Consejo General de la Psicología ESPAÑA

Papeles del Psicólogo (2022), 43(3), 185-199

Papeles del Psicólogo
Psychologist Papers
https://www.papelesdelpsicologo.es/ • ISSN 0214–7823

PAPELES DEL PSICÓLOGO
PSYCHOLOGIST PAPERS

Revista del Consejo General de la Psicología de España

Article

Psychology and gender dysphoria: Beyond queer ideology

Marino Pérez Álvarez and José Errasti

Universidad de Oviedo, Spain

ARTICLE INFO

Received: June 3, 2022
Aceptado: June 20, 2022

Keywords
Rapid-onset gender dysphoria
Queer ideology
Affirmative therapy
Detransitioners
Watchful waiting

ABSTRACT

Gender dysphoria in childhood and adolescence is currently more under the domain of queer ideology than within scientific and professional knowledge. This dominance of ideology translates into important practical consequences such as self-determination of gender identity based on sentiment and affirmative therapy of felt identity as the only acceptable option. As a result, psychological aspects are left out of evaluation, and pharmaco-surgical transitions are undertaken that do not solve the problem for everyone. In particular, there is the new phenomenon of those who regret having changed their gender and detransitioners who would like to reverse the process. The health professions, including psychology, as well as psychiatry and pediatrics, should demand the same scientific and professional standards for gender dysphoria that they apply to other problems, starting with exploration, evaluation, functional analysis, diagnosis, prudence, and attentive waiting, instead of simply adopting affirmative therapy without question.

La psicología ante la disforia de género, más allá de la ideología *queer*

Palabras clave
Disforia de género de comienzo rápido
Ideología *queer*
Terapia afirmativa
Destransicionistas
Espera atenta

RESUMEN

La disforia de género en la infancia y la adolescencia está hoy en día más bajo el domino de la ideología queer que dentro de los conocimientos científicos y profesionales. Este dominio de la ideología se traduce en importantes consecuencias prácticas como la autodeterminación de la identidad de género con base en el sentimiento y la terapia afirmativa de la identidad sentida como la única opción aceptable. Como resultado, quedan fuera de evaluación los aspectos psicológicos y se emprenden transiciones fármaco-quirúrgicas que no resuelven el problema para todos. En particular, surge el nuevo fenómeno de los arrepentidos de haber cambiado de género y destransicionistas que quisieran volver atrás. Las profesiones sanitarias incluida la psicología, así como la psiquiatría y la pediatría, debieran reclamar ante la disforia de género los mismos estándares científicos y profesionales que aplican en los demás problemas, empezando por la exploración, la evaluación, el análisis funcional, el diagnóstico, la prudencia, la espera atenta, en vez de asumir sin más la terapia afirmativa.

Cite this article as: Pérez, M., and Errasti, J. (2022). Psychology and gender dysphoria: Beyond queer ideology. *Papeles del Psicólogo, 43*(3), 185-199.
https://doi.org/10.23923/pap.psicol.3001
Correspondence: marino.perezalvarez@gmail.com

Gender dysphoria is today under the domain of an ideology, rather than within scientific knowledge. Thus, psychology (and psychiatry too) is practically excluded from being applied to gender dysphoria—particularly in childhood and adolescence—other than to affirm what the child feels and says. Psychological exploration is excluded (Gómez-Gil et al, 2020; Rodríguez Magda, 2021a), and dysphoria becomes a matter for endocrinologists and surgeons, for injections and scalpels.

The ideology in question is none other than transgender or queer ideology. Transgender/queer ideology is an amalgam of postmodern philosophy and political activism. While its philosophy is characterized by the discrediting of scientific knowledge, reason and truth, and the embracing of subjectivism and linguistic constructivism, its activism awards itself a particular social justice based on felt identities and not exactly on the universal rights of individuals (Binetti, 2021; Errasti & Pérez-Álvarez, 2022; Malo, 2021; Pluckrose & Lindsay, 2020). It is an ideology, because the term "theory," insofar as it assumes an organized system of ideas and knowledge, would be an oxymoron in this case due to its hodgepodge of ideas. The denomination of "queer philosophy" would also be excessive due to the disbelief of reason and the contradictions within its doctrine. It would therefore be best considered as an ideology, in the double sense of an amalgamation of ideas and of functioning as a cover for interests such as the "body market" (Binetti, 2021).

Queer ideology is powerful not in spite of being an ideology, but precisely because it is an ideology in the way it is. It is an ideology that is in tune with the spirit of the times, if it does not itself define the spirit of the times. Key aspects of this attunement are the appeal to feelings, self-determination of identity, and wish fulfillment, all within the language of do-gooderism and social justice (only you know how you feel, human rights). In fact, transgender ideology constitutes a powerful lobby capable of influencing not only ordinary language by imposing a neolanguage, but also institutions, corporations, and scientific and professional societies, including the American Academy of Pediatrics (AAP), the American Psychological Association, and the American Psychiatric Association (APAs) (Ekman, 2022; Errasti & Pérez-Álvarez, 2022). In particular, the APAs make ideological statements in favor of affirmation as the only option, ignoring the scientific knowledge and good professional practices that they themselves support in relation to all other issues other than the aforementioned dysphoria.

Queer ideology and the new orthodoxy that it is creating have two major implications: on the one hand, for feminism, erasing women as political subjects in the name of genderism (Ekman, 2022; Errasti & Pérez-Álvarez, 2022; Rodríguez Magda, 2021a), and on the other, for gender dysphoria in childhood and adolescence, the subject of this article.

Psychology has much to say about gender dysphoria. To begin with, psychology offers knowledge about how people's identity is constituted in the context of culture, society, language, and the vicissitudes of development. From Vygotsky to Skinner, to cite only two references, it is known that self-knowledge is social contact with oneself, not something that spontaneously arises. Likewise, psychology offers knowledge about social influence and the formation of feelings, instead of, for example, assuming essentialism.

In the face of gender dysphoria, psychology does not propose to do anything other than what it does with any other subject and problem: study it and see how best to offer the appropriate help. On the other hand, psychology also examines the ideology and implicit assumptions that may be part of its knowledge and procedures. Thus, it is careful of essentialism, dualism, and biomedical reductionism, aiming to see the problems and the help or solutions available in the context of the person and his or her circumstances, without skimping on social and institutional criticism in order to change society and not merely adapt individuals uncritically (González-Pardo & Pérez-Álvarez, 2007; Pérez-Álvarez, 2021). The present article focuses on what is known as rapid-onset gender dysphoria that occurs in childhood and adolescence.

Rapid-onset gender dysphoria: the coal mine canary.

What is known as rapid-onset gender dysphoria (ROGD), refers to a phenomenon, described in 2018 by gynecologist and researcher Lisa Littman, according to which a girl suddenly feels and declares herself to be a boy, or vice versa, although its occurrence is more frequent (82.2%) in girls (Littman, 2018). The study consisted of a 90-question (open-ended, multiple-choice, Likert-type) survey of 256 parents recruited from three websites where they had reported sudden or rapid onset of gender dysphoria occurring in their adolescent or young adult children (mean age 15 years). Although it came as a surprise to the parents, the sons' or daughters' reported experience did not occur overnight. Of all the parents in the study, 86.7% report that their child recently maintained increased use of social media, belonged to a group of friends in which one or more friends identified as transgender, or both. According to the parent report, 41% of the sons and daughters had expressed a non-heterosexual sexual orientation prior to identifying as transgender. Furthermore, many (62.5 %) had been diagnosed with at least one mental health disorder or neurodevelopmental disability prior to the onset of their gender dysphoria (Littman, 2018).

The controversy

The abovementioned author points to social contagion and maladaptive coping mechanisms, as well as parent-child conflict, as possible explanations for the sudden dysphoria, which should be explored. She adds, "The findings of this study suggest that clinicians should be cautious before relying solely on self-report when youths seek social, medical, or surgical transition. Adolescents and young adults are not trained clinicians. When kids diagnose their own symptoms based on what they read on the Internet and hear from their friends, they may well come to the wrong conclusions. It is the duty of the clinician, when faced with a patient seeking transition, to perform his or her own assessment and differential diagnosis to determine whether or not the patient is correct in his or her self-assessment of his or her symptoms and conviction that he or she would benefit from transition. This is not to say that the patient's convictions should be discounted or ignored. Of course, some may benefit from transition. However, careful clinical examination should not be neglected either. The fact that the patient's history is significantly different from the parents' account of the child's history should serve as a red flag

that further evaluation is needed and that other sources should verify as much information as possible about the patient's history" (Littman, 2018, p. 37).

Littman's paper proved controversial right from the start, to the extent that her own university (Brown University) withdrew it from the repository and the journal revised it a second time including a correction the following year (Littman, 2019), in the face of pressure from transgender activism. While its removal by the University deserves all reproaches according to the former dean of Harvard Medical School (Flier, 2018), the second revision involved no substantive change other than improved contextualization of the study (Bartlett, 2019; Littman, 2019).

Objections to the study focused on three aspects: the hypothesis of social contagion and the role of associated psychological problems, alleged methodological flaws, and lack of clinical evidence of ROGD. In relation to the first, the objection is surprising for proposing hypotheses about the findings of an exploratory study. These hypotheses are otherwise entirely plausible and are in fact supported by the exponential growth of the phenomenon, the concurrence of other previous disorders and the new phenomenon of transition regret and detransitioners (Entwistle, 2020; Littman, 2021; Vandenbussche, 2021). For example, repentant individuals speak of influences that led them to a precipitous transition (Alsedo, 2022a; Bell, 2021; Dagny, 2019). Regarding the alleged methodological flaws, they in no way invalidate the study, which, in fact, remained practically intact (Bartlett, 2019; Littman, 2019), showing in the end that its methodology is consistent with that used in the field of gender dysphoria, as demonstrated by the author in response to her critics (Littman, 2020).

A social phenomenon

Regarding the lack of evidence of ROGD as a clinical entity, the truth is that it has no clinical entity, nor does it claim to have one. And, to put it bluntly, neither does the gender dysphoria/incongruence included in the diagnostic systems DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition) or ICD-11 (International Classification of Diseases, 11th edition). (Nor should it claim to have a clinical entity). Not only should ROGD not be included in future diagnostic systems, but gender dysphoria/incongruence should be removed from the current catalogs of mental disorders or illnesses. However, the so-called ROGD is still a new *social* phenomenon in the context of transsexual and transgender history, in view of its growth of thousands per cent in a few years, the change in the female-to-male ratio as opposed to the other way around as in the adult sphere and the occurrence at increasingly younger ages (Bonfatto & Crasnow, 2018; Errasti & Pérez-Álvarez, 2022, p. 195; Kaltiala-Heino et al, 2018; Zucker, 2019).

The objections to Littman's study, beyond the discussion that all scientific work deserves, respond to ideological motivations related to the hypotheses of social contagion and the role of other problems. These hypotheses are in contradiction with the supposed innate, natural, and unmodifiable condition of felt identity as queer ideology wants to present gender incongruence/dysphoria. The truth is that what is known as ROGD is a new social phenomenon.

The mother of the lamb

To see it from the perspective of the parents, it is understandable that they may be disconcerted by the statement—undoubtedly sincere, heartfelt, and long-suffering—of a girl who says she feels, and is, in reality a boy (or the other way around) and who also wants to be called by another name from now on, since she is no longer who she was until then.

Parents will soon see that the change is neither sudden nor lacking in firmness. The girl is clear, and well versed, about what to say in the face of any parental reticence and remarks, including saying that if they don't support her, it is a sign that they don't love her, or that she may commit suicide. Parents will also see that the change may have already been happening at school, in the peer group, and in social networking communities, where the girl has probably already chosen a new name and pronouns. The parents will also see that in the health center, where they will most likely go, the professionals (pediatricians, endocrinologists, psychiatrists, psychologists) are already up to date on what to do in gender dysphoria. Professionals will probably end up telling parents that they have a son instead of a daughter or the other way around. And the parents will eventually see that it is better to have a transgender child than a dead one, as is often stated. Thus, we come to the mother of the lamb.

Unlike how parents were at the beginning, schools and health centers have an official policy: self-determination of gender identity by feeling (felt identity) and affirmative therapy consisting of affirming the felt identity with no acceptable option other than accompaniment for the purpose of gender transition.

The trans train

The transition can have four phases. Briefly, these would be as follows: *social transition* of changing name, pronouns, and appearance, *puberty blocking* (around 11-12 years, depending on development) with gonadatropin-releasing hormone analogs that suppress the production of sex hormones (testosterone or estrogen), *cross-hormonal treatment* (around 16 years) based on testosterone for girls and estrogen for boys, and gender affirming *surgery* (from 18 years of age, but if done earlier it would not be the first time). Gender affirming surgery may include mastectomy, vaginectomy, and phalloplasty for female-to-male (transgender male) change, and vaginoplasty consisting of penile reconversion into a vaginal cavity for male-to-female (transgender female) change, in addition to other complementary plastic surgeries (Claahsen-van der Grinten et al, 2021). Table 1 presents the surgical procedures for natal males and females.

It is not necessary to go through all of the above phases to consider oneself a transgender person. It may not even be necessary to go through any of them, as the self-affirmation of feeling trans may be enough for some. Social transition, however, is part of a whole conveyor belt or train that takes the majority of people to the next phase. This majority continuity of phases—starting with social transition—does not necessarily occur because the feeling was firm and definitive from the beginning (although this is not ruled out). It may also occur because social transition itself promotes hormonal blockade and orients the individual in that direction, and from there to hormonal cross-treatment, and then on

Table 1.
Surgical procedures for the treatment of gender dysphoria (Claahsen-van der Grinten et al, 2021).

Males at birth	Females at birth
Breast surgery = augmentation mammoplasty with implants. Genital surgery (sex reassignment surgery): • Penectomy = removal of the penis. • Orchiectomy = removal of testicles. • Vulvoplasty = creation of female external genitalia including functional neoclitoris. • Vaginoplasty = creation of female genitalia including a functional vaginal cavity using the penis and scrotal skin, creation of a functional neoclitoris. Other surgical interventions: • Facial feminization surgery (including bone structure alteration surgery, rhinoplasty, blepharoplasty, forehead lift, lipofilling, use of fillers). • Liposuction or lipofilling of body fat. • Voice change surgery. • Thyroid cartilage reduction. • Buttock augmentation (implants/lipofilling). • Hair reconstruction (hair root, male type alopecia).	Breast surgery: subcutaneous mastectomy, creation of a male breast and nipple areola. Genital surgery (sex reassignment surgery): • Hysterectomy + salpingo-oophorectomy • Urethral lengthening that can be combined with a metoidioplasty (creation of small male genitalia with the use of local tissue) or with a phalloplasty (using for example a microsurgical free flap of skin). • Vaginectomy. • Scrotoplasty. • Implantation of erectile and/or testicular prosthesis. Other surgical interventions: • Voice surgery (rare). • Liposuction or lipofilling. • Pectoral implants.

to surgical interventions. All of this constitutes a psychosocial process, as well as a biomedical one, which involves and commits the person in a certain direction, rather than supposedly revealing a crystalline feeling. It will be seen that before the affirmative policy was established (as of 2013) most dysphoria remitted on its own. However, since this policy has been in existence, the likelihood of an individual who enters one phase moving on to the next is almost one hundred percent, particularly from social transition to puberty blocking and from puberty blocking to hormone treatment. The newly emerging phenomenon of regretters and detransitioners suggests that the policy of affirmation is going too far for some, as will be seen.

In the end, even without being aware of the road ahead, parents will realize that they have no choice but to affirm and accompany their son or daughter. Thus, some parents become more affirming than anyone else, while others feel abandoned by the system, if not doomed to lose their "parental authority" or even to go to a psychologist themselves (Alsedo, 2022b; Ekman, 2022, p. 280).

The self-determination and affirmation that are now obligatory for all derive from the gender ideology that queer activism has managed to impose on institutions as official policy. They do not derive from research or scientific consensus. Scientific consensuses are actually ideological statements such as those of the AAP and the APAs (Cantor, 2020; Errasti & Pérez-Álvarez, 2022, pp. 223-229). The "Standards of Care for the Health Care of Trans and Gender Variant People" (7th edition) of the World Professional Association for Transgender Health (WPATH, 2012) are usually taken as a reference. However, this guide, like the others that are inspired by it, cannot be taken as a "gold standard" as it is considered, due to the poor assessment of its quality in important domains (Dahlen et al, 2021, p. 8). Pending the 8th edition of the WPATH standards, trusting that it will be more science-based than ideology-based, there does not exist an ethically and scientifically grounded consensus as has been called for (Clayton, 2022; Gómez-Gil et al, 2020; Griffin et al, 2021; Levine, Abbruzzese, & Mason, 2022).

Clinicians on a knife's edge

To the extent that ideology prevails over science, prudence, and common sense, education and health professionals are failing not only parents, but children and adolescents themselves. Schools are failing to the extent that indoctrination prevails over knowledge. Health professionals are failing as well, to the extent that children and adolescents with gender dysphoria do not receive the same standards of clinical care, assessment, and support as any other child or adolescent accessing health services, due to the constrictions imposed by affirmative therapy. Clinicians are on a knife's edge: either they risk being accused of transphobia if they explore the case, or they remain silent while attending to the uncontrolled experiment of affirmative therapy (Griffin et al, 2021, p. 297).

Children and adolescents as a battlefield

What has happened? Where has trans childhood emerged from? The official version says that greater visibility and tolerance bring to the surface gender dysphoria or incongruities that were already there. However, this does not seem to be the explanation according to what has been said and what will be said later. If scientific research does not force us to think otherwise, it is possible to think that trans childhood, more than an underlying reality that is now uncovered, would be a battlefield where the war of genderism is being waged. The problem is not in childhood or in the body, but in society with its still stereotyped gender roles, and in the transgender activism that naturalizes them, elevates them to a political category, and turns them into law. In this sense, children and adolescents become the canary in the old coal mines: a sign that something is wrong with the system. What is wrong with the system? The prevalence of ideology over science.

The prevalence of ideology over science and its consequences

Healthcare institutions starting with pediatrics, psychiatry, and psychology, as well as educational institutions, are failing children and adolescents, their parents, and society in general, to the extent that they uncritically adopt gender identity self-determination and affirmative therapy as the only acceptable option contrary to their knowledge and practices in all other fields.

In this regard, it is worth highlighting the manifesto of the professionals of the Gender Identity Units of the Spanish health system, showing on the one hand the ideological pressure and on the other hand claiming the knowledge of health experts (Gómez-

Gil et al, 2020). Thus, for example, they raise a debate on the "Legislative decisions on health issues not based on ideological positions: professionals consider that health aspects are being legislated based more on the pressure of associations, ideological positions, or political interests, than on the recommendations of the scientific literature or the knowledge that can be provided by health experts working in the field, and who, a posteriori, are the ones that must respond and assume responsibility for care. " (Gómez-Gil et al. 2020, p. 6).

What is the problem with transgender ideology? We will highlight three issues: the dogmatic implantation of affirmative therapy as the only acceptable option, the self-diagnosis that assumes that children are wise, and the hasty transitions that give rise to the new problem of detransitions.

Dogmatic implementation of affirmative therapy as the only acceptable option

Ultimately, affirmative therapy is not as self-evident as it is made out to be. The evidence reviewed by the National Institute for Health and Care Excellence (NICE) on puberty blockers shows that it is difficult to draw conclusions from the existing studies, because they lack a control group, they are small, and they do not describe what other physical and mental health problems a young person may have in addition to gender dysphoria. Ultimately, the review found no evidence of goodness of treatment (NICE, 2020a). Although puberty blockers as a routine intervention for children and young people are associated with few known medical risks, Bernadette Wren, associate director of the British health system's Gender Identity Development Service (GIDS), is quick to acknowledge potential unknown consequences, adding, "It is well known that rigorous longitudinal trials are lacking and the available evidence is of limited quality, although many leading doctors write in favor of it." (Wren, 2019, p. 208). In particular, one study followed the evolution (at least one year) of 44 adolescents (aged 12-15 years) with persistent and severe gender dysphoria treated with blockers. Although the participants generally reported a positive experience, no improvements in psychological distress, quality of life, or degree of gender dysphoria were observed (Carmichael et al, 2021). A 2015 study had already shown that puberty blockers were no better than psychological support in reducing psychological distress (Biggs, 2019; Costa et al, 2015).

In relation to cross-hormonal treatment, a NICE review found that the evidence for the clinical effectiveness and safety of gender-affirming hormones was also of "very low" quality. As it points out, any potential benefit of gender-affirming hormones must be weighed against a hitherto unknown long-term safety profile (NICE, 2020b). A Cochrane Library systematic review concludes, "We found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches (estradiol alone or in combination with cyproterone acetate or spironolactone) for transgender women in transition. The evidence is very incomplete, demonstrating a gap between current clinical practice and research" (Haupt et al, 2020, p. 11).

On the other hand, even though affirmative sex reassignment surgery shows short-term (one or two year) beneficial effects, unfortunately, the long-term benefits at ten-year follow-ups disappear. A 10-year average follow-up study conducted in Sweden on 324 transsexuals who, over a thirty-year period (1973-2003), received affirmative surgery shows that they have considerably higher risks of mortality, suicidal behavior, and psychiatric morbidity than the general population. Compared to the general population, patients who underwent surgery had a rate of completed suicide that was 19 times higher, nearly three times the rate of all-cause mortality, nearly three times the rate of psychiatric hospitalization, and nearly five times the rate of suicide attempts (Dhejne et al, 2011). A recent Swedish study shows that affirmative surgery does not actually improve the mental health of transgender people compared to transgender people who did not undergo surgery (Correction to Bränström & Pachankis, 2020; Van Mol et al, 2020), contrary to the authors' optimistic conclusions in an early version of the article (Bränström & Panchankis, 2020) that they had to correct.

A long-term retrospective study of 8,263 patients referred to the gender clinic at the University of Amsterdam between 1972 and 2017 found that the annual rate of completed suicides among transgender subjects was "three times higher" than the general population. The incidence of suicide deaths was almost equally distributed across the different stages of transition. In other words, neither social nor medical transition reduced the suicide rate (Wiepjes et al. 2020). Importantly, the mean time between commencing hormones and suicide was 6.1 years for natal males and 6.9 years for natal females (Wiepjes et al. 2020). An earlier study had already shown this delayed effect. Thus, in a sample of 1,331 transsexuals followed for an average of 18 years, while there were no suicides in the first 2 years, there were 6 after 2 to 5 years, 7 after 5 to 10 years, and 4 after more than 10 years since cross-sex hormone treatment (Asscheman et al. 2011). The results suggest that short-term or even medium-term studies overlook the phenomenon of suicide.

These findings do not imply that hormonal or surgical treatment *causes* suicide. This occurs because transgender people suffer a high incidence of "comorbidities" that correlate with suicide (depression, self-injurious behavior, anorexia, autism spectrum, trauma), as well as discrimination, disrespect, and violence (Biggs, 2020; Zucker, 2019). What these results show, at least, is that neither hormonal nor surgical affirmation solve all the initial problems, nor do they solve them completely. Moreover, these individuals do not seem to be on the path to a healthy life, contrary to the enthusiasm and haste with which the transition is promoted.

From the perspective of these studies, the purported "new evidence" supposedly supporting affirmation surgery—based on a general survey that, incidentally, merely shows lower odds of psychological distress in the past month, and of smoking and suicidal ideation in the past year, compared to transgender people without a history of affirmation surgery—is not justified (Almazan & Keuroghlian, 2021). Also not justified is the emphasis in favor of affirming medication based on short-term improvements, which, on the other hand, also cannot be ruled out as being due to other things, such as possible psychiatric medication and family support that the authors themselves acknowledge (Tordoff et al, 2022). The best help for children and adolescents does not start with getting them directly into affirmative therapy (D'Angelo et al, 2021; Griffin et al, 2021; Levine et al, 2022; Marchiano, 2021; Zucker, 2019).

Nor is the haste with which a pediatric clinical guideline recommends affirmative therapies justified on the assumption that, if "they are delayed excessively or there is no affirmative social intervention to support these minors, there could be an overall increase in psychopathology and other undesirable situations" (Moral-Martos et al, 2022, p. 3). As the guideline itself acknowledges: "Although experience in the management of hormonal and surgical treatments is increasingly extensive, the scientific evidence is weak and relatively scarce due to the lack of methodologically adequate studies that assess long-term results, especially for treatments initiated in the peripubertal stage; however—as the guideline continues—there is evidence that demonstrates the benefits of both pubertal blocking and gender affirmation treatment on the health of trans people" (Moral-Martos et al, 2022, p. 3). In this regard, the guideline cites as evidence four studies (Chew et al, 2018; López de Lara et al, 2020; T'Sjoen et al, 2019; Turban et al, 2020), which themselves are, curiously, examples of studies that are methodologically inadequate to assess long-term outcomes, due to their acknowledged or readily demonstrable low quality and certainly no long-term follow-up. Table 2 shows what these studies contribute.

Table 2.
Quality and conclusions of the purported evidence of the Clinical Guideline for the care of transsexual minors (Moral-Martos et al, 2022).

Studies cited:	Quality / Conclusions:
Chew et al, 2018	"Low-quality evidence suggests that hormone treatments for transgender adolescents may achieve their intended physical effects, but evidence on their psychosocial and cognitive impact is generally lacking." (Abstract). "There is a medium to high risk of bias in existing studies, given the small sample sizes, retrospective nature, and lack of long-term follow-up." (p. 16).
López de Lara et al, 2020	Sample bias consisting of "simple volunteering" from a "very favorable setting"; 1-year follow-up after initiation of cross-sex hormone therapy; control group of little relevance (recruited from pediatric endocrinology practice), not for example gender incongruent adolescents without, or awaiting, hormone therapy.
T'Sjoen et al, 2019	"The current available research is based primarily on cross-sectional studies, with limited longitudinal data." (p. 112). "Future studies should [...] provide evidence on the effect of gender-affirming treatment in the non-binary population." (Abstract).
Turban et al, 2020	Despite its dissemination in the media, their finding derives from low quality studies, as shown by Biggs, 2020, who concludes that "Turban et al (2020) contribute nothing to our knowledge of the effects of pubertal suppression in adolescents."

It is inconceivable that a pediatric guideline would take the supposed evidence for affirmative therapy so lightly, or be so naïve, as will also be discussed below.

Self-diagnosis as if children were wise

Felt identity and affirmative therapy imply "self-diagnosis" with no other options for the professional than accompaniment and a "one-size-fits-all" approach (D'Angelo et al, 2021). On the other hand, the presence of psychological disorders is well known in adolescents with gender dysphoria, including depression, anxiety, self-injurious behavior, suicidal ideation and behavior, eating problems, and autism spectrum (Kaltiala-Heino et al, 2018).

It is understood that a professional knows more than a child or adolescent. Children and adolescents are not wise, and—like other people—their feelings are not exempt from social influences. To provide the best possible help, the professional needs—of course—to study and understand the different aspects involved in people's suffering. Psychology has the knowledge and resources to understand people in order to know what is happening to them and to make the best decisions. The professional relationship is based on respect and empathy, but respect does not necessarily consist of affirming everything the client or patient says, as if he or she were a customer in a department store. Nor does empathy consist of merely agreeing, but rather it consists of taking seriously what we are told in accordance with our professional knowledge. In fact, agreeing to everything could be disrespectful, even more so in a scientific, ethical, and professional context.

Consider these situations. In the context of psychotherapy for depression, anxiety, autism spectrum, anorexia, or self-injurious behavior, the client says she is a boy. Has the psychotherapy ended here? Does the newly stated gender dysphoria/incongruence explain everything? Should the practitioner focus on the initial problem apart from the dysphoria? Should the practitioner include dysphoria in the ongoing psychotherapy? By including it, does he/she not run the risk of being accused of supposedly applying "conversion therapy" instead of the mandatory affirmative therapy? In the context of accompanying affirmative therapy, problems of depression, anxiety, autism spectrum, anorexia, or self-injurious behavior emerge. Should these problems be left aside and the affirmative therapy continued? Should they be treated in parallel? Should we simply assume that these problems derive from gender dysphoria and expect that affirmative therapy will solve them? What if these problems predate the dysphoria and everything seems to indicate that the dysphoria derives from them? These are dilemmas to which the policy on gender dysphoria leads, contrary to the knowledge and procedure applicable to all other problems.

It is argued that the application of psychology to dysphoria would be tantamount to pathologizing it. Apart from the fact that no such connection—psychology-pathologizing—can be made at all, the irony is that nothing amounts to greater pathologizing than a pharmaceutical-surgical therapy such as affirmative therapy. If gender dysphoria/incongruence is considered to be a psychosocial discomfort with one's own body (since no one is born in the wrong body), affirmative therapy becomes a psychotherapy with a scalpel that turns a healthy person into a patient for life.

Hasty transitions leading to the new problem of de-transitions

Whilst there is no denying that transition may be the best option for someone, the new phenomenon is also true; that of individuals who regret the transition undertaken and would like to de-transition when there has already been irreversible damage (Shrier, 2021). Although the transactivist movement attempts to deny or minimize its existence, the fact is that the case of regretters who want to go back is a new phenomenon that has been underestimated until now. At present, there are no predictors that allow us to know in advance for whom transition would be the best option. There is a dilemma

here between the suffering of waiting if transition does not happen *now* and the irreversible damage due to rushing into transition. Transactivism seems to favor the first option. However, waiting may bring the solution or lead to the requested option from the age of 18, while irreversible damage is forever. There are no predictors, but there is a growing rate of regret and detransitioners. According to a study conducted in the United Kingdom, 6.9% of people treated with affirmative therapy were detransitioners within 16 months of starting treatment, and another 3.4% had a pattern of medical care suggestive of detransition (Hall, Mitchell, & Sachdeva, 2021, p. 6).

Another study also from the United Kingdom found that 12% of those who had started hormone treatments either detransitioned or required further evaluation, and 20% ceased treatment for a variety of reasons. As the authors conclude, "The rate of detransition found in this population is new and raises questions about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields." (Boyd, Hackett, & Bewley, 2022, p. 13).

A study conducted online, with the purpose of describing a population of people who experienced gender dysphoria, chose to undergo a drug-surgical transition, and then dropped out, recruited one hundred participants, 69 natal females and 31 natal males (Littman, 2021). The study was interested, among other things, in the reasons for both transition and detransition. Table 3 shows some of the reasons for transition and Table 4 for detransition.

Table 3.
Reasons for transition (Littman, 2021)

More than one answer is possible	Female	Male
	69%	31%
I wanted to be perceived according to the desired gender	77%	77%
I thought transitioning was my only option to feel better	72%	68%
I felt bad in my body the way it was	72%	68%
I did not want to be associated with my native sex/gender	74%	61%
It made me uncomfortable to be perceived romantically/ sexually as a member of my birth sex/gender	71%	58%
I thought transitioning would eliminate my gender dysphoria	39%	29%
I was not satisfied with the physical results of the transition (insufficient)	62%	71%
I felt I would become the real me	61%	71%

Table 4.
Reasons for detransition (Littman, 2021)

More than one answer is possible	Female	Male
	69%	31%
I felt more comfortable identifying with my native gender	65%	48%
I was concerned about possible medical complications from the transition	58%	29%
My mental health did not improve during the transition	49%	35%
I was dissatisfied with the physical results of the transition/ feel that the change was too much	50%	16%
I found out that my dysphoria was due to something else (trauma, abuse, mental health)	40%	32%
My mental health worsened during the transition	39%	29%
I was not satisfied with the physical results of the transition	32%	35%
I found more effective ways to help me with gender dysphoria	36%	22%
My physical health worsened during the transition	30%	35%

Another online study, in this case with the purpose of analyzing the specific needs of detransitioners, recruited 237 participants, of whom 217 (92%) were natal females and 20 (8%) natal males (Vandenbussche, 2021). Table 5 shows excerpts from experiences of exclusion from LGBT+ communities reported by detransitioners.

Table 5.
Excerpts from experiences of exclusion of LGBT+ communities reported by detransitioners (Vandenbussche, 2021).

—"The LGBT+ community does not support detransitioners and I lost all the LGBT+ friends I had because I was considered transphobic/terf, only non-LGBT+ friends supported me."
—"Where I live, most of the LGBT community views detransitioners badly, so it's hard to talk about it freely."
—"It is unacceptable that, at least in my experience, detransition is not something that is allowed to be talked about in LGBT spaces."
—"I was only helped by lesbians and feminists. The trans and queer community demonized and marginalized me because of my reidentification."
—"I lost a lot of support and attracted a lot of hostility from trans people when I did social detransition."
—"LGBT organizations don't want to talk about detransition. I didn't feel welcome at LGBT events after I resigned from transition."
—"Telling my trans friends that I desist is nearly impossible. The community is too toxic to allow any kind of discussion about alternatives to transitioning, sources of dysphoria beyond 'that's who you are,' or stories about detransitioners."
—"I have been rejected by most of my friends who identify as trans. I had to leave my former doctor, therapist, and LGBT group out of shame."
—"I have several detrans friends who had permanent body alterations that they regretted and that led to more dysphoria, and eventually their suicides. The biggest factors were lack of medical support and outright rejection from LGBT communities."
—"I still have transgender friends who don't want me to talk about detransitioning. They're fine with me, but they don't want me to criticize transition or discuss its negative effects."

Similarly, the study shows negative medical experiences during detransition ("When I first mentioned to my doctor that I wanted to get off testosterone, they were very dismissive and condescending about it;" "As soon as I 'detransitioned' I was discharged from all gender services, despite asking for help in dealing with sexual dysphoria in case it resurfaced," etc.) as well as difficulties in finding therapists that are friendly to detransitioners (Vandenbussche, 2021, p. 11).

After the enthusiastic support for the transition, the abandonment of people who repent and want to de-transition leads them to form self-help groups, an initiative that is also undertaken by groups of parents. Table 6 lists some of these self-help groups. Beyond these aids, "clinical guidelines" are required for detransitioning according to its typology if it is motivated by the cessation of transgender identity or for other reasons (Boyd et al, 2022; Expósito-Campos, 2021).

The prevailing narrative about detransitioning says that most people who detransition will transition again and that the reasons for detransitioning are discrimination, pressure from others, and non-binary identification (Turban et al., 2021). Although that does also occur, case studies shed light on a broader and more complex range of experiences that include a variety of psychological problems, worsening mental health after transition, reidentification with natal sex, and difficulty separating sexual orientation from

Table 6.
Some self-help groups for detransitioners and parents

Self-help groups for detransitioners:
— Detrans Voices. https://www.detransvoices.org/about/
— Detransition Advocacy Network. https://www.detransadv.com/about
— Pique Resilience Project: https://www.piqueresproject.com
— Post Trans. https://post-trans.com/About-Us
— r/detrans | Detransition Subreddit reddit.com/r/detrains
Parent support groups:
— Amanda (Agrupación de Madres de Adolescentes y Niñas con Disforia de Género)
— Bayswater Support Group. https://www.bayswatersupport.org.uk/
— Cardinal Support Network. https://www.cardinalsupportnetwork.com/
— No Corpo Certo. https://nocorpocerto.com/
— Our Duty. https://ourduty.group/

gender identity (D'Angelo, 2020; De Celis Sierra, 2021; Expósito-Campos et al, 2022; Levine, 2018; Pazos Guerra et al., 2020; Withers, 2020). It is crucial to study each case if we want to understand and recognize the reality of this suffering (which involves multiple dimensions) and offer help and solutions tailored to the individual beyond the "one-size-fits-all" approach imposed by affirmative therapy.

What to do instead of affirmative therapy?

What all clinicians do in all cases: evaluation, exploration, functional analysis, clarification, questions, confrontation, common sense, prudence, attentive waiting, help according to needs and problems. No "blanket approach". The issue should probably be not so much about diagnosing whether one is actually transgender or not, but more about helping according to the issues, including transition support. The drive to diagnose whether or not someone is actually trans involves a double bias—essentialist and biomedical—which does not correspond to the fluid, nonlinear dynamics of gender identity development (Pullen Sansfaçon et al, 2020), including desistance (Steensma et al, 2011). Properly informed consent should be a process rather than an event (Levine et al, 2022; Wren, 2019).

However—incredible as it may seem—everything that clinicians do regarding the other problems is forbidden here, under the accusation of "conversion therapy." Fortunately, conversion therapy is not applied today, even though it is used as a disqualification for everything that is not affirmative therapy. According to Roberto D'Angelo et al, exploratory psychotherapy, which is neither affirmative nor conversion therapy, should be the first line of help for children and adolescents with gender dysphoria, thus avoiding invasive and irreversible medical procedures (D'Angelo et al, 2021, p.13). If only for the Hippocratic principle "First, do no harm", affirmative therapy should be the last resort, not the first.

What would happen without affirmative therapy?

Most children and adolescents would naturally resolve gender incongruence, in the order of 60% to 90% according to studies (Cantor, 2020; Levine et al, 2022; Ristori, & Steensma, 2016; Singh, Bradley, & Zucker, 2021). This was the case before the current affirmative policy that, in practice, begins with social transition.

Thus, a follow-up study of an average of 20 years conducted in Canada between 1975-2009 followed the evolution of children (boys) with gender dysphoria with an average age of 7 years. Of the 139 participants, 17 (12.2%) were classified as persistent and the remaining 122 (87.8%) as desisters. Data on sexual orientation in fantasy for 129 participants were: 82 (63.6%) were classified as biphilic/androphilic, 43 (33.3%) as gynephilic, and 4 (3.1%) reported having no sexual fantasies. Regarding the behavioral sexual orientation of 108 participants: 51 (47.2%) were classified as biphilic/androphilic, 29 (26.9%) were classified as gynephilic, and 28 (25.9%) reported no sexual behaviors (Singh et al, 2021). Similarly, a follow-up study (mean 23 years) of 25 girls with gender dysphoria of a mean age of 9 also conducted in Canada between 1975 and 2004 showed that 12% continued with dysphoria and 88% had remitted. In terms of sexual orientation, 8 participants (32%) were classified as bisexual/homosexual in fantasy, and 6 (24%) were classified as bisexual/homosexual in behavior (Drummond et al, 2008).

A follow-up study of an average of 10 years conducted in the Netherlands between 1989 and 2005 followed 77 children with gender dysphoria (59 boys and 18 girls with an average age of 8 and 5 years respectively). Twenty-seven percent (12 boys and 9 girls) were still gender dysphoric and 43% (28 boys and 5 girls) were no longer gender dysphoric. The other 30% (19 boys and 4 girls) did not return for follow-up. It is reasonable to assume that those who did not return could be desisters, considering that in the Netherlands treatment is accessible and free of charge and the only place where it is provided is at the clinic where the study was conducted (Wallien, & Cohen-Kettenis, 2008, p. 1430). In another study also conducted in the Netherlands, of 127 adolescents (79 boys and 48 girls) who were 15 years or older during the 4-year follow-up period between 2008 and 2012, 37% (23 boys, 24 girls) were identified as persistent, requested medical treatment, and were considered eligible to undertake it. While the remaining 63% (56 boys and 24 girls) did not return to the clinic, so it can be assumed that their dysphoria subsided, in line with what was said above about services in the Netherlands (Steensma et al, 2013, p. 583).

However, studies currently show low desistance and high persistence. Thus, a study conducted in the USA between 2013 and 2017 on 317 transgender children with an average age of 8 years (208 transgender girls and 104 transgender boys) found that 94% maintained transgender identity five years after the onset of social transition (Olson et al, 2022). Another study consisting of a retrospective observational review of the medical records of all children under 18 years of age who attended the Gender Identity Unit of Catalonia between 1999 and 2016, found a persistence of 97.6% at a follow-up of an average of 2.6 years (De Castro et al, 2022). The high persistence found in these studies, and not just these ones, contrasts with previous desistance sometimes summarized in the controversial figure of "80% desistance", the subject of replications (Temple Newhook et al, 2018) and counter-replications (Steensma & Cohen-Kettenis, 2018; Zucker, 2018).

Among the reasons for this discrepancy is the greater visibility and acceptance of gender dysphoria in our time, which may facilitate its "expression" as well as family support (De Castro et al, 2022; Olson et al, 2022). However, things are not so simple.

On the one hand, the supposed "expression" of dysphoria thanks to visibility and acceptance implicitly carries the assumption that gender dysphoria was already there inhabiting the wrong body, a metaphysical and ideological explanation if ever there was one (Errasti & Pérez-Álvarez, 2022; Moschella, 2021; Sadjadi, 2019).

On the other hand, visibility and acceptance themselves involve modeling and shaping functions, according to well-known processes in psychology. More specifically, social transition is already part of the treatment of gender dysphoria in current studies (Olson et al, 2022; De Castro et al, 2022, p.7). Far from being a neutral, spontaneous, natural expression, social transition already implies a model, a ritual, an approval, a style, and a way of being, not only acceptable but even particularly valued (hero, cool). This is not to say that there are no extreme gender differences prior to social transition (Rae et al, 2019), but in the current context, social transition is already part of the affirmative therapy train or conveyor belt.

Clinical settings take social transition very naturally and with the best intentions in the world. However, clinicians are not being neutral or allowing the free expression of who one is, as they may believe. The uncritical, often enthusiastic, assumption of social transition means confirming and validating a discourse and a state of affairs that may still remain to be seen for what it is. In a clinical context, social transition already implies psychosocial treatment (Cass, 2022; Levine et al, 2022; Zucker, 2018).

The aforementioned pediatric guideline indicates: "Address the child by the name he/she has chosen for him/herself, and according to the gender identity expressed. If they have a non-binary identity, ask with which pronoun and name they want to be addressed" (Moral-Martos et al, 2022, p. 3). However, what the clinician does is not a mere social treatment (however intentionally respectful), but a psychosocial treatment, a kind of "wild psychotherapy" (recalling Freud's famous expression) that validates and orients in a certain direction and not in another or in none. It orients towards affirmative pharmaco-surgical therapy, and without delay, as the aforementioned guideline continues the "psychological accompaniment", it says, "must not imply postponing a possible affirmative therapy". It is not proposed here to invalidate the experience and suffering, which are undoubtedly real. The question is how they have become real, without taking for granted that they are the pristine expression of an inner essence or soul inscribed in the body (Sadjadi, 2019). Far from desistance research being irrelevant (Ashley, 2021), it is fundamental for a better understanding of the natural course of dysphoria and the best help for each individual, rather than "one size fits all" (D'Angelo et al, 2021).

It is a delicate matter to quibble about "family support" and "affirmation". But if parents want the best for their children, as they undoubtedly do, and as clinicians do for their clients, then they should think more about what they are doing, rather than following mantras. What would the clinician do if, for example, they received a cachectic anorexic teenager who sees herself as too fat and wants to lose weight, or a suicidal teenager who is convinced that life is meaningless and the best thing to do is to die? Support and affirm? What would parents do if their children told them they were happy staying at home playing on their cell phone instead of going to school or high school?

How did we get here?

How has this ideology imposed itself on professional practice over knowledge and standards in other fields? How has queer moved from marginality to being the new orthodoxy? How has a small number of organizations influenced public bodies, institutions, professional practices, as well as common language? How does an intolerant minority impose itself on the majority? Perhaps this last question is explained by Nassin Taleb's rule of the intransigent minority willing to gamble with its skin (Taleb, 2019). It is not possible to answer the other questions satisfactorily here, but they cannot be left unasked. Since neither scientific findings nor evidence-based practice justify the new orthodoxy that is being imposed, it is necessary to look beyond it. A few threads will be pointed out that a systematic investigation would surely have to unravel.

Like bamboo

There is an accumulation of proximate and ultimate conditions intermingled. Nothing comes out of nowhere or suddenly. Like bamboo, the ideology of queer/trans genderism has grown fast, but it has taken its time to take root in the shade. The proximate conditions in the shade are those roots that suddenly surprise us with their growth. But it all depends on a propitious soil and climate: its ultimate conditions.

In relation to ultimate conditions, we have to situate ourselves in Western society, open, democratic, cosmopolitan, and affluent, even though neither wealth nor well-being are equally distributed. This open society is also a liquid society with a particular spirit of the times characterized by subjectivist, expressive, and narcissistic individualism, which is embodied in a floating (liquid, flexible, fluid) individual. Fluid sex and gender are not alien to the liquid society we live in. *Felt* gender identity is not something independent of subjectivist individualism, no matter how much it may seem to each one that it springs from his or her primal nature, his or her true self, or something like that. Ideology is in charge of making people believe it.

In this context, one would not fail to cite the declining birth rate (Douthat, 2021), the decline of sexual relations (Herbenick et al, 2022; South, & Lei, 2021), or the irrelevance of biological sex (Ekman, 2022; Miyares, 2022; Stock, 2022) as a breeding ground for transgender ideology, which in turn feeds back into it. More specifically, subjectivist individualism—expressive and narcissistic—is characteristic of neoliberal capitalism, which is characterized precisely by the creation of desires as if they were expressions of natural essences that one carries within oneself. And here, to the astonishment of history, this subjectivist individualism is the raison d'être of the identitarian left, which turns desires into rights, such as gender dysphoria, which curiously satisfies neoliberal capitalism with its pharmaceutical-surgical industry. Unlike the classical universalist left that believed in science, truth, and universal rights, and highlighted the contradictions of capitalism, the identitarian left has become the best ally of neoliberal capitalism. We are before an example of "how theories or positions that at first were thought to be progressive and left-wing, have not only shown their political ineffectiveness, but have been successfully assumed by neoliberalism" (Rodríguez Magda, 2021a, p. 20).

The queer/trans ideology has social justice and human rights as its banner, so presumably it has the approval of everyone. It is difficult to find anyone who is not in favor of social justice and human rights. However, not everything is as it seems. The social justice of the queer movement has become a "new religion", a secular religion hostile to reason, to falsification and to any disagreement other than its own truth, a truth based on the "lived experience" of marginalized people and groups, who by the fact of being marginalized are "enlightened" and declare others incapable of understanding anything. We are no longer speaking of a universal social justice capable of understanding the objective conditions of reality, but of an experiential and tribal social justice, according to the tribe to which one belongs (Errasti & Pérez-Álvarez, 2022, ch. 6; Malo, 2021, ch. 6). With regard to human rights, it is not easy to see whether they are taken seriously, or whether they have a partisan (judging by the abandonment in which the detransitioners are left, as has been seen) and strategic use, as will be said. It is certainly easy to be on the queer side, because it is supposed to be the good side and lends itself to virtue signaling, a form of ethical posturing.

However, we would not get here without the proximate causes - how the roots suddenly sprouted - referring in particular to the trans lobby. Not to mention the social networks, without which nothing would be the same. As far as we are concerned, suffice it to recall the strategies of transgender activism, while still "following the money".

Activist strategies

The strategies of transgender activism are described in the paper uncovered by James Kirkup (Kirkup, 2019; 2021) that was produced by the law firm Dentons, the Thomson Reuters Foundation, and the International Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Youth and Student Organization (IGLYO) entitled "Only Adults? Good practices in legal gender recognition for young people" (Dentons, Thomson Reuters, & IGLYO, 2019). Table 7 lists lobbying tactics to change laws so that self-determination of gender identity with no age minimum prevails over what parents and professionals say (Dentons et al, 2019, p. 15).

Table 7.
Strategies to promote gender self-determination in minors (Dentons et al, 2019).

1. *Target young politicians*.
2. *De-medicalize the campaign*, "so that gender recognition can be seen in the eyes of the public as distinct from gender-confirming treatments" (p. 18).
3. *Use case studies of real people*.
4. *Anonymize the narratives*.
5. *Get ahead of the political agenda of governments* with legislative proposals that will be accepted by the people (p. 19).
6. *Use human rights as a campaign point*, knowing that "human rights arguments have been instrumental in several successful campaigns to promote more progressive gender recognition laws" (p. 19).
7. *Tie the campaign to a more popular reform*, e.g., marriage equality, so that it serves as a hook for harder-to-get support such as for gender identity.
8. *Avoid excessive press coverage and exposure*.
9. *Carpe diem*. "Activists need to capitalize on the political moment" (p. 20).
10. *Work together* (with other domestic organizations).
11. *Be cautious with commitment* (because it is a double-edged sword, don't commit too much).

With regards to "following the money," there are corporations and billionaire families funding queer genderism (Bilek, 2018; 2020; *Contra el Borrado de las mujeres* [Against the Erasure of Women], 2020; Miyares, 2022, pp.113-115). Far from being marginal, the queer movement is now a rich and powerful lobby.

None of this denies the good intentions of the activists. But intentions do not guarantee that the best is being done. According to the well-known phrase of Nobel Prize-winning physicist Steven Weinberg: "Religion or no religion, good people do good things and bad people do bad things. But for good people to do bad things, you need a religion".

You might think of it as progressive

One might think that gender identity is a progressive and liberating idea. But it is actually backward and oppressive. It is backward because of the following:

1. It reintroduces sexual stereotypes on account of gender identity; it cannot be assumed, for example, that a girl who likes soccer is actually a boy according to gender identity protocols (Ekman, 2022; Errasti & Pérez-Álvarez, 2022).
2. It denies that women exist as political subjects defined by their biological bodies and, instead, offers a tautological definition according to which "women are those who feel themselves to be women" (Ekman, 2022; Rodríguez Magda, 2021b; Miyares, 2022; Stock, 2022).
3. It reintroduces the soul/body dualism, where now the soul is the felt gender identity, trapped in the wrong body which must be corrected (Moschella, 2021; Sadjadi, 2019).
4. While the de-medicalization of adult trans people is being promoted, minors with gender dysphoria are increasingly being medicated (Grup d'ètica CAMFiC, 2022).

It is oppressive because of the following:

1. It imposes affirmative therapy as the only acceptable option, not only without support to justify it, but with evidence to the contrary, as we have seen.
2. It imposes a neo-language that distorts the meaning of things, such as "sex assigned at birth," and circumlocutions to avoid the word "woman" ("pregnant people," etc.)
3. It prevents the debate on the transgender issue under the pretext that it is a matter of human rights, used in reality as a strategy, not to mention the well-worn accusation of transphobia used as a wild card to cancel all debate.
4. It blackmails parents with the dilemma "transition or death," "a trans child is preferable to a dead child," "if you don't support them, you don't love them," and "they will probably commit suicide."

What to do?

It is appropriate to consider the Statement on LGBTIQ+ issues from the International Psychology Network on Lesbian, Gay, Bisexual, Transgender, and Intersex Issues (IPsyNet, 2018). There is agreement on a variety of proposals, including increasing psychological knowledge of human diversity on issues of sexual orientation, gender identities, gender expressions, and on applying this knowledge in support of well-being and the full enjoyment of

human rights; there is also agreement on depathologizing LGBTIQ+ people, differentiating between sexual orientation and gender identity, as well as rejecting both conversion therapy and the reinforcement of gender stereotypes. However, the assumptions that the IPsyNet Declaration adopts and the inconsistencies it incurs cannot be ignored.

The Declaration adopts what are known as the Yogyakarta principles, which are neither based on scientific knowledge, nor should they have more relevance than the private proposal of a pressure group. At the very least, their definition of gender identity as a "deep inner feeling" is highly debatable, which, as has been said, implies an essentialist conception that does not correspond to the changing process and fluidity of gender identity. Not to mention the expression "sex assigned at birth," which is entirely ideological, as well as counterfactual. The Declaration is blatantly inconsistent. If, on the one hand, it states that identities and orientations "do not require therapeutic interventions to be changed" (point 3), on the other hand, it goes on to support "affirmative approaches" and, in point 4, it calls for access to "available treatments", again referring to affirmative transition which, as is well known, includes irreversible pharmaco-surgical interventions. In general, the Declaration is oriented towards affirmative therapy. Its rejection of conversion therapy, which, it seems, includes anything but affirmation, overlooks the fact that between affirmation and conversion there are a variety of alternatives. Given the insistence on affirmation it might be suggested that the greatest conversion therapy is in fact affirmative therapy, known to leave no room for potential desisters that have always existed and knowing the new phenomenon of repenters and detransitioners.

Another inconsistency is found between the stated differentiation between sexual orientation and gender identity and their continued use as if they were on a par. It also states that "sexual orientation and gender identity remain fairly constant throughout life," only to add that "changes in orientation and gender identity may occur across developmental stages within the life course. Finally, the Statement assumes that the psychological difficulties associated with gender incongruence occur solely because of stigma and discrimination, without considering the possibility that the identity distress itself may result from a variety of prior psychological problems.

Given their more judicious and thoughtful consideration, four ideas taken from the Ethics Group of the Catalan Society of Family and Community Medicine (Grup d'ètica CAMFiC, 2022) are proposed:

Start with the right of minors to the free development of their identity, instead of prioritizing the right to transition. Take parents, guardians, and teachers into account when making decisions that involve important and irreversible consequences.

Demand professional evaluation. Self-determination in minors cannot be unconditional and affirmative.

Implement watchful waiting as an alternative to affirmative therapy, as well as psychological evaluation and exploration.

Accept that exploring and questioning the desire to transition is not at all about being against people (parents or children). The person presenting with gender dysphoria/gender incongruence should be treated as an individual person, not as a collective.

Conclusions

Rapid-onset gender dysphoria (ROGD) is a social phenomenon, not a clinical entity or a malaise to be pathologized. As a discomfort, it involves a suffering that must be understood and addressed according to the circumstances of each person.

The psychological study of gender dysphoria in no way implies its pathologization as is erroneously and tendentiously assumed by excluding psychological or psychiatric exploration for the sake of affirmative therapy.

No one is trapped in the wrong body, if anyone is trapped at all it is in erroneous discourses based on sexual stereotypes presented as gender identities, under the protection of genderism that naturalizes and essentializes them. Gender identity represents a new version of the soul within the body, the revived dualism.

Self-determination of identity based on sentiment and affirmative therapy as the only acceptable option constitute the ideology that dominates the health professions, instead of scientific knowledge, evidence-based practice, and prudence.

Affirmative therapy should be the last resort, not the first as it has been established.

Exploratory psychotherapy, functional behavior analysis, psychological assessment, and attentive monitoring are examples of practices by which to begin to understand gender dysphoria with a view to the best help for each individual. None of these practices is conversion therapy, nor is it affirmative therapy.

"Treating trans people with dignity, respecting their autonomy and right to decide, does not mean uncritically acceding to their demands for treatment. It means giving their suffering the same concern, consideration, and value as given to other people. Treating trans people equally does not mean treating them the same but rather taking into account their unique needs so that they have the same opportunities to achieve their fullest possible life" (Esteva de Antonio, Expósito-Campos, & Gómez-Gil, 2021, p. 150).

Conflict of interest

The authors declare that there is no conflict of interest.

References

Almazan, A. N., & Keuroghlian, A. S. (2021). Association between Gender-Affirming Surgeries and mental health outcomes. *JAMA surgery, 156*(7), 611–618. https://doi.org/10.1001/jamasurg.2021.0952

Alsedo, Q. (2022a). Ame en el laberinto del género: "Creí que era trans, pero me equivocaba" [Ame in the labyrinth of gender: "I thought I was trans, but I was wrong"]. *El Mundo*, 19th April 2022. https://www.elmundo.es/papel/historias/2022/04/18/625d96cbfdddffbe598b4585.html

Alsedo, Q. (2022b). "Dicen que mi hija es un chico, pero en realidad tiene depresión" [They say my daughter is a boy, but she actually has depression]. *El Mundo*, 27th April 2022.

Ashley, F. (2021). The clinical irrelevance of "desistance" research for transgender and gender creative youth. *Psychology of Sexual Orientation and Gender Diversity.* Advance online publication. https://doi.org/10.1037/sgd0000504

Asscheman, H., Giltay, E. J., Megens, J. A., de Ronde, W. P., van Trotsenburg, M. A., & Gooren, L. J. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology*, *164*(4), 635–642. https://doi.org/10.1530/EJE-10-1038

Bartlett, T. (2019). "Journal issues revised version of controversial paper that questioned why some teens identify as transgender". *The Chronicle of Higher Education*. Consultada el 28/4/2022.

Bell, K. (2021). Keira Bell, la chica arrepentida de convertirse en hombre, gana el juicio con polémica [Keira Bell, the girl who regretted becoming a man, wins controversial trial]. *Nius*. https://www.niusdiario.es/vida/visto-oido/keira-bell-chica-transgenero-gana-juicio-terapia-hormonal-transexuales_18_3052095284.html (Retrieved on 1/5/2022).

Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with Gender Dysphoria. *Journal of Sexual Medicine*, *16*(12), 2043. https://doi.org/10.1016/j.jsxm.2019.09.002

Biggs, M. (2020). Puberty blockers and suicidality in adolescents suffering from Gender Dysphoria. *Archives of sexual behavior*, *49*(7), 2227–2229. https://doi.org/10.1007/s10508-020-01743-6

Bilek, J. (2018). Who are the rich, white men institutionalizing transgender ideology? *The Federalist*. https://thefederalist.com/2018/02/20/rich-white-men-institutionalizing-transgender-ideology/ (Retrieved on 20/5/2022)

Bilek, J. (2020). The Stryker Corporation and the Arcus Foundation: Billionaires behind The New 'LGBT' Movement. *Uncommon Ground Media*. https://uncommongroundmedia.com/stryker-arcus-billionaires-lgbt/ (Retrieved on 20/5/2022)

Binetti, M. J. (2021). La ideología queer y sus dispositivos económico-políticos para sustituir el "sexo" por la "identidad de género" [Queer ideology and its economic-political devices to replace "sex" with "gender identity"]. *Red Sociales, 8*, 15-30.

Bonfatto, M., & Crasnow, E. (2018). Gender/ed identities: An overview of our current work as child psychotherapists in the Gender Identity Development Service. *Journal of Child Psychotherapy*, *44*(1), 29-46. https://doi.org/10.1080/0075417X.2018.1443150

Boyd, I., Hackett, T., & Bewley, S. (2022). Care of transgender patients: A general practice quality improvement approach. *Healthcare, 10*(1), 121. https://doi.org/10.3390/healthcare10010121

Bränström, R., & Pachankis, J. E. (2020). Reduction in mental health treatment utilization among transgender individuals after Gender-Affirming Surgeries: A total population study. *American Journal of Psychiatry, 177*(8), 727–734. https://doi.org/10.1176/appi.ajp.2019.19010080

Cantor, J. M. (2020). Transgender and gender diverse children and adolescents: Fact-checking of AAP policy. *Journal of Sex & Marital Therapy*, *46*(4), 307–313. https://doi.org/10.1080/0092623X.2019.1698481

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PloS one*, *16*(2), e0243894. https://doi.org/10.1371/journal.pone.0243894

Cass, H. (2022). *Independent review of gender identity services for children and young people: Interim report*. https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

Chew, D., Anderson, J., Williams, K., May, T., & Pang, K. (2018). Hormonal treatment in young people with Gender Dysphoria: A systematic review. *Pediatrics*, *141*(4), e20173742. https://doi.org/10.1542/peds.2017-3742

Claahsen-van der Grinten, H., Verhaak, C., Steensma, T., Middelberg, T., Roeffen, J., & Klink, D. (2021). Gender incongruence and gender dysphoria in childhood and adolescence-current insights in diagnostics, management, and follow-up. *European Journal of Pediatrics*, *180*(5), 1349–1357. https://doi.org/10.1007/s00431-020-03906-y

Clayton, A. (2022). The Gender Affirmative Treatment Model for youth with Gender Dysphoria: A medical advance or dangerous medicine? *Archives of Sexual Behavior*, *51*(2), 691–698. https://doi.org/10.1007/s10508-021-02232-0

Contra el Borrado de las mujeres [Against the Erasure of Women] (2020). El Lobby. La financiación del generismo queer [The lobby. Financing for queer generism]. https://contraelborradodelasmujeres.org/financiacion/ (Retrieved on 20/5/2022).

Correction to Bränström and Pachankis. (2020). *American Journal of Psychiatry*, *177*(8), 734. https://doi.org/10.1176/appi.ajp.2020.1778correction

Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with Gender Dysphoria. *Journal of Sexual Medicine*, *12*(11), 2206–2214. https://doi.org/10.1111/jsm.13034

D'Angelo, R. (2020). The man I am trying to be is not me. *International Journal of Psycho-analysis*, *101*(5), 951–970. https://doi.org/10.1080/00207578.2020.1810049

D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for Gender Dysphoria. *Archives of Sexual Behavior*, *50*(1), 7–16. https://doi.org/10.1007/s10508-020-01844-2

Dagny (2019). Ex-'trans man' wants the world to know that social media fuels kids' decision to change sex. *LifeSite*. https://www.lifesitenews.com/news/ex-trans-man-wants-the-world-to-know-that-social-media-fuels-kids-decision-to-change-sex/ (Retrieved on 1/5/2022).

Dahlen, S., Connolly, D., Arif, I., Junejo, M. H., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. *BMJ open, 11*(4), e048943. https://doi.org/10.1136/bmjopen-2021-048943

De Castro, C., Solerdelcoll, M., Plana, M. T. et al., (2022). High persistence in Spanish transgender minors: 18 years of experience of the Gender Identity Unit of Catalonia. *Revista de Psiquiatría y Salud mental*. https://doi.org/10.1016/j.rpsm.2022.02.001

De Celis Sierra, M. (2021). Pensar analíticamente sobre el transgenerismo, una tarea urgente. (Reseña de una controversia y un caso clínico en el IJP de noviembre de 2020) [Thinking analytically about transgenderism, an urgent task. (Review of a controversy and a clinical case in the IJP of November 2020).]. *Aperturas Psicoanalíticas* (66), Artículo e10. http://aperturas.org/articulo.php?articulo=0001148

Dentons, Thomson Reuters & Iglyo. (2019). Only adults? Good practices in legal gender recognition for Youth. International Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Youth & Student Organisation. https://www.iglyo.com/wp-content/uploads/2019/11/IGLYO_v3-1.pdf (Retrieved on 25/5/2022).

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PloS one*, *6*(2), e16885. https://doi.org/10.1371/journal.pone.0016885

Douthat, R. (2021). *La sociedad decadente. Cómo nos hemos convertido en víctimas de nuestro propio cuerpo* [The decadent society. How we have become victims of our own body]. Ariel.

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, *44*(1), 34–45. https://doi.org/10.1037/0012-1649.44.1.34

Ekman, K. E. (2022). *Sobre la existencia del sexo. Reflexiones sobre la nueva perspectiva de género* [On the existence of sex. Reflections on the new gender perspective]. Cátedra.

Entwistle, K. (2020). Debate: Reality check - Detransitioner's testimonies require us to rethink Gender Dysphoria. *Child and Adolescent Mental Health, 26*(1), 15–16. https://doi.org/10.1111/camh.12380

Errasti, J., & Pérez-Álvarez, M. (2022). *Nadie nace en un cuerpo equivocado: éxito y miseria de la ideología de género* [Nobody is born in the wrong body: The success and misery of gender ideology]. Deustt/ Planeta.

Esteva de Antonio, I., Expósito-Campos, P., & Gómez-Gil, E. (2021). Atención sanitaria a la transexualidad. Necesidad de experiencia interdisciplinar [Healthcare for transsexuality. The need for interdisciplinary experience]. In R. M. Rodríguez Magda (Coord.), *El sexo en disputa. De la necesaria recuperación jurídica de un concepto* [Sex contested. On the necessary legal recovery of a concept].] (pp. 129-152). Centro de Estudios Políticos y Constitucionales.

Expósito-Campos, P. (2021). A typology of gender detransition and its implications for healthcare providers. *Journal of Sex & Marital Therapy*, *47*(3), 270–280. https://doi.org/10.1080/0092623X.2020.1869126

Expósito-Campos, P., Gómez-Balaguer, M., Hurtado-Murillo, F., García-Moreno, R. M., & Morillas-Ariño, C. (2022). Medical detransition following transgender identity reaffirmation: two case reports. *Sexual Health*, *18*(6), 498–501. https://doi.org/10.1071/SH21089

Flier, J. S. (2018). As a former Dean of Harvard Medical School, I question Brown's failure to defend Lisa Littman. *Quillette*. Consultada el 28/4/2022.

Gómez-Gil, E., Esteva de Antonio, I., Fernández Rodríguez, M. et al. (2020). Nuevos modelos de atención sanitaria para las personas transgénero en el sistema sanitario español: Demandas, controversias y reflexiones [New models of healthcare for transgender people in the Spanish health system: Demands, controversies and reflections]. *Revista Española de Salud Pública, 94*, 16 de noviembre e202011123.

González-Pardo, H., & Pérez-Álvarez, M. (2007). *La invención de los trastornos mentales* [The invention of mental disorders]. Alianza.

Griffin, L., Clyde, K., Byng, R., & Bewley, S. (2021). Sex, gender and gender identity: A re-evaluation of the evidence. *BJPsych Bulletin*, *45*(5), 291–299. https://doi.org/10.1192/bjb.2020.73

Grup d'ètica CAMFiC (2022). Protección a menores con disconformidad-disidencia de sexo-género [Protection of minors with sex-gender nonconformity]. *Blog del Grupo de Ética de la Sociedad Catalana de Medicina Familiar y Comunitaria.* https://ecamfic.wordpress.com/2022/05/09/proteccio-als-menors-amb-disconformitats-dissidencies-de-sexe-genere/ (Retrieved on 18/5/2022).

Hall, R., Mitchell, L., & Sachdeva, J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: Retrospective case-note review. *BJPsych Open*, *7*(6), e184. https://doi.org/10.1192/bjo.2021.1022

Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *The Cochrane Database of Systematic Reviews*, (11), CD013138. https://doi.org/10.1002/14651858.CD013138.pub2

Herbenick, D., Rosenberg, M., Golzarri-Arroyo, L. *et al.* (2022). Changes in penile-vaginal intercourse frequency and sexual repertoire from 2009 to 2018: Findings from the National Survey of Sexual Health and Behavior. *Archives of Sexual Behavior, 51*, 1419–1433. https://doi.org/10.1007/s10508-021-02125-2

IPsyNet (2018). *Declaración sobre cuestiones LGBTIQ+, por parte de The International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues (IPsyNet), la Red de Psicología Internacional de Asuntos Lésbico, Gay, Bisexual, Transgénero e Intersexual* [Statement on LGBTIQ+ Issues, by The International Psychology Network for Lesbian, Gay, Bisexual, Transgender and Intersex Issues]. https://www.apa.org/ipsynet/advocacy/policy/statement-context-spanish.pdf (Retrieved on 18/5/2022).

Kaltiala-Heino, R., Bergman, H., Työläjärvi, M., & Frisén, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics*, *9*, 31–41. https://doi.org/10.2147/AHMT.S135432

Kirkup, J. (2019). The document that reveals the remarkable tactics of trans lobbyists. *The Spectator*. https://www.spectator.co.uk/article/the-document-that-reveals-the-remarkable-tactics-of-trans-lobbyists (Retrieved on 26/5/2022)

Kirkup, J. (2021). Revealed: the secret trans-rights lobbying operation in parliament. *The Spectator*. https://www.spectator.co.uk/article/revealed-the-secret-trans-rights-lobbying-operation-in-parliament (Retrieved on 26/5/2022)

Levine, S. B. (2018). Transitioning back to maleness. *Archives of Sexual Behavior, 47*(4), 1295–1300. https://doi.org/10.1007/s10508-017-1136-9

Levine, S. B., Abbruzzese, E., & Mason, J. W. (2022). Reconsidering informed consent for trans-identified children, adolescents, and young adults. *Journal of Sex & Marital Therapy*, 1–22. Advance online publication. https://doi.org/10.1080/0092623X.2022.2046221

Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE, 13*(8), e0202330. https://doi.org/10.1371/journal.pone.0202330

Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE, 14*(3), e0214157. https://doi.org/10.1371/journal.pone.0214157

Littman, L. (2020). The use of methodologies in Littman (2018) is consistent with the use of methodologies in other studies contributing to the field of Gender Dysphoria research: Response to Restar (2019). *Archives of Sexual Behavior*, *49*(1), 67–77. https://doi.org/10.1007/s10508-020-01631-z

Littman, L. (2021). Individuals treated for Gender Dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, *50*(8), 3353–3369. https://doi.org/10.1007/s10508-021-02163-w

López de Lara, D., Pérez Rodríguez, O., Cuéllar-Flores, I. et al. (2020). Evaluación psicosocial en adolescentes transgénero [Psychosocial assessment in transgender adolescents]. *Anales de Pediatría, 93*, 41-48. https://doi.org/10.1016/j.anpedi.2020.01.019

Malo, P. (2021). *Los peligros de la moralidad. Por qué la moral es una amenaza para las sociedades del siglo XXI* [The dangers of morality. Why morality is a threat to 21st century societies]. Deusto.

Marchiano, L. (2021). Gender detransition: a case study. *Journal of Analytical Psychology, 66*(4), 813-832. https://doi.org/10.1111/1468-5922.12711

Miyares, A. (2022). *Delirio y misoginia trans. Del sujeto transgnero al humanismo* [Delirium and trans misogyny. From the transgender subject to humanism]. Catarata.

Moral-Martos, A., Guerrero-Fernández, J., Gómez-Balaguer, M. et al. (2022). Guía clínica de atención a menores transexuales, transgéneros y de género diverso [Clinical guidelines for the care of transsexual, transgender, and gender-diverse minors]. *Anales de Pediatría, 96*(4), 349.e1-349.e11. https://doi.org/10.1016/j.anpedi.2022.02.002

Moschella, M. (2021). Trapped in the wrong body? Transgender identity claims, body-self dualism, and the false promise of Gender Reassignment Therapy. *Journal of Medicine and Philosophy*, *46*(6), 782–804. https://doi.org/10.1093/jmp/jhab030

NICE (2020a). *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria*. https://arms.nice.org.uk/resources/hub/1070905/attachment

NICE (2020b). *Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria*. https://arms.nice.org.uk/resources/hub/1070871/attachment

Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender identity 5 years after social transition. *Pediatrics*, *150*(2), e2021056082. https://doi.org/10.1542/peds.2021-056082

Pazos Guerra, M., Gómez Balaguer, M., Gomes Porras, M., Hurtado Murillo, F., Solá Izquierdo, E., & Morillas Ariño, C. (2020). Transexualidad: Transiciones, detransiciones y arrepentimientos en España [Transexuality: Transitions, detransitions, and regrets in Spain]. *Endocrinología, Diabetes y Nutrición, 67*(9), 562–567. https://doi.org/10.1016/j.endinu.2020.03.008

Pérez-Álvarez, M. (2021). *Ciencia y pseudociencia en psicología y psiquiatría: Más allá de la corriente principal* [Science and pseudoscience in psychology and psychiatry: Beyond the mainstream]. Alianza.

Pluckrose, H., & Lindsay, J. (2020). *Cynical theories: How universities made everything about race, gender, and identity*. Faber And Faber.

Pullen Sansfaçon, A., Medico, D., Suerich-Gulick, F., & Temple Newhook, J. (2020). "I knew that I wasn't cis, I knew that, but I didn't know exactly": Gender identity development, expression and affirmation in youth who access gender affirming medical care. *International Journal of Transgender Health*, *21*(3), 307–320. https://doi.org/10.1080/26895269.2020.1756551

Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, *30*(5), 669–681. https://doi.org/10.1177/0956797619830649

Ristori, J., & Steensma, T. D. (2016). Gender Dysphoria in childhood. *International Review of Psychiatry, 28*(1), 13-20. https://doi.org/10.3109/09540261.2015.1115754

Rodríguez Magda, R. M. (2021a). La identidad de género y la imposible autodeterminación del sexo [Gender identity and the impossible self-determination of sex]. In R. M. Rodríguez Magda (Coord.), *El sexo en disputa. De la necesaria recuperación jurídica de un concepto* [Sex in dispute. On the necessary legal recovery of a concept] (pp. 17-56). Centro de Estudios Políticos y Constitucionales.

Rodríguez Magda, R. M. (Coord.), (2021b). *El sexo en disputa. De la necesaria recuperación jurídica de un concepto* [Sex in dispute. On the necessary legal recovery of a concept]. Centro de Estudios Políticos y Constitucionales.

Sadjadi, S. (2019). Deep in the brain: Identity and authenticity in pediatric gender transition. *Cultural Anthropology*, *34*(1), 103-129. https://doi.org/10.14506/ca34.1.10

Shrier, A. (2021). *Un daño irreversible: La locura transgénero que seduce a nuestras hijas* [An irreversible damage: The transgender madness that seduces our daughters]. Deusto/Planeta.

Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with Gender Identity Disorder. *Frontiers in Psychiatry*, *12*, 632784. https://doi.org/10.3389/fpsyt.2021.632784

South, S. J., & Lei, L. (2021). Why are fewer young adults having casual sex? *Socius*. https://doi.org/10.1177/2378023121996854

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, *16*(4), 499-516. https://doi.org/10.1177/1359104510378303

Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood Gender Dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52*(6), 582–590. https://doi.org/10.1016/j.jaac.2013.03.016

Steensma, T. D., & Cohen-Kettenis, P. T. (2018). A critical commentary on "A critical commentary on follow-up studies and "desistence" theories about transgender and gender non-conforming children". *International Journal of Transgenderism, 19*(2), 225–230. https://doi.org/10.1080/15532739.2018.1468292

Stock, K. (2022). *Material girls. Por qué la realidad es importante para el feminismo* [Material girls. Why reality matters for feminism]. Shackelton.

T'Sjoen, G., Arcelus, J., Gooren, L., Klink, D. T., & Tangpricha, V. (2019). Endocrinology of transgender medicine. *Endocrine Reviews*, *40*(1), 97–117. https://doi.org/10.1210/er.2018-00011

Taleb, N. N. (2019). *Jugarse la piel. Asimetrías ocultas en la vida cotidiana* [Risking one's skin. Hidden asymmetries in everyday life]. Paidós.

Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M.-L., Jamieson, A., & Pickett, S. (2018). A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children. *International Journal of Transgenderism, 19*(2), 212–224. https://doi.org/10.1080/15532739.2018.1456390

Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving Gender-Affirming Care. *JAMA Network Open, 5*(2), e220978. https://doi.org/10.1001/jamanetworkopen.2022.0978

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, *145*(2), e20191725. https://doi.org/10.1542/peds.2019-1725

Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors leading to "detransition" among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT Health*, *8*(4), 273-280. https://doi.org/10.1089/lgbt.2020.0437

Wallien, M. S., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(12), 1413–1423. https://doi.org/10.1097/CHI.0b013e31818956b9

Van Mol, A., Laidlaw, M. K., Grossman, M., & McHugh, P. R. (2020). Gender-Affirmation Surgery conclusion lacks evidence. *The American Journal of Psychiatry*, *177*(8), 765–766. https://doi.org/10.1176/appi.ajp.2020.19111130

Vandenbussche, E. (2021). Detransition-related needs and support: A cross-sectional pnline survey. *Journal of Homosexuality, 69*(9), 1602-1620. https://doi.org/10.1080/00918369.2021.1919479

Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Blok, C., Coumou, B., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). *Acta Psychiatrica Scandinavica*, *141*(6), 486–491. https://doi.org/10.1111/acps.13164

Withers, R. (2020). Transgender medicalization and the attempt to evade psychological distress. *Journal of Analytical Psychology*, *65*(5), 865–889. https://doi.org/10.1111/1468-5922.12641

WPATH (2012). *Normas de atención para la salud de personas trans y con variabilidad de género* [Standards of care for trans and gender variant health]. https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_Spanish.pdf (Retrieved on 20/5/2022).

Wren, B. (2019). Ethical issues arising in the provision of medical interventions for gender diverse children and adolescents. *Clinical Child Psychology and Psychiatry*, *24*(2), 203–222. https://doi.org/10.1177/1359104518822694

Zucker, K. J. (2018). The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018). *International Journal of Transgenderism, 19*(2), 231–245. https://doi.org/10.1080/15532739.2018.1468293

Zucker, K. J. (2019). Adolescents with Gender Dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*, *48*(7), 1983–1992. https://doi.org/10.1007/s10508-019-01518-8