

Gender-affirming model still based on 2014 faulty Dutch study

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Abstract

The 2014 article “Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment” by de Vries, McGuire, Steensma, Wagenaar, Doreleijers and Cohen-Kettenis is the one and only positive evaluation of the gender-affirming model to cure gender dysphoria in minors and restore their well-being. After critically presenting the scarce foundations of ‘gender dysphoria’ as described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), this contribution examines the article’s methodology. The 2014 article does not show scientific evidence for the effectiveness of the “Dutch model”, due to subjects who left the sample group and the failure to include data subject who died. While this three-staged model with drugs for puberty suppression during ages 12-14, cross-sex hormones at 16 and sex-reassignment surgery at 18 is still not proven, it is being applied in a growing number of countries, and is even officially recommended.

Keywords: gender dysphoria, Dutch model, adolescents, transsexuality, transgenderism.

1. Introduction

The 2014 article with the title “Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment” by Annelou L.C. de Vries, Jenifer McGuire, Thomas D. Steensma, Eva C.F. Wagenaar, Theo A.H. Doreleijers and Peggy T. Cohen-Kettenis is the one and only positive evaluation of the gender-affirming model to cure gender dysphoria in minors and restore their well-being at the end of “sex-change” process at 18¹. This contribution examines the article’s methodology, starting with the very concept of ‘gender dysphoria’.

Gender dysphoria currently appears as a diagnosis for children and adolescents in the DSM-V (APA 2013)². Instructions to diagnose someone with ‘gender dysphoria’ highlight unease with one’s assigned gender. ‘Gender’ is defined in sociology as the differentiated behaviour culturally transmitted and required from males and females. This meaning is never openly contested by the medical literature, but – under the influence of post-modern philosophy (see the works of Judith Butler) – the term ‘gender’ is often misused as synonym of ‘sex’ (e.g. ‘gender-reassignment surgery’), creating confusion: the DSM-V allows the diagnosis of gender dysphoria in people without problems in subjectively acknowledging their sex³.

¹ The verb ‘to cure’ is appropriate for the amelioration of a condition that is listed in a manual for therapists of mental disorders (DSM), written to describe and classify them.

² In 2019 the WHO has changed the label to ‘gender incongruence’, in order not to classify gender dysphoria as a mental disturbance anymore. Nevertheless, if the WHO – the World Health Organization – is making efforts to describe criteria for diagnosing something that requires medical intervention, this something must be an illness.

³ In this kind of literature the expression “sex assigned at birth” is often found, though it does not make sense for the 99% of us who are not intersex (estimates reported by the Intersex Society of North America ‘ISNA’: <https://isna.org/faq/frequency/>). The objection that the verb ‘to assign’ is useful to shift attention to the social process of creating gender, is also devoid of meaning for sexed beings, as *all words* are part of the arbitrary social process which we call language. Language is arbitrary in connecting particular sounds to concepts and reality, but aims at describing what we experience. Therefore it is uninformative to call attention to the “assigning” of sex, in the sense of connecting this biological reality with the (arbitrary) words ‘male’ and ‘female’.

‘Gender dysphoria’ is therefore a new condition⁴ that has little to do with transsexuality, the desire to change one’s sex. The same can be said for its predecessor ‘Gender identity disorder’, similarly described in the DSM-III and IV since 1980. The increasingly popular ‘transgender’ identity in fact refers to the lack of desire to change sex. The current diagnosis of “gender dysphoria” can be made just by checking a list of behaviours that are judged inappropriate by gender norms. The *only* necessary requirement is about gender, both for minors and adults. This is its formulation for children: “A1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender)”. For adolescents and adults only the wording is different: “A1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)”. The criterion does refer to physical sex but does not require its subjective rejection. The two items indicating discomfort with one’s sex are not obligatory to check: “A7. A strong dislike of one’s sexual anatomy; A8. A strong desire for the primary and/or secondary sex characteristics that match one’s experienced gender”. Again, for adolescents and adults only the wording is different: “A2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)”; “A3. A strong desire for the primary and/or secondary sex characteristics of the other gender”. Moreover, this last criterion can be considered not defined, as “the other gender” refers to social consideration and behaviour, not to a physical characteristic.

The DSM does require psychological suffering (Criterion B) in order to assign this diagnosis. But it does not consider the items in A as the *cause* of the mental and Social problems described for all ages: “B. The condition is *associated* with clinically significant

⁴ Referred to with this name since 2013. Before, a similar diagnosis went under the label ‘gender identity disorder’ – see further. Both could qualify as “postmodern diseases”, in the sense given by Seamus O’Maheny (2019, 170/479), as the article will show: “Non-coeliac gluten sensitivity is thus a model for what might be called a post-modern disease. It does not have a validated biological marker (such as a blood test or a biopsy), and the diagnosis is made on the basis of a dubious and highly arbitrary symptom score. Its ‘discovery’ owes much to patient pressure and the suborning of expert opinion by commercial interests”.

distress or impairment in social, school, or other important areas of functioning” (my italics). This “association” must have lasted for six months or longer.

Since the late '90s a medical treatment for minors affected by ‘gender dysphoria’ has been developed by the Centre of Expertise on Gender Dysphoria at the VU University Medical Centre in Amsterdam: the Gender-affirming Model (Cohen-Kettenis, Steensma, and de Vries 2011). The first stage of the treatment consists of blocking puberty in 12-13 years-old (stage Tanner 2), while socially making them members of the opposite sex. The second stage entails non-reversible body re-morphing with hormones of the other sex (legal at age 16). The “final third stage” is sex-reassignment surgery, requiring the age of consent. In reality, the third stage is not final, as the subject will have to assume artificial hormones for a lifetime. Mental health support is also provided. Besides curing gender dysphoria, the model is geared to the practical result of having trans people be more satisfied with their transition, since the earlier they start, the best their physical appearance will align with that of the other sex.

The only study claiming good results for the gender-affirming model in curing gender dysphoria, and in the general well-being of the subject, is the research done in Amsterdam on the group of the first 70 eligible candidates who received puberty suppressors between 2000 and 2008 (de Vries *et al.* 2011, and especially de Vries *et al.* 2014). The 2014 article was, in the authors’ words, the “first longer-term longitudinal evaluation of the effectiveness of this approach” (de Vries *et al.* 2014, 696) and it is still the only one. On its favourable results the current Endocrine Society’s “evidence-based guidelines” are traced (Hembree *et al.* 2017)⁵. The guidelines also quote a NHS document as favourable evidence (NHS 2016), but its only source is the same 2014 study. The 2014 article is quoted

⁵ That, incidentally, are not considered evidence-based by the Canadian patients’ organization ECRI: “ECRI provides a ‘Trust Scorecard’ that rates the quality of the guidelines, based on evidence strength and the measures taken to reduce bias in the recommendations. After searching the ECRI database for transgender care guidelines, the only guideline posted was the ‘Endocrine Society Clinical Practice Guidelines of Gender-Dysphoric/Gender-Incongruent Persons, 2017’. It was not given a Trust Scorecard rating. The WPATH SOC [the Standard of Care guidelines by the World Professional Association for Transgender Health] was not included in the database” (LisaMacRichards 2019), meaning that these two documents are not evidence-based. The quoted article also exposes the conflict of interest of proponents of the gender-affirming model.

in other guidelines and research reviews by “gender specialists” (Lopez *et al.* 2017; Telfer *et al.* 2018; Turban, and Ehrensaft 2018) and also by critics (Heneghan and Jefferson 2019) in the same favourable terms that appear in its abstract: “After gender reassignment, in young adulthood, the GD [gender dysphoria] was alleviated and psychological functioning had steadily improved. Well-being was similar to or better than same-age young adults from the general population. Improvements in psychological functioning were positively correlated with postsurgical subjective well-being” (de Vries *et al.* 2014, 696).

Reading the original source and its methodology reveals very different results.

2. The first cohort cured with the gender-affirming approach

The article “Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment” (de Vries *et al.* 2014) presents a follow-up to the evaluation of the first two stages of the model (de Vries *et al.* 2011). Results in the group of the 70 “transgender minors” were found good enough to proceed with the third stage of genital surgery. All the minors on puberty blockers proceeded with the transition, despite the stated motivation of suppressing puberty in order to give the young person more time to think (Arnoldussen 2019). In the 2011 study, it was found that: “Behavioral and emotional problems and depressive symptoms decreased, while general functioning improved significantly during puberty suppression. Feelings of anxiety and anger did not change between T₀ and T₁” (de Vries *et al.* 2011, 2276); “We demonstrated improvement in several domains of psychological functioning after, on average, 2 years of puberty suppression while GD remained unchanged” (de Vries *et al.* 2014, 697).

In these articles, there are no ‘patients’, but rather ‘transgender adolescents’ diagnosed with ‘gender dysphoria’ (not strictly using the DSM-V⁶) or ‘eligible candidates’ for the puberty suppressors, because of a diagnosis of ‘gender identity disorder’ and “no psychosocial problems interfering with assessment or treatment” (de Vries *et al.* 2014, 697).

⁶ “Transgender adolescents experience an incongruence between their assigned gender and their experienced gender and *may* [my italics] meet the Diagnostic and Statistical Manual of Mental Disorders 5 criteria for gender dysphoria (GD)” (de Vries *et al.* 2014, 697). So the treatment shouldn’t be about their sex at all!

The group of 70 ‘transgender adolescents’ comprising the participants of the 2014 study is not a sample, but rather the universe of the eligible candidates in the 8 years since the model was first applied. They were tested rather shortly (one year) after their sex-reassignment surgery: “The young adults were invited between 2008 and 2012, when they were at least 1 year past their GRS [gender-reassignment surgery] (vaginoplasty for transwomen, mastectomy and hysterectomy with ovariectomy for transmen; many transmen chose not to undergo a phalloplasty or were on a long waiting list)” (de Vries *et al.* 2014, 697). This research design could have been what statisticians call a longitudinal panel with the 2011 research, but since questions were substantially different in the two studies, the design is only similar to a panel.

Reduction in cohort size was from 70 to 55 subjects (21.4%), bigger than the 20% considered acceptable in longitudinal panels. But the cohort was further reduced, even more than halved, in the numbers that responded to the different questionnaires, without any explanation or even mention from the authors for these further reductions, which are tucked away in the small prints of the tables.

Only 45 subjects were assessed for body image, thus the drop-out rate became 36% (de Vries *et al.* 2014, 699, Table 2). The Utrecht Gender Dysphoria Scale was administered to only 33 subjects, less than half the cohort (47% of the cases), and at only one year post-surgery. The conclusion that gender dysphoria was resolved by the gender-affirmative model does not seem sound. Ten measures of psychological functioning are shown in detail in Table 3 (de Vries *et al.* 2014, 700), with a drop in participation from 55 to 32 subjects in 4 measures, and to 43 subjects in 3: on these measures, the drop-out rate ranges from 38% to 54%. The only measures taken on 55 (sometimes 54) subjects are Subjective Well-Being: Quality of Life, Satisfaction with Life, and Subjective Happiness, where they score indistinguishably from the larger population. Authors attribute the lack of participants’ response to the fact that they administered questionnaires at different times.

These fall rates alone should have a destroying effect on the allegedly positive results. However, if we look at the reasons for the fall from 70 to 55 subjects, there is more.

3. Arbitrary exclusions and unexplained refusals / withdrawals / dropouts

A detailed list of reasons for the reduction of participants from 70 to 55 is given by the authors: “Nonparticipation (n=15, 11 transwomen and 4 transmen) was attributable to not being 1 year postsurgical yet (n=6), refusal (n=2), failure to return questionnaires (n=2), being medically not eligible (eg, uncontrolled diabetes, morbid obesity) for surgery (n=3), dropping out of care (n=1), and 1 transfemale died after her vaginoplasty owing to a postsurgical necrotizing fasciitis” (de Vries *et al.* 2014, 697). This last tragic outcome will be examined in more details later.

The first reason seems bizarre and rather *ad hoc*. There is no discernible justification to pose a threshold at (only) one year post-surgery. The period for the evaluation of life-changing medical events is definitively too limited, especially considering that full maturity of the human brain happens at 25 years of age that the subjects of the study have mostly reached by now but not when they were assessed. De-transitioners describe a “honeymoon” period of 1-3 years when they were very happy about what they later came to deeply regret, only shortly later. The arbitrary time-constraint left out 6 subjects: why could the data-gathering not wait until the biggest group excluded could complete even the arbitrary year required after genital surgery? Why has there been no update to the results?

The second biggest group is composed of the 5 people who either refused (n=2), or failed to return the questionnaire (n=2), or dropped out of care (n=1). What were the reasons behind refusal and withdrawal? In addition, is it possible that the subject who “dropped out of care” did so in order to de-transition?

The third group had medical reasons for not being eligible for surgery (n=3), and the authors give “uncontrolled diabetes and morbid obesity” as two examples of their reasons. It would be interesting to know if the subjects developed these serious conditions after the first two stages of the model. If they did, it should be part of the model evaluation. If not, if the subjects had these conditions before, it is medically questionable to give hormones that further unbalance the body to young people with dangerous health problems.

These conditions can mean the subjects had other body-image problems underlying gender dysphoria that cannot be solved with a sex change.

Leaving aside the question of the scarce representation of the subjects examined in relation to the whole cohort, the arbitrary exclusion of 6 subjects point to the possibility of some doctoring of the results, while 8 subjects who did not want to or could not take part point to the possibility of unrecorded dissatisfaction. The authors themselves write that their results are not necessarily extendable to their universe of subjects: “despite the absence of pretreatment differences on measured indicators, a selection bias could exist between adolescents of the original cohort that participated in this study compared with nonparticipants” (de Vries *et al.* 2014, 703).

The researchers’ question: “After gender reassignment, how satisfied are young adults with their treatment and how do they evaluate their objective and subjective well-being?” (de Vries *et al.* 2014, 697) cannot be answered positively, especially when they exclude the death of one of the study participants, that is related to the gender-affirming model.

This is not the first negative evaluation of the Dutch studies. In a recent review of primary studies, researchers examined the hormonal treatment of transgender adolescents and assessed its psychosocial, cognitive, and/or physical effects, including both the 2011 and 2014 Dutch studies (Chew *et al.* 2018). The review points to the lack of validation of the gender-affirming model: “puberty suppressors (GnRHa, gonadotropin-releasing hormone analog) treatment was associated with improvement across multiple measures of psychological functioning but not gender dysphoria itself, whereas the psychosocial effects of gender-affirming hormones in transgender youth have not yet been adequately assessed. Low-quality evidence suggests that hormonal treatments for transgender adolescents can achieve their intended physical effects, but evidence regarding their psychosocial and cognitive impact are generally lacking. Future research to address these knowledge gaps and improve understanding of the long-term effects of these treatments is required” (Chew *et al.* 2018).

Criticism towards the gender-affirming approach rises (for example Brunskell-Evans 2019; Moore and Brunskell-Evans 2019), with accusations to the Tavistock and Portman NHS Trust clinic in London of hastily transitioning gay and lesbian minors at their Gender

Identity Development Service (GIDS) (Bannerman 2019)⁷, and the absolution in 2018 of Kenneth Zucker as Director of the Child Youth and Family Gender Identity Clinic in Toronto, accused of practicing “conversion therapy” for not applying the gender-affirming model on all youth showing at his clinic. A ‘do-no-(physical)-harm’ approach towards minors in distress seems to be the wisest.

4. Death in the cohort

“One transfemale died after her vaginoplasty owing to a postsurgical necrotizing fasciitis” (de Vries *et al.* 2014, 697). Being a scientific article, the outcome of death following surgery, performed by or at the prescription of the team, can surely be recorded in such an impassive way. But was it correct to exclude this subject from the research, calling her death “nonparticipation”, as if the person could not fill the questionnaire for any other reason? The cause of death of the adolescent transwoman is an integral part of the model under evaluation, as its third stage *is* the sex-reassignment surgery. Death occurred as a consequence of the model, therefore the last subject did not fall out of the sample at all. Death is a possible outcome of the gender-affirming model.

Admittedly it is a very rare occurrence, though the genital surgery does have a fairly high rate of non-lethal complications. According to an expert opinion: “Necrotizing fasciitis is due to an infectious disease, often methicillin-resistant *Staphylococcus aureus*. The infection might come from poor hygiene in post-surgical dilation of the neovagina, required every day for many years. Death would likely not occur in someone who was keeping clean and adhering well to instructions, but some depressed subjects do not perform it”⁸.

Although rare, death did occur in the cohort, so the question of assessing general well-being becomes one of ascertaining the probability of positive versus very negative outcomes. True results at the third stage are a 1/56 probability of death, and 55/56 probability

⁷ Confirmed by the *Bell v. Tavistock* judgement establishing on December 1st 2020” that adolescents under 16 are very unlikely to be able to give informed consent to puberty blockers.

⁸ Epidemiologis, transsexual and currently desister, personal correspondence.

to be (in the mean) in better psychological health and free from ‘gender dysphoria’ according to the claimed results regarding the reduced cohort.

How to rate the well-being of a dead person should not be a major qualitative problem. He or she is not quite well anymore, as we are debating science, not religion. Death can be considered a proxy for extreme dissatisfaction with the affirmative model performed for curing gender dysphoria in puberty. How exactly to measure death on the scale of psychological well-being might, admittedly, be a quantitative problem⁹.

Had the authors fully examined their proper cohort, consisting of 56 subjects, they should have commented on the probability of death from their gender-affirming model. A 1.8% probability of post-op death compares rather well with the high risk of suicide touted by the proponents of the gender-affirming model with studies that have also been exposed to be methodologically unreliable, overestimating the possibility of suicide (Horváth 2018). If we consider the risk contingent only to vaginoplasty, the risk for transwomen rises to 1/23, that is 4.3%.

What to make of the Dutch model, then? Given that the subjects are of age at the time of their genital surgery, defenders could argue that we just let youth decide whether to enter the third stage with its fatal risks. However, the model does not start when we consider someone an adult. It is minors that are led through two previous stages to the third stage of sex-reassignment surgery, which is a culmination step to the medical interventions starting at the onset of puberty. Minors cannot consent to such possible dangerous outcomes. Invalidation of the model by the high risk of death means that the first stage should be suppressed, as it not possible to delay it until coming of age, and the second stage should be delayed.

Results of better psychological well-being as a consequence of treatment in a group where a death has occurred following treatment cannot be valid. This occurrence must be included in the sample and discussed. Studies and guidelines quoting the favourable outcomes of the gender-affirming model from the Dutch study are therefore wrong and in need of revision, including the Guidelines of the Endocrine Society.

⁹ Were I to give a measure for dissatisfaction and not-well-being, I would put the number at infinite, thus cancelling out whatever progress the other 55 (minus the further drops) subjects made on the measured variables.

Generally speaking, the ‘gender dysphoria’ diagnosis in minors has allowed for the gender-affirming model to intervene on physical sex to align children’ and adolescents’ bodies with their ‘gender identity’, affirming ‘gender’ at the expense of sex. In fact, the model does exactly what it promises.

5. Language tricks and their material and symbolic outcomes

A closer look at the first Dutch study also reveals that its favourable results come from wrongly used or manipulative language. The abstract reads: “Gender dysphoria and body satisfaction did not change between T₀ and T₁”. So it seems surprising that, two lines down, the conclusion instead purports: “Puberty suppression may be considered a valuable contribution in the clinical management of gender dysphoria in adolescents” (p. 2276). But read carefully: “clinical management” does not mean therapy, the phrase does not signify nor imply that gender dysphoria can be resolved by puberty suppression. I take the liberty to paraphrase the conclusion in clear and down-to-earth language: offering puberty suppression is useful for getting adolescents who have a problem with their assigned gender (not sex, see the diagnosis criteria in DSM-V) to become patients of our clinic and get the drugs we hand out. Needless to say, in this capitalist world there are producers of these drugs that have an economic interest in promoting them, in making the public pay for them by introducing a medical diagnosis for a social problem, in expanding the target of the drug users, in this case assuring life-long treatment of persons that were previously healthy, recruited at the youngest possible age. There is also the well-known logic of organizations – studied by numerous sociologists – that routinely try to expand their field of competence and of intervention. This logic can be applied to understand one motivation of the clinicians who invented and promoted the Dutch model: widening the scope of transsexuality intervention, in which they are specialized, to include minors. On the other hand, there is a “demand” by minors who are non-conforming in their gender presentation and have associated psychological or functional problems, who identify the proposed treatment of “changing sex” (called “gender reassignment”) as a solution to all of their problems. It is then difficult that persons transitioned since a very young age would back up from a socially encouraged sex-change, as they have built up their identity

and had mostly irreversible bodily changes around something that most of their peers experiencing gender-nonconformity grow out of (Bartlett *et al.* 2000; Singh 2012; Drescher, and Pula 2014). Most of gender-nonconform children become gay or lesbian youth, as a study about 4,600 young people found: “the levels of gender-typed behavior at ages 3.5 and 4.75 years, although less so at age 2.5 years, significantly and consistently predicted adolescents’ sexual orientation at age 15 years, both when sexual orientation was conceptualized as 2 groups or as a spectrum” (abstract). The authors conclude that: “The current results converge with other lines of retrospective and prospective research to suggest that childhood gender nonconforming behaviour is a consistent early predictor of future nonheterosexual orientations” (Li *et al.* 2017, 774). To assume a homosexual identity is harder the younger the person is, and peer pressure can bring to transitioning as a solution to bullying and homophobia. Another difficulty in admitting that the transition was not resolatory comes from the fact that ‘desisters’ are stigmatized, their voices are censored by the supporters of the transitioning of minors, and research about them is discouraged¹⁰.

When the Dutch team calls the operation that they perform as a part of the gender affirming model, ‘gender-reassignment’ surgery, they are wrongly using the concept of ‘gender’, that is different from ‘sex’. So even “gender specialists” appear to be confused about the supposed object of their activity. In their review, Turban and Ehrensaft (2018) list 13 definitions of key terms, from ‘Sex assigned at birth’ to ‘Gender diverse’, including a sociologically correct definition of ‘Gender roles’: “A characteristic that is considered ‘male’ or ‘female’ by a particular culture”. But Turban and Ehrensaft never offer a definition of ‘gender’ itself so they can surreptitiously use it as a synonym of ‘sex’.

Postmodernists have argued that sex does not exist in itself, all is gender (Danna 2020). Nevertheless, the medical interventions for ‘gender dysphoria’ are aimed at the minors’ physical sex. This is the (postmodernist) “original sin” of all this literature and all these

¹⁰ Sources for these evaluations are to be found, for example, in the website *4th Wave Now* (4thwavenow.com), self-described as “A community of people who question the medicalization of gender-atypical youth”, with contributions by therapists, clinicians, academics, and first-hand experiences of families and trans people. The site also documents the problems that “nonconforming research” meets in the current postmodernist intellectual climate.

interventions: if ‘gender’ substitutes ‘sex’, the body is excluded, and all that is left are the socially organized norms and perceptions of what is appropriate to one sex or the other. The effort of the gender-affirming model is the opposite of changing gender norms and making them less oppressive. It aims instead at changing the sex of ‘eligible candidates’, who suffer from society’s lack of acceptance of gender deviance.

Children learn from adults how to go from the experience of discomfort and social problems relating to their gender to the idea that “changing” their sex would solve their social and identity problems. The ‘child-led’ approach of the gender-affirmative model (Ehrensaft 2011) is a delusion: children do not know by themselves what artificial hormones and surgery can and cannot do, for example that they cannot really change one’s sex but only give cosmetic corrections. Martin, Ruble and Szkrybalo (2002) established that before 7 children mostly connect one’s sex with the clothes one is wearing. However, what the treated minors reportedly wish for is exactly a change of sex. Rather than an exact knowledge of the effects of different hormones (which is specialized, medical knowledge), it is vital that youth grasp the idea that sex is immutable, as it is inscribed in every cell of our body, and can be changed only in a social sense, not biologically. Adults know this and can give consent to body-altering interventions that affect their health (though sometimes they regret it), but minors are not in the position of deciding. Their best knowledge is generally insufficient and they are not mature enough to grasp the long-term implication of altering one’s hormonal balance. Some children and adolescents do know the limitations of hormones and surgery, but are fed the message that this will “fix” all their problems.

There is a host of other substantial problems lurking underneath this proposed and practiced treatment of minors, including the social climate that favours the “transitioning” of minors as a self-affirming and attention-calling strategy. But substituting ‘gender’ for ‘sex’ is really confusing *relationships*, implicit in social roles, with *things* – in so far as sex and the whole body can be called a thing. Instead of seeing the problem in social and personal relationships, the Dutch model considers the body as the problem, and supports minors who look for a solution for their problems in conforming to an assigned gender by changing their sex.

As noted, the subjects of the gender-affirming model are not ‘patients’: in the 2011 article they are called ‘eligible candidates’, and in the 2014 article ‘transgender adolescents’. The last expression is not even a diagnosis, though authors also call them ‘adolescents who have gender dysphoria’. A ‘transgender person’ should not be a ‘patient’ at all, as it is simply someone who does not fit with the social prescriptions for his or her sex, while – according to the DSM – nothing might be wrong with their perception of their own sex. What are these people doing in medical settings, getting drugs to alter their bodies, medications paid for by the public or by private insurance?

On this sand, the positive review of studies has been built. Surely the current discussion in the World Professional Association for Transgender Health (formerly the Harry Benjamin Society) for the preparation of their 8th Standard of care is using the same building blocks.

A host of problems is therefore revealed not only with the Dutch studies, but also upstream at the peer reviewing level and downstream at the quotation level: all the articles of authors that cite the studies quote their purportedly positive results¹¹, and even the official guidelines by a medical society does it. The authors of the studies themselves never acknowledged these methodological problems¹². Let us hope they will do so from now on.

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¹¹ Even those who acknowledge ethical problems (Vrouenraets *et al.* 2015).

¹² In 2021 Steensma lamented that “the rest of the world is blindly adopting our research” (Tetelepta 2021).

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