dissatisfaction on this measure) and the extent to which they regretted or did not regret receiving the intervention (1 indicated no regret; 7, strong regret; we considered scores of 5-7, ie, above midpoint responses, to indicate regret when reporting the number of participants who reported regret on this measure).

In a small number of cases, youth or parents gave difficult-to-interpret answers (eg, indicating maximum satisfaction and regret for the same treatment). We describe these cases and our treatment of them in more depth in eAppendix 2 in [Supplement 1](#). Their exact response values were used to compute measure-specific values (eg, means) reported throughout the article. However, to calculate the total number of individuals experiencing regret, their other responses (eg, written comments and response to the forced-choice question below) were considered when evaluating whether to categorize them as being a person who did or did not experience regret.

Youth were also asked to select 1 of 4 statements about their experience with each treatment: (1) "I wish I'd received them at an earlier age," (2) "I think I received them at the right age," (3) "I wish I'd received them at a later age," or (4) "I wish I'd never received them" (the latter response was considered an unambiguous indication of regret).

Side Effects, Likes, and Dislikes

Youth and their parents were asked a series of open-ended questions about side effects and complications, likes, dislikes, and unusual experiences with puberty blockers and hormones. Their responses to these questions and the associ-

Table 1. Demographic Characteristics and Gender History of the Main Sample and Secondary Sample

Characteristic	Main sample (n = 220)	Secondary sample (n = 49)
Age at most recent participation, mean (SD), y	16.07 (2.40)	15.00 (2.27)
Age at social transition, mean (SD), y	6.69 (2.17)	7.63 (2.17)
Started puberty blockers		
No. (%)	219 (100)	49 (100)
Age at starting blockers, mean (SD), y	11.22 (1.14)	11.13 (1.13)
Started gender-affirming hormones		
No. (%)	182 (83)	35 (71)
Age at starting hormones, mean (SD), y	13.25 (0.97)	13.01 (1.04)
Race/ethnicity, No. (%) ^a		
Multiracial, non-Hispanic	30 (14)	5 (10)
White, Hispanic	18 (8)	4 (8)
White, non-Hispanic	155 (70)	30 (61)
Other racial or ethnic background	17 (8)	10 (20)
Parent with bachelor's or advanced degree, No. (%) ^b	186 (85)	37 (76)
Household income >\$75 000, No. (%) ^b	151 (69)	32 (65)
Sex assigned at birth, No. (%)		
Female	79 (36)	19 (39)
Male	141 (64)	30 (61)
Gender at last interaction, No. (%) ^c		
Boy	68 (31)	18 (37)
Gender diverse, eg, nonbinary	20 (9)	5 (10)
Girl	132 (60)	26 (53)

^a Youth race and ethnicity were defined according to earliest parent report; specific race and ethnicity groups with 10 or more participants in the main or secondary sample are described with a distinct label. The "other racial or ethnic background" category includes groups with fewer than 10 individuals; this includes Asian, Black (Hispanic and non-Hispanic), Hispanic with unknown race, multiracial Hispanic, and Native American.

^b Parent education and household income were defined according to earliest parent report. If multiple parents reported this information at the same time, we used the response from the parent in more frequent contact with the research team.

^c Youth gender is defined by the most recent information (either self-report or parent report). If the most recent self-report and parent report were provided on the same date, the self-reported gender was used.

ated coding of their answers are described in eTables 2 through 7 in Supplement 1.

Statistical Analysis

Study data were stored and managed using REDCap^{14,15} tools hosted at Princeton University. Analyses were conducted in R version 4.4.0 statistical software,¹⁶ using RStudio¹⁷ with the tidyverse,¹⁸ lubridate,¹⁹ rstatix,²⁰ knitr,²¹ and kableExtra²² packages. Two-tailed $P < .05$ was considered statistically significant.

Because the satisfaction and regret ratings were not normally distributed, we report nonparametric statistics. To evaluate overall satisfaction and regret, we compared participant responses to the scale midpoint of 4 using 1-sample Wilcoxon tests. As a follow-up analysis, we used Spearman

rank-order correlations to see whether time since beginning the intervention correlated with either satisfaction or regret. These tests were not conducted on parent reports of regret about hormones, because all answering parents gave the same response, 1. Note that treating these ratings as continuous (1-7) or binary (1 [dissatisfied] vs 0 [not dissatisfied]; 1 [regretful] vs 0 [not regretful]) produced the same pattern of results.

Results

Among the 220 youths in the main sample, the mean (SD) age at most recent participation was 16.07 (2.40) years. In this sample, 30 (14%) were multiracial, non-Hispanic; 18 (8%) were White, Hispanic; 155 (70%) were White, non-Hispanic; and 17 (8%) were of other race and ethnicity. At last interaction, there were 68 boys (31%), 132 girls (60%), and 20 gender-diverse or nonbinary individuals (9%).

Satisfaction and Regret

Youth and parents reported high rates of satisfaction and low rates of regret (Table 2). Dissatisfaction with blockers was reported by 5 of 160 youths and 3 of 55 parents; regret with blockers was reported by 9 of 159 youths and 3 of 55 parents. Dissatisfaction with hormones was reported by 4 of 119 youths and 0 of 51 parents; regret with hormones was reported by 5 of 119 youths and 0 of 51 parents. Wilcoxon tests revealed that participants were statistically unlikely to express dissatisfaction or regret (Table 2). Although participants varied in how recently they had begun each intervention, time was not significantly associated with either satisfaction or regret (Table 2).

In general, most participants reported the timing being just right or expressed a wish that the intervention had begun earlier (blockers: 149 of 158 youths [94%] and 51 of 54 parents [94%]; hormones: 112 of 117 youths [96%] and 50 of 50 parents [100%]) (Table 2). Between 0% and 6% of respondents for each intervention indicated a wish that the youth had accessed this aspect of gender-affirming medical care either later or never.

Continuation of Care and Regret

Within the main sample, 214 of 220 youths (97%) reported continuing gender-affirming medical care through this study's end point (Table 3). Table 4 shows details about all youth in the main sample who have (1) stopped care or (2) shown clear regret with respect to at least 1 treatment. They are considered to have shown regret with respect to a treatment if they expressed either the wish that they had never received the treatment on the forced choice measure or a combination of regret above the scale midpoint and satisfaction below the scale midpoint.

Nine of 220 youths (4%) in the main sample demonstrated clear regret for at least 1 treatment. Of these, 4 have continued gender-affirming medical care. Four have stopped care. One is continuing care but plans to stop. In other words, regret was not always associated with stopping care, although those changes could occur later.

Table 2. Youth Satisfaction, Regret, and Evaluation of Timing With Puberty Blockers and Gender-Affirming Hormones According to Youth and Parents

Outcome	Blockers		Hormones	
	Youth (n = 162)	Parents (n = 57)	Youth (n = 129)	Parents (n = 53)
Satisfaction ^a	(n = 160)	(n = 55)	(n = 119)	(n = 51)
Score				
Mean (SD)	6.38 (1.12)	6.67 (1.25)	6.52 (1.16)	6.92 (0.27)
Median (IQR)	7 (6-7)	7 (7-7)	7 (7-7)	7 (7-7)
Dissatisfied participants, No.	5	3	4	0
1-Sample Wilcoxon test				
V	11 327.00	1480.00	6516.50	1326.00
P value	<.001	<.001	<.001	<.001
r	0.87	0.90	0.88	0.97
Spearman rank correlation between time since beginning of intervention and satisfaction, r (df)	0.09 (158)	−0.16 (53)	0.01 (117)	0.19 (49)
P value	.29	.25	.87	.18
Regret ^b	(n = 159)	(n = 55)	(n = 119)	(n = 51)
Score				
Mean (SD)	1.53 (1.33)	1.33 (1.31)	1.39 (1.22)	1.00 (0.00)
Median (IQR)	1 (1-1)	1 (1-1)	1 (1-1)	1 (1-1)
Regretful participants, No.	9	3	5	0
1-Sample Wilcoxon test				
V	514.50	59.50	267.00	NA
P value	<.001	<.001	<.001	NA
r	0.85	0.91	0.88	NA
Spearman rank correlation between time since beginning of intervention and regret, r (df)	0.04 (157)	0.11 (53)	0.10 (117)	NA
P value	.60	.41	.29	NA
Access preference, No. (%)				
Wish earlier	29 (18)	2 (4)	44 (34)	10 (19)
Correct age	120 (74)	49 (86)	68 (53)	40 (75)
Wish later	5 (3)	0	2 (2)	0
Wish never	4 (2)	3 (5)	3 (2)	0
Nonresponse	4 (2)	3 (5)	12 (9)	3 (6)

Abbreviation: NA, not applicable.

^a Satisfaction was evaluated on a scale of 1 (not at all happy) to 7 (extremely happy). Participants with scores of 1 to 3 (below the midpoint) were considered dissatisfied.

^b Regret was evaluated on a scale of 1 (no regret) to 7 (strong regret). Participants with scores of 5 to 7 (above the midpoint) were considered regretful.

Secondary Sample

The secondary sample includes the 49 members of the TYP cohort who are at least 12 years old, who are known to have started blockers and/or hormones, and about whom neither youth nor parent completed the relevant questions in 2023. Continuation of care in the secondary sample is also high (46 of 49 [94%]) (Table 3). Among these 49 youths, the mean (SD) age at most recent participation was 15.00 (2.27) years. In this sample, 5 (10%) were multiracial, non-Hispanic; 4 (8%) were White, Hispanic; 30 (61%) were White, non-Hispanic; and 10 (20%) were of other race and ethnicity. At last interaction, there were 18 boys (37%), 26 girls (53%), and 5 gender-diverse or nonbinary individuals (10%).

Eleven youths in the secondary sample reported their satisfaction with blockers and hormones in the prior annual survey (2022), using a similar satisfaction measure completed by the main sample (scale end points differed, ranging from 1 [not at all happy] to 7 [very happy]); youth were asked none of the

other questions; parents were not asked any questions on this topic). As in the main sample, means for this group were well above the midpoint: the mean (SD) score for blockers was 5.73 (1.68), and the mean (SD) score for hormones was 6.00 (1.73). Eleven youths reported on blockers and 9 youths reported on hormones; we did not include statistical testing because of the small sample size.

Of the remaining 38 cohort members known to have started blockers and/or hormones, we found that 4 had previously offered unprompted, positive comments about gender-affirming medical care (eg, from a parent: “she is now on the medical path of having her body reflect her gender identity. She is thrilled.”). None had made unprompted negative comments about this care. Of the remaining 34 youths, most of the families have remained in touch with the research team. Sixteen have been in contact since 2022; another 11 have been in contact since 2020 but have offered no specific comments about blockers or hormones.

Table 3. Continuation of Care

Outcome	Main sample	Secondary sample
Continuing gender-affirming medical care		
Participants, %	97	94
Started and continuing to use blockers, No.	35	13
Started and stopped blockers, started and continuing to use hormones, No.	63	9
Started and continuing to use blockers, started and continuing to use hormones, No.	114	23
Other continuation of care, No. ^a	2	1
Stopped care		
Participants, %	2	4
Started and stopped blockers, No.	3	1
Started and stopped blockers, started and stopped hormones, No.	2	1
Other ^b		
Participants, %	0	2
Planning to stop, No.	1	0
Unknown, No.	0	1

^a Youth are classified as "other continuation of care" if they (1) never used blockers and are currently using gender-affirming hormones (n = 1 in the main sample) or (2) used blockers, started and stopped gender-affirming hormones, and still use blockers (n = 1 in the main sample, n = 1 in the secondary sample).

^b Two youths are classified as "other," both of whom had started both blockers and hormones before detransitioning. In the main sample, the youth was in the process of detransitioning at their most recent visit with us and was planning to stop treatment. In the secondary sample, we know of the youth's detransition from an email update from the family and have no further information about their use of blockers or hormones.

Discussion

A mean (SD) of 4.86 (2.42) years after starting puberty blockers and 3.40 (1.96) years after starting hormones, a large cohort of early-transitioning transgender youth and their parents reported very high levels of satisfaction and low levels of regret with this care. The overwhelming majority have continued gender-affirming care.

A small number of youths and parents reported regret: 9 individuals (4% of participants in the main sample) expressed regret about blockers and/or hormones. Of these, 4 (2% of the main sample) have stopped all gender-affirming medical care. Four are continuing care, while 1 additional participant was continuing care at the time of the survey but was interested in stopping. While these experiences were rare, they are important for health care professionals and parents to understand to improve care for all youth, insofar as the goals of treatment are both to maximize benefit (ie, provide care that is useful, beneficial, and satisfying to people who want it) and to minimize costs (ie, reduce the number of people who regret care).

Unfortunately, our question did not differentiate between different types of regret,²³ such as regret about having received the treatment, regret about the process or outcome, or regret about the social implications. Based on participants' responses to the other questions, including their open-ended answers, we observed some individuals who expressed re-

gret over having begun treatment at all and some individuals who expressed regret about an aspect of the process of care, such as an adverse effect or developmental delay relative to their peers. Investigating these different aspects of regret is an important direction for future research.

As indicated in the additional information in eTables 2 through 7 in Supplement 1, the most common like reported by youth and parents for both blockers and hormones was experiencing the desired physical side effects (eg, starting or stopping breast development). A large percentage (38%-62%, depending on reporter and treatment) of youth and parents reported no dislikes; those who did report dislikes most commonly indicated that pain, difficulty, or a bad experience related to the method of administration of the medication (eg, insertion of an implant) was the biggest problem. When directly asked, the plurality of youth and parents said the youth experienced no side effects of either treatment.

The sample in the present work was unique in a few ways that are notable for interpretation of these results. Most showed signs of their transgender identity by 4 years of age. On average, they socially transitioned at age 6.7 years, and most were fairly binary in their gender identities and gender expressions throughout childhood.^{24,25} Early-identifying youth who are especially insistent about their identities are also more likely to socially transition in childhood²⁶ and identify as transgender or continue to show gender dysphoria in adolescence and early adulthood.^{27,28}

This early developmental trajectory, along with having high levels of parental support²⁹ and fairly normative mental health,³⁰⁻³² likely made earlier access to gender-affirming medical care possible in a way not available to youth who come out later, have less family support, or have severe underlying mental health issues. Likely as a result, the youth in the current study accessed blockers and hormones at younger ages than most youth accessing this care in the literature.²⁻⁴

This study had many distinct strengths as compared with past work. First, the study directly assessed satisfaction and regret. Second, there has been a high rate of retention of participants in this cohort over time. Even when participants did not complete this survey, we had enough information from families to examine whether they continued to receive gender-affirming care. We found evidence that at least some participants felt comfortable expressing quite negative experiences. That the research team is not and has never been involved in their medical care may contribute to their level of comfort in updating us. We have also expressed to families throughout the study our interest in tracking their outcomes regardless of identity. Further, the study design itself is prospective in that recruitment was not based on having accessed gender-affirming medical care; rather, it was based on social transition status.

Limitations

There are also limitations to this study. Some participants only received gender-affirming care quite recently. While some studies have shown that regret and detransition can sometimes happen years after receiving care,^{11,33} other studies have suggested that some people who regret their care early sometimes

Table 4. Details About Main Sample Participants Who Have Received Blockers or Hormones and Expressed Regret About at Least 1 of These Treatments or Discontinued Care

Participant No.	Regret description		Care summary	Care description	
	Blockers	Hormones		Blockers	Hormones
1	Regret	Regret	Stopped	Started and stopped	Started and stopped
2	No regret	Regret	Stopped	Started and stopped	Started and stopped
3	Regret	NA	Stopped	Started and stopped	Not started
4	Regret	NA	Stopped	Started and stopped	Not started
5	Regret	Regret	Continuing	Started and continuing	Started and continuing
6	Regret	No regret	Continuing	Started and continuing	Started and stopped
7	Regret	No regret	Continuing	Started and stopped	Started and continuing
8	Regret	No regret	Continuing	Started and stopped	Started and continuing
9	Regret	Unknown, nonresponse	Continuing, plans to stop	Started and continuing	Started, current use unclear
10	No regret	NA	Stopped	Started and stopped	Not started

Abbreviation: NA, not applicable.

also revise those feelings and feel more positive about their prior care later.^{34,35} It will be important to continue to monitor these indicators of satisfaction.

Another limitation is that we did not have information about satisfaction or regret from 34 individuals (13%) of the sample who have accessed blockers and/or hormones and are 12 years or older. As most of these participants remain in contact with the research team, we expect to be able to learn more about their experiences in the coming years.

The youth in this study come from a wide geographic area and, as a result, see a wide range of health care professionals with a wide range of approaches to care. A further limitation of the current work is that we did not have enough information about their care to ask if differences in that care (eg, whether they used an informed consent model, if they understood the impacts of the care) are related to variability in levels of satisfaction or regret, as some past work has suggested.³⁶ This is an important topic for future research.

Our sample is disproportionately White and from higher-income backgrounds. While these biases are often seen in

clinic-based samples as well,^{4,37} it is unknown whether the current results would apply to samples of primarily lower-income individuals and/or youth from racial and ethnic minoritized backgrounds. Some available evidence suggests that transgender people of color and those from lower-income backgrounds have more negative experiences with and/or lack of access to the medical system,³⁸⁻⁴⁰ suggesting they may be less satisfied with their care.

Conclusions

In the last few years, there have been moves to ban or restrict access to gender-affirming care for minors in areas within the US, UK, and Scandinavia. Many of those restrictions would result in youth who otherwise would have been satisfied with their care not receiving it. Our hope is that these data, reflecting the experiences of youth who accessed these treatments, will contribute to continued updating of decisions regarding the provision of gender-affirming care to adolescents.

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Additional Information: Other articles using the Trans Youth Project dataset can be found at <https://hudl.princeton.edu/publications-O>.

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