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DOI
10.1111/1467-9566.13727

Publication date
2024

Document Version
Final published version

Published in
Sociology of Health and Illness

Received: 22 December 2022 | Accepted: 27 September 2023

DOI: 10.1111/1467-9566.13727

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE

Doing and undoing transgender health care: The ordering of 'gender dysphoria' in clinical practice

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Abstract

A formal Gender Dysphoria classification— as outlined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*— is a prerequisite for the reimbursement of both gender-affirming medical care and transgender mental health care in the Netherlands. Gender Dysphoria and its conceptual precursors have always been moving targets: moving due to research, policy, care practices and activism both within and outside of medicine. This raises the question of what Gender Dysphoria *is* exactly. To elucidate this question, we turn to the people who use the concept in clinical practice to come to a diagnosis and treatment indication: mental health professionals working in gender-affirming medical care and transgender mental health care. Using a material semiotics approach, we reflect upon how Gender Dysphoria is done in clinical practice. Based on an analysis of seventeen practice-based interviews with clinicians as well as an examination of clinical guidelines and texts, we describe four modes in which Gender Dysphoria is ordered. These modes of ordering illustrate that Gender Dysphoria is not one, but multiple. We illus-

trate how in the mode of *isolating,* Gender Dysphoria is something which is carefully isolated from mental disorders, while in the modes *doing the future* and *narrating,* Gender Dysphoria is done as a continuous and predictable object of care. Such orderings of Gender Dysphoria potentially conflict with a fourth mode of ordering: the *doing of diversity* in transgender health care. The study's findings provide empirical insights into how transgender health care is currently done in The Netherlands and provide a foundation on which ethical debates on what *good* transgender health care should entail.

KEYWORDS
gender dysphoria, gender incongruence, material semiotics, modes of ordering, ontology, transgender, transgender healthcare

INTRODUCTION

A formal 'Gender Dysphoria' classification—as outlined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)—is a prerequisite for the reimbursement of both gender-affirming medical care and transgender mental health care in the Netherlands. Gender Dysphoria and its conceptual precursors have always been moving targets: moving due to research, policy, care practices and activism both within and outside of medicine. This raises the question of what Gender Dysphoria *is* exactly.

To elucidate this question, we turn to the people who use the concept in their clinical practice to come to a diagnosis and treatment indication: mental health professionals working in gender-affirming medical care and transgender mental health care. Using a material semiotics approach, we reflect upon how Gender Dysphoria is done in clinical practice. Based on an analysis of seventeen practice-based interviews with clinicians as well as an examination of clinical guidelines and texts, we describe four modes in which Gender Dysphoria is ordered. These modes of ordering illustrate that Gender Dysphoria is not one, but multiple.

In more technical terms: we argue that the ontology of Gender Dysphoria is dependent on the practices concerned with it. This is an important argument, as showing the multiplicity of Gender Dysphoria brings the norms underpinning the practice of transgender health care into view. Making these norms more visible helps to fuel discussions about what *good* transgender health care entails. The study's findings provide insights into how transgender health care is currently done in The Netherlands as well as an empirical foundation for ethical debates on what *good* transgender health care should entail.

This article is structured as follows. First, we sketch a brief genealogy of gender and Gender Dysphoria, illustrating how particular norms are inherent to the creation of both these concepts. Next, we describe our study's methods. In the Findings section, we describe four modes in which Gender Dysphoria is ordered in clinical practice. Finally, in the Discussion section, we present what Gender Dysphoria is *ordered into.* There, we elaborate on Gender Dysphoria's multiple

ontology, and how these ontologies might carry particular norms about Gender Dysphoria, gender and transgender clients within them.

BACKGROUND

The idea of gender originated in the 1950s in a clinical environment, when the New Zealand psychologist, Money, adopted the term from linguistics and used it as an analytical tool to help him study the man- and womanliness of children born with anatomical features that were not fully ascribable to the male or female sex (Germon, 2009). At the beginning of his career, Money encountered children whose sex (which was then understood as a combination of gonadal, genital, hormonal and other bodily parameters) was not medically determinable as either male or female. In other words: their sexual characteristics were too layered, too complex, to fit into the established sex binary. Additionally, these children had particular sexed *experiences* of themselves. To be able to refer to these experiences, Money coined the term 'gender' (Gill-Peterson, 2018), which he understood as the psycho-social dimension of the category of sex. Soon after, psychiatrist Robert Stoller unpacked the concept into 'gender identity' and 'gender role'. Stoller, unlike Money, mainly worked with children whose sense of self was differently gendered than their bodies. Where Money regarded gender as *a part of* sex, Stoller separated gender from sex conceptually, enabling him to understand that both could be misaligned with, or 'opposed' to the other (Germon, 2009). Through this analytical move, clinicians could not only use the concept to theorise children with 'ambiguous' sexual characteristics but also those with a non-normative gendered sense of self. Indeed, Stoller's mind-body split meant that the idea of gender no longer relied on the category of (inter)sex.

The now well-known concept of 'gender dysphoria' also has its roots in Money's theorising in the 1950s, in which he describes his aims for intersex medicine as a good adjustment for the intersex child to the social environment. In the words of historian Gill-Peterson, Money's theorising meant 'the visible body could be identified as pathological *because it might lead to social stigma or psychosocial distress*', and thus 'dysphoria' was the result of transphobic circumstances (Gill-Peterson, 2018, p. 117).

The fruits of Money's and Stoller's theorising got taken up in the third version of the DSM in 1980, under the name 'Transsexualism,' and was defined by the manual as 'a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex' (APA, 1980, pp. 261–262). In 1994, the American Psychiatric Association (APA) recoined the diagnostic category 'Transsexualism' in 'Gender Identity Disorder,' which it defined as '[a] strong and persistent cross-gender identification' (APA, 1994, p. 537). After the publication of the fourth edition of the DSM in 1994, trans people, clinicians and academics alike expressed criticism of the framing of diverse gender identities as disordered. Similarly, critics posed that trans health care typically had a binary understanding of gender (Suess Schwend, 2020). To meet these criticisms, the working group for the DSM-5 decided on the term 'Gender Dysphoria' to emphasise that the dysphoria resulting from the experienced incongruence between one's gendered body and gendered self should be the focus of clinical attention, rather than (trans)gender identity per se (Beek et al., 2016). The fifth edition of the DSM no longer requires the need for 'cross-gender identification'. Instead, it refers more loosely to '[a] marked incongruence between one's experienced/expressed gender and assigned gender' (APA, 2013, p. 452). While 'Gender Dysphoria' was first listed in the DSM in 2013, conceptually it has its roots in Money's theorising in the 1950s.

Outside the gender clinic, the discourse on transgender medicine has grown increasingly hostile in recent times. While on the one hand, there is a growing visibility of trans movements and greater visibility of trans people in media and culture, anti-trans perspectives have also grown, in orthodox-religious and conservative right-wing political groups, as well as so-called trans-exclusionary radical feminist circles (Hines, 2019). In the Global North, gender clinics have seen a rise in applications for health care, and more young people who are assigned female at birth present for care than was traditionally the case (see, for instance, Aitken et al., 2015). Critics have reacted to the rising applications for gender clinics and their changing demographics by arguing that people can obtain a diagnosis of Gender Dysphoria too easily, and that gender-affirming medical care has become a solution for 'underlying' mental health concerns, or the misogynist culture to which those assigned female at birth are exposed (Ashley, 2020).

Certainly, the various theorisations and contestations of transgender health care have their influence on how the field is structured. Social scientists have shown how particular understandings of transgender, for instance as a mismatch between 'body' and 'mind', are tied up with practices in transgender health care, such as trying to distinguish who is 'truly' trans from others who would not benefit from gender-affirming treatment. Body and identity, in this way, are both understood as stable and distinguishable categories that can, or could not be aligned with one another in terms of gender (van Eijk, 2014; see Sadjadi, 2019). Distinguishing who is 'truly' trans and who is not then becomes the task of the 'gender specialist' (Pearce, 2018), a kind of practice often referred to as the 'gatekeeping' of transgender health care (Naezer et al., 2021; Shuster, 2016, 2021; Speer & Parsons, 2006; Whitehead et al., 2012). Arguably, a cultural discourse calling for greater pushbacks against trans rights could further intensify these kinds of medical practices (see for instance MacKinnon et al., 2021).

Here, we see how, due to shifting clinical and societal understandings of 'trans', the understanding of transgender healthcare's object changed remarkedly over the years. Gender Dysphoria, thus, is a 'moving target' (Hacking, 2006, p. 1) with its roots in former diagnostic concepts pertaining to a gendered mind-body incongruence as well as Money's early theorising about gender. As Gender Dysphoria is shaped by cultural notions related to gender, health and public order, the field of transgender medicine is a contested one. In this study, we zoom in on Gender Dysphoria as a *diagnostic object,* focusing on the ways clinicians in transgender health care order it in practice.

Certainly, not only clinicians and their guidelines, but trans people *do* the object of transgender health care as well. Indeed, the experiences and narratives of trans people may elucidate implicit norms in transgender health care (see for instance Pearce, 2018). In this study, however, we focus on health-care providers, as they often stay out of the picture when it comes to the social study of transgender health care. We will reflect on the implications and limitations of this decision in the Discussion section of this article.

ANALYTICAL FRAMEWORK

Stoller's splitting gender from sex was not only used to theorise gender non-conforming children in the clinic but also proved a useful analytical tool outside of medical settings. Studying gender outside of the clinic became an active intervention against the idea that male and female characteristics were (biologically) determined and helped to open up sociological analyses about how gender is 'done' in society and culture. The most notable is Butler, 1990, who argued that gender is *performative.* In Butler's understanding, gender is *produced* and *reproduced* in human

interactions. Via these repetitive actions, via these *doings,* gender is brought into being and solidifies. Butler does not see gendered behaviour as the *effect* of gender identity but suggests that it might be the other way around: a solidified gendered experience is the effect of everyday cultural gendered practices. When we talk of 'doing' in this article, it is this performativity we refer to.

The idea that categories can be *performed* not only pertains to gender but diagnostic concepts as well. As Mol (2002, p. vii) notes, medicine 'attunes to, interacts with, and shapes its objects in its various and varied practices'. She argues that, because of these various practices, objects of medicine become slightly different in the entanglements of the specific practice concerned with them. This allows us to understand 'Gender Dysphoria' as an object enacted in practice. Within every practice, Gender Dysphoria then becomes something (slightly) different: is not one, but multiple (Mol, 2002, p. viii). This theoretical approach, often referred to as 'material semiotics', is not necessarily concerned with what objects *mean* in various settings but with what they *are*.

Thus an object is not one, but multiple. But how so? In his fieldwork, focused on the organisation of a laboratory, Law (1994) coined the concept 'modes of ordering' to understand how this organising was done. Organising, he suggests, for a large part exists of ordering: the ordering of information, of words, of materials such as desks and paperwork. Law talked about several modes of ordering, such as an 'entrepreneurial mode' and an 'administrative mode', which exist next to each other. Within these different modes, information and materials are ordered differently. At the same time, these 'modes of ordering' are never totally separate from one another. Various modes can be present at the same time, and these can 'include, exclude, depend on, and combat one another' (Mol & Law, 2002, p. 10). And, as Mol suggests, these modes of ordering are entangled with the object they order. The 'doing' of an object, such as Gender Dysphoria, thus exists of various 'modes of ordering' which are all entangled with and thus enact a slightly different object. In health care, as in every type of organisation, various modes of ordering are present as well: information is ordered to come to a life history, treatment choices are made to enact this or that reality and test results and stories of clients are ordered to come to a diagnosis. These various orderings enact various objects. This is how multiplicity comes about.

We turn to the question of which sets of practices, or, which various 'modes of ordering' are present in transgender healthcare. Additionally, we are also concerned with the question of how these modes order Gender Dysphoria in particular ways: what *is* Gender Dysphoria, within these particular modes of ordering?

The ontology of Gender Dysphoria has very real consequences for clinical practice, and thus for the clients who present for care. Studying the *ontology* of Gender Dysphoria in practice may help to facilitate normative debates on what good care should entail (Mol, 2002, p. viii). By studying Gender Dysphoria as such, we hope to create further ground on which clinicians, advocates, researchers and policymakers can ask questions and deliberate about the appropriateness of the ways Gender Dysphoria is done in transgender health care.

In times of worldwide major drawbacks to transgender rights, theorising the multiplicity of Gender Dysphoria is a precarious undertaking. We believe, however, that the current argument is an important one to make. The 'multiplicity' of diagnostic objects is not unique to transgender health care. Indeed, as others have shown, diagnosis is 'a social process' (Hayes et al., 2022), wherein medical objects are 'enacted' in particular ways (Mol, 2002). Moreover, Gender Dysphoria's ontology being multiple does not make it any less 'real'. Instead, we illustrate how these various ontologies are entangled in differing norms and practices with very *real* consequences for transgender health care and its clients.[1]

METHODS

Design

To examine how Gender Dysphoria is done in transgender health care, we conducted semi-structured interviews with health-care professionals and analysed clinical guidelines and documents.

Settings

Currently, in the Netherlands, three multidisciplinary University Medical Centres and, increasingly, non-academic mental health-care settings that work in partnerships with somatic health-care providers offer gender-affirming medical care. All these centres work according to Dutch clinical guidelines, which are, in turn, mainly based on the Standards of Care as outlined by the World Professional Association of Transgender Health. During the research we describe in this article, the seventh version of these standards was in effect (Coleman et al., 2012). In September 2022, the eighth version of these standards was published (Coleman et al., 2022).

This research is part of a larger study on shared decision-making in gender-affirming medical care for adults in the Netherlands (2019–2022). Our research team conducted 11 interviews in a previous qualitative study with health-care professionals in academic and non-academic gender-affirming medical care (see Gerritse et al., 2022). Additionally, we interviewed five mental health professionals who work in transgender mental health care, a setting where clinicians offer counselling and psychological treatment to transgender people.

Participant selection

All interlocutors included in this study had a minimum of 1 year of working experience in transgender health care. We purposively sampled interlocutors based on professional backgrounds and years of experience (Green & Thorogood, 2018). See Gerritse et al. (2022) for the recruitment and selection of health-care professionals in gender-affirming medical care. The fourth author (BK) brought us in contact with a mental health professional working in transgender mental health care, through which we snowball sampled the other interlocutors.

Data collection

First, this research made use of 11 transcripts of qualitative interviews with health-care professionals (six mental health professionals and four somatic healthcare professionals) in gender-affirming medical care that KG and BM conducted in the context of a study focusing on the ethical challenges in transgender health care. They conducted the interviews between May 2020 and February 2021, nine of which took place via Microsoft Teams due to the COVID-19 pandemic. See Gerritse et al. (2022) for the details of data collection.

Second, WB conducted five interviews with mental health professionals working in transgender mental health care. WB approached six mental health professionals, one of whom refused due to concerns regarding anonymity. WB conducted the interviews between April

and July 2021 via Microsoft Teams. In the first interview, KG was also present to ensure continuity in the data collection. In these interviews, WB probed into the everyday clinical practice of clinicians and asked how they ascertain whether someone has Gender Dysphoria, and how their clinical encounters play out. In these interviews, the focus was not on clinicians' opinions but on how their care practices play out while determining if someone 'has' Gender Dysphoria (also see Mol, 2008). The interviews were audiotaped, transcribed verbatim and anonymised.

Third, we collected documents consisting of clinical guidelines, introductory texts and medical and psychological literature on gender and Gender Dysphoria. We included these documents in the conviction that these 'order' Gender Dysphoria, too, and strongly influence how transgender health care is structured. These documents include the chapter on Gender Dysphoria in DSM-5 and the *Standards of Care 7*.

Data analysis

We thematically analysed (Braun & Clarke, 2006) all interview transcripts and relevant sections of the collected documents. We coded textual fragments in Atlas.ti, either when they stated *what* gender dysphoria is or *how* health-care professionals establish if someone has Gender Dysphoria. In naming the codes, we remained as close as possible to the original quotes (in-vivo coding) and used steps of *open, axial* and *selective* coding (Green & Thorogood, 2018). We drew from principles of 'the constant comparison method' to ensure codes and themes did not overlap and were sufficiently distinctive (Boeije, 2002). First, WB and KG coded the first transcript and reached a consensus about the used codes through discussion. Next, WB coded all 14 remaining interviews. Throughout this process, WB discussed codes recurrently with KG. Together they grouped the various codes into code groups and then merged these groups into themes, reaching a consensus through discussion. They subsequently presented the code groups and themes and discussed them with the other authors. This process resulted in the conceptualisation of four modes of ordering Gender Dysphoria. We discussed our preliminary findings twice with health-care professionals working in transgender health care to sharpen our analysis.

Ethical considerations

We submitted the study protocol of the larger study to an officially accredited institutional review board, the Medical Ethics Committee (location of the study group). The Committee issued a declaration stating that under Dutch law, a full ethical review was unnecessary (date and code of decision). We informed eligible respondents via an email about the study and their rights at least a week before the interview. We emphasised that participation in the study was voluntary and that participants could withdraw from the study at any moment. We provided the opportunity to ask questions and obtained written informed consent before the interview. At the beginning of each interview, we reiterated the study objectives and data management and obtained oral informed consent.

To protect the anonymity of our interlocutors, we omitted their work locations and changed personal characteristics such as gender. Additionally, we use broad categories to describe professional backgrounds (for instance, 'mental health professional' instead of 'psychologist' or 'psychiatrist'). The names used in the Findings section are pseudonyms.

FINDINGS

First mode of ordering: Doing diversity

The first mode of ordering we identified was the ordering of Gender Dysphoria as a matter of diversity. Understanding gender identities as a matter of diversity is something which is endorsed by the *Standards of Care 7,* in its opening chapter explicitly mentioning that '[b]eing transsexual, transgender, or gender-nonconforming is a matter of diversity, not pathology' (Coleman et al., 2012, p. 168). Senna, a mental health professional in gender-affirming medical care, reflected on her last years working in the gender team:

> Well, since we are now talking to more non-binary people as well ... we do more often have conversations like, what is your position on the gender spectrum? And is it more like this, or is it more like that? And that somebody says that what they want the most is to have that 'X' in their passport, but well, that's not possible ... Or more coming from a feeling like, well, I *really* don't feel like a woman, I *really* don't want people to see me as a woman because that just doesn't fit me at all.

Here Senna stretches how gender-affirming care has changed in recent years: while before, there was a binary understanding of gender, nowadays, the conversations in the clinic have changed, and Senna talks about somebody's place on a spectrum instead of one's binary position. *Doing diversity* is, we suggest, a way of perceiving gender identities that is *not* about mental disorders but which is about understanding them as a form of gender diversity.

While this mode might be particularly important in transgender healthcare, it's also one for which the system does not seem to be ideally suited. As Sem, a mental health professional in gender-affirming medical care, questioned:

> How do you justify that we require a diagnosis of a mental disorder [Gender Dysphoria], but we take that out of its context? Instead, we say: 'It [Gender Dysphoria] is not a psychiatric disorder, but an expression of diversity... I am not sure if this [way of working] is what I wish for. Because if we do that [work from a diversity perspective], I am inclined to say, like, let's get rid of that diagnosis and say, 'there's just diversity.' If someone walks through the door and says, 'I have a gender problem,' then that is diversity, and then doesn't that whole diagnosis become fundamentally unnecessary? ... It seems like in our team, to an increasing extent, there's the following logic: let's not talk too much about that [the question of whether Gender Dysphoria is a form of gender diversity or a psychiatric disorder]. To the outside world, we have to sell gender diversity, but on the inside, we have strict criteria that everyone should meet [to be considered for gender-affirming medical care]. I think that is a problematic way of working.

In the fragment above, Sem identifies a tension between psychiatric classification and fully embracing gender diversity. Indeed, when a phenomenon must be classified using a psychiatric manual but is concurrently understood as 'an expression of diversity', these two understandings rely on different frameworks that conflict with each other. This conflict raises an important question for transgender health care: is it possible to truly account for gender diversity when one has to work within a 'mental health' framework?

Second mode of ordering: Isolating

One of the tasks of professionals working in gender-affirming medical care is knowing whether a client *has* Gender Dysphoria. To the professionals we spoke to, a first step in coming towards this classification is getting to know about the client's 'gender identity'. But, as Gerda, a mental health professional in gender-affirming medical care, explained, she was well aware that the gendered experiences of her clients were largely inaccessible to her:

> See, what's hard, is that it [Gender Dysphoria] is about identity and that [one's identity] is very hard to classify like: is it there or not? And yes, how someone experiences their identity is, of course, very personal and per definition 'true.' Because if someone says they have a particular identity or gender identity... that is, yes... that is 'true' because someone just feels it that way. Still, in the diagnostic process, we try to assess whether that's right. So, I always think that's kind of complicated: when someone experiences their identity in a certain way... to still look at that critically.

While Gerda says that someone's identity is always 'true' *because* that is how someone feels, she still needs to evaluate the start of treatment. Similarly, Paula, a mental health professional in gender-affirming medical care, tries to understand whether it is 'wise' to start or continue treatment at a particular moment in time:

> The only thing I know at a particular moment is that it is not wise [to start gender-affirming medical care] because there are so many extra problems. Things that are mixed up and that are intertwined... At such a point, you have to say 'Stop.' And then, you first have to assess what we ought to do first. What is wise?

We can understand Paula's statement better in the context of the *Standards of Care* which recommend that for clients to be eligible for hormone therapy 'significant medical or mental health concerns ... must be reasonably well-controlled' (Coleman et al., 2012, p. 187) (Coleman et al., 2012, p. 187). However, as Paula mentioned, for her, this is a very complex task, as things are 'mixed up' and 'intertwined'. Like many other mental health professionals, Paula opts for the following strategy: circumventing gender identity and focusing on mental health diagnoses she *can* be surer about. As she told us:

> The only thing I can do is to explore, together with you [the client], whether there aren't any other things that play a part in ... leading you [the client] to think: I am gender dysphoric. While if we were to solve those things, maybe nothing of [the] gender dysphoria remains. That is what we have to figure out. Because if we don't do that and continue blindly, it could be the case that later on, we think like, well damn it, now we've done irreversible things. That's not wise.

As Paula explains, for her as a mental health professional, it is not always clear whether gender dysphoric feelings *are part of* Gender Dysphoria. Here Paula complicates Gerda's account: while Gerda states that someone's Gender Dysphoria is always *true,* Paula problematises this. She distinguishes between 'true' Gender Dysphoria and gender dysphoric feelings that are not 'really' Gender Dysphoria but a part of something else. Rob, a mental health professional in gender-affirming

medical care, talks about the potential consequences of starting gender-affirming treatment for something that is not 'truly' Gender Dysphoria:

> See, I think it's important that people whose gender dysphoria actually arises from psychiatric problems, well, get identified quickly. It is quite rare, [but] I have seen it several times in the last years. That during the diagnostic trajectory, it becomes obvious that the gender dysphoria, or the alleged gender dysphoria, really stemmed from a psychotic disorder, for instance. … And well, if we would've started [gender-affirming] medical treatment with these patients, that would've done a lot of harm, I think. Because then we would've started sex reassignment surgery [*sic*] for the wrong reasons. … That is a problem because if the psychosis were treated, a patient would realise that… That he would regret it [gender-affirming treatment] and have a body that is no longer congruent with his gender identity. While before, this was the case. … I tell this story to illustrate that I think there is still an important role for the health professional to filter out these kinds of cases.

Within this mode of ordering, to 'get to' Gender Dysphoria, mental health professionals tend to take a detour via other objects. In other words: by ruling out or establishing mental health concerns that are *not* Gender Dysphoria, mental health professionals try to 'get to' Gender Dysphoria. As Gender Dysphoria is assessed alongside mental health conditions, and in a context where clinicians use the DSM, there is a tendency for Gender Dysphoria to be *done* similarly. Therefore, there might be a discrepancy between the way Gender Dysphoria is *seen* or *talked about* in a treatment team (as a form of diversity) and the way it is *done in* clinical practice (as a mental disorder, or as in this mode of ordering, in between mental disorders).

Third mode of ordering: Doing the future

To the question of what is important to her in decision-making, Senna, a mental health professional in gender-affirming medical care, responded:

> [Y]ou don't have a crystal ball. You can't look into the future. … So, you have to think really hypothetically about what a particular [treatment] step is going to provide you and what it's probably not going to provide. … That you have thought about all the scenarios at least once. … Like, suppose that [a particular scenario] would happen. What would that mean for me [the client]? And would that change the client's decision?

While Senna considers it essential for clients to have considered various hypothetical scenarios, she knows that someone can never be entirely sure about the future. To increase (a sense of) certainty regarding current decision-making, clinicians invoked various temporal dimensions. As Bart, a mental health professional in gender-affirming medical care, explained:

> [I]t is important that someone knows what they're getting into. And that someone, for instance, has already socially transitioned or … knows what the support system [i.e., family and friends] thinks about things [i.e., gender-affirming medical care]. … Someone [may then] assess the risk of disappointment, regret, I don't know,

> whatever, much better, compared to someone who may have had a very clear gender development but is still nowhere regarding their social transition.

The idea of a 'social transition' is that a client starts practising their experienced gender. Clients may do so in various ways: by using make-up and particular clothing, changing how they talk or move, telling people in their social environment about their gendered experiences and adopting a new name. By doing so, clients gain experiences that may provide valuable insights for themselves and clinicians. For Bart, this is more important than having a 'clear gender development' because a 'social transition' allows him to assess if someone can 'bear all the complicated bumps in the road that you will experience if you are openly transgender'. Here we see how Bart brings in *gender*, and not so much as a concept via which he can assess Gender Dysphoria but as a tool to evaluate future outcomes. By practising a particular social gender role, clients are *doing their gender,* a doing in the here and now that may inform decision-making about gender-affirming care. Decision-making which is concerned with the future. While Senna stated that it is impossible to predict the future, Bart described a practice that helps him gauge and thus feel more certain about the future. A social transition, then, is one of the temporal dimensions by which Gender Dysphoria is done.

And there are others. Another common temporality in Dutch gender-affirming medical care is waiting. Senna reflects on how waiting is a temporality that potentially complicates her assessment of eligibility:

> Well, they [clients] just want... They want something, right? They come to get something from us. And the faster, the better for most people. Now and then, there is someone who says like, 'Help me to clear things up. I really don't know it at all, I want to investigate it.' But most people, especially with the current waiting times, have a really concrete idea of what they are coming to get from us. Well, and the more you say... about the stuff a [mental health professional] wants to know more about or maybe has concerns about, well, the longer the diagnostic trajectory takes, and the longer it takes before you [i.e., the client] have a doctor in front of you [to initiate gender-affirming medical care].

Here Senna describes how, while a client is waiting, Gender Dysphoria is rendered inaccessible to her as a clinician. 'Especially with the current waiting times', Senna says, indicating that during *that* time, some clients may become more certain about their Gender Dysphoria and what to do about it. Here, she also brings in another tension that seems to be the effect of waiting: she says that clients might be hesitant to share information about 'their Gender Dysphoria' as they might be afraid that this lengthens the diagnostic process. Here a double-edged temporality seems to be at work. While the process appears to be unnecessarily prolonged for a client because they have to wait for a longer time, for Senna, it is harder to access the Gender Dysphoria she needs to decide about. Here two contradictory forces seem to be at play: while a client might become more certain about 'their Gender Dysphoria' and their treatment wishes during the (excessively long) time they are on the waiting list, such certainty seems to contradict with Senna's wish to openly investigate with a client. Paradoxically, Senna feels like she needs more time to investigate a Gender Dysphoria about which a client is 'more sure', thereby lengthening the process further.

In sum, although clinicians might readily acknowledge that they cannot predict the future, they employ several temporalities to approximate it. These practices, which happen *now,* order Gender Dysphoria into something that is not only present at the moment but also in the future.

Fourth mode of ordering: Narrating

We asked Christian, a mental health professional in transgender mental health care, about the steps he takes to establish if someone *has* Gender Dysphoria. He said that knowing if someone has Gender Dysphoria was not such an interesting question. To him, what mattered is 'the story that you work on in treatment, that is what you are giving shape to'. He elaborated:

> Well, what you [i.e., the client] have gone through and how it felt. How it was when you wanted to play soccer with the boys at school and weren't allowed to, or you got sent out of the girls' dressing room. How that impacted your development, and how things are now. ... You give someone a chance to let the story come out a little, also concerning the future: What do you want to be? What do you think and feel about that? What do you hope? We aren't entirely malleable, right, so the outcome might not match your ideal. When you're born as a man, [and] you're one meter ninety, you weigh a hundred kilos, and you want to transition to womanhood, then that's quite a complicated thing, and you'll have to reconcile with ... certain aspects of yourself and learn to embrace things that weren't on your wish list. That also has to do with letting someone's story be.

Christian reflects on how, together with a client, he *narrates* the past. Via the practice of narrating, the mental health professional and the client may 'give shape to a story' or 'let a story come out'. In this story, Gender Dysphoria is stabilised by anchoring it in various stages of someone's life story. This becomes apparent in what Christian says: a story is about someone's youth, but also the present. It is also about the future: how may the client's past inform this unknown temporality? Locating Gender Dysphoria at these various stages arguably serves a similar function as a 'social transition'. Gender Dysphoria is rendered a reasonably stable, continuously existing entity, affording the clinician a sense of security regarding its existence in the future.

The way Christian talks about the way he helps to let 'a story come out' suggests that the story is already there, waiting to be excavated. At the same time, Christian stated that, together with his client, he 'gives shape to' a story. The notion that this is an interactive process implies that another story could 'come out'. Sem, in the following fragment, highlights the role of clients in this process:

> Well, I've spoken to many people over the years who ask me, 'Look, what do you want to hear?' To which I respond, 'Well, your story,' so to speak. And then people say, 'No, you don't! You say you are, but what you want to hear is that I've suffered from gender dysphoria for a long time; that I meet two out of seven DSM criteria because then I have the diagnosis; that I suffer tremendously; and that I haven't felt like a man but a woman since years long past and I would've preferred to have been born a woman; and that I don't have any problems, or at least not too many. That's what you want to hear!'

Here, Sem describes he is well aware that *his clients are well aware* of what kinds of stories mental health professionals want to hear from them to be able to receive treatment. However, stories may also be challenging to the clinician for other reasons. Sem continues:

> [R]ecently, I saw a new patient … with a colleague, and we had huge doubts [about initiating gender-affirming medical care]. This patient met four or five DSM criteria, but there was no suffering … Or at least, no suffering that we could see.

Because 'suffering' is a criterion needed for the classification of Gender Dysphoria in DSM-5, in Sem's account, the absence of suffering from the client's story complicates the formal classification and hence the indication for gender-affirming medical care.

Lisette, another mental health professional in gender-affirming medical care, also stated that some clients' narratives might impede her work as a clinician:

> I have one client, and that's also rather complicated, he is on the spectrum of, well… 'In 75 percent of the cases, I feel like a man, but in 25 percent of the cases, I feel like a woman. And so, 75 percent of the time, my body troubles me, but 25 percent of the time, it doesn't.' But still, he wants a breast removal. Well, I think that's rather complicated! … because that person themselves also doesn't know so clearly what they want. And well, I don't either. And in addition, if you refer [for gender-affirming treatment], you [i.e., the clinician] *do* have to be sure that someone [i.e., the client] is doing something that they won't regret. And well, if you want something for 75 percent of the time but for 25 percent of the time you don't … Those are complicated bases!

Here, Lisette reflects how a story that is not linear or binary might complicate things in the process of decision-making, as she cannot be as sure as with other stories that someone is not going to regret gender-affirming medical care.

In the end, narrating is a way of creating continuity, and much like 'doing the future', offers (a sense of) a grip on the future. But, as shown, health-care professionals can see some stories as more useful to make decisions about the future than others, thereby rendering some stories more viable than others.

DISCUSSION

This article centred on the question of *what* Gender Dysphoria *is* in clinical practice. We showed that Gender Dysphoria is not just something 'out there', but enacted in various ways through different modes of ordering. We identified four such modes: *doing diversity, isolating, doing the future* and *narrating.* In what follows, we reflect on the various norms that appear to be embedded in these particular modes of ordering: what is Gender Dysphoria in these particular modes? We then reflect on our study's limitations and corresponding suggestions for future research. We conclude by reflecting on 'the Gender Dysphoria' we enacted in this article.

Depathologising: Saying and doing

In the mode of ordering that we call *isolating,* mental health-care professionals struggle with classifying and making treatment decisions while holding Gender Dysphoria inaccessible. One strategy clinicians could employ to still be certain about its presence is getting to it via a detour: via objects they regard as more readily accessible.

Transgender studies scholar Davy (2015) notes how in transgender health care, clinicians assess gender via its negative: health-care professionals and clients know someone 'is' of a particular gender because someone is not 'the other' (for an empirical example, see Hirschauer, 1997). In this study, we wrote about a mode of ordering in which Gender Dysphoria, too, is encountered via its negative. In this case: through assessing 'other' mental health categories, like psychosis or autism. Establishing the latter categories appears to provide clinicians with a means through which they can get closer to Gender Dysphoria and hence, classification and medical decision-making. In *isolating*, Gender Dysphoria is placed between other mental health categories.

In this mode of ordering, we could understand Gender Dysphoria and its predecessors (such as 'Gender Identity Disorder') as 'absent presences' (M'charek et al., 2014). While contemporary discourse on transgender health care centralises depathologisation, the way its object is done in clinical practice arguably shows the struggle of fully relinquishing a pathologised account of gender diversity (Shuster, 2016; Whitehead et al., 2012). It is important to stress that this is not a matter simply on behalf of clinicians, but it's also an institutional matter: in biomedical contexts, it might be hard to do anything other than 'isolating', as it is a mode of ordering that meets biomedical logic. Nevertheless, notwithstanding the effects of pulling Gender Dysphoria out of the realm of mental disorders, its history arguably deters different modes of ordering it.

Delays: Getting a grip on the future

Our findings illustrate how time is a central 'thing' that does Gender Dysphoria. Within the mode of ordering 'doing the future', it becomes evident how temporal dimensions are played with to become 'more sure' about Gender Dysphoria. What seems to be an implicit norm here, is the idea that Gender Dysphoria, and therefore gender and gender identities, are (to some extent) predictable.

Pitts-Taylor (2020) emphasises how pauses or delays have historically been used to help 'measure' the stability and authenticity of (trans)gender identities. These 'delays' might be proposed by a clinician. But, in Dutch gender-affirming medical care, delays are also ubiquitous in the form of lengthy waiting lists. As current waiting times for an initial consultation in Dutch gender-affirming medical care can exceed 3 years in some clinics, clients often start expressing and 'doing' their experienced gender long before their first appointment. While clients' 'already-doing' proved insightful for Bart, Senna stated that it might also 'close off' Gender Dysphoria, thus encumbering her work: because clients understand very well what they want, they 'come to get something' from the clinician. Through the eyes of Senna and Bart, we see that the workings of time can have different outcomes with varying consequences for clinical encounters. Time can do various things to Gender Dysphoria and, depending on how the clinician looks at things, can close off Gender Dysphoria as an object: as something which is easier or harder to engage, and thus, harder or easier to make decisions about.

Here we also see how various modes of doing might clash or contradict each other. For instance, isolating and doing the future might be in harmony: both modes of ordering might help to make sure that Gender Dysphoria 'is there'. Doing the future in a linear way, however, makes less sense in combination with a mode of ordering as 'doing diversity', as it is inherent to this mode that gender might be a fluid phenomenon or might be more open-ended. Getting a grip on the future is almost impossible here. These modes of ordering thus do not stand by themselves but are dependent on each other as well.

Looking for the right story

Finally, Gender Dysphoria may be narrated and thus rendered into a story. As within 'doing the future', in this mode of ordering, Gender Dysphoria becomes an object that exists now and should exist in the future. The norm implicit in the narration of Gender Dysphoria seems to be that identity should be continuous.

Our findings illustrate how, within this mode of ordering, health-care professionals experience challenges in grappling with particular narratives. This is in line with the ethnographic findings of our research group (Gerritse et al., 2018) on ethical challenges in gender-affirming medical care. We found, for instance, that health-care professionals deemed the narratives of clients presenting with a persistent, lifelong or 'early-onset' Gender Dysphoria more convincing than those with a later onset. This, again, is in line with the guidelines, which stipulate that there should be '[p]ersistent, well-documented gender dysphoria' (Coleman et al., 2012, p. 187). Here, the logic inherent to 'doing the future' is dominant, which assumes that when a gender identity narrative has been 'stable' in the past, it might also be stable in the future. At the same time, this mode of ordering shows how other narratives are harder to grapple with for clinicians, such as a narrative in which Gender Dysphoria sometimes is present, and sometimes is not, or a narrated Gender Dysphoria that comes about in adolescence or early adulthood.

As we, as well as others (see for instance Shuster, 2016, 2021), elaborately illustrated, there is uncertainty involved in diagnosing Gender Dysphoria. As a consequence, the diagnosis is 'negotiated' between the client and the clinician (Lane, 2020). This negotiation feeds into a dynamic in which clients know they must tell a particular story to help them get the treatment they need (see Davy, 2015). This raises questions about what it exactly is that is being 'affirmed' in gender-affirming medical care, as affirmation potentially rests on the client affirming the story 'the clinic' wants to hear. Here, as well as in the other modes of ordering that we described, via the shaping of particular stories, the category of Gender Dysphoria is reified into a stable entity that existed in the past and will exist in the future.

Limitations and future research

This study is not without limitations. First, due to the COVID-19 pandemic, we conducted interviews online via Microsoft Teams and could not conduct on-site participant observations. This complicated our grappling with the 'materiality' of transgender health care, as a material semiotics approach proposes. By being attentive to 'doings' and 'materials' and by including guidelines, texts and literature, we sought to account for the latter. Still, the risk of our current study is that material techniques used by clinicians (such as psychological tests, blood tests, and surgical interventions) and fleshy materials in the form of bodies are disappearing into the background. Certainly, health care being 'affirmative' does not solely have to do with talking and listening to the stories of clients. We suggest that future in-person social scientific work further grapples with these materials, as these pose an essential component of transgender health care. This could be done by focusing on multidisciplinary meetings and clinical practice, emphasising its material dimensions.

Second, the modes of ordering we encountered might be typical for the clinical settings we investigated. We focused on mental health care professionals' practices and the enactment of guidelines in clinical encounters. It would be worthwhile to 'open up' care practices in other branches of transgender health care to further clarify their modes of ordering. Undoubtedly

the modes of ordering we encountered are entangled with the Dutch context in which they are done. It would be worthwhile to investigate care practices in different national contexts. Also, we focused solely on mental health-care professionals. It would be of great value to investigate the care practices of other clinicians working in transgender health care, such as surgeons and endocrinologists, as well as other clinicians not working *in,* but also concerned *with* transgender health care, such as general practitioners. Addedly, it would also be worthwhile to investigate care practices outside a biomedical context. Other promising avenues to do so include trans-led grass-roots clinics and private mental health care settings. There, Gender Dysphoria or gender identity will be 'ordered' as well, but in supposedly very different ways than the ways we encountered.

An even more critical question is how trans people 'do' Gender Dysphoria within and outside of health care settings. 'Gender euphoria' is a concept which, unlike 'gender dysphoria', did not arise in the clinic, but is used by trans and gender nonconforming folks to describe when they have positive feelings about their gender or sex, and in this sense is the great counterpart of 'Gender Dysphoria' (Beischel, Gauvin and van Anders, 2022). Similarly, trans people have reported self-care and trans community care practices (see for instance Malatino, 2020). Further studying these practices might present new insights and questions beneficial for transgender health care, for instance: do self-care practices order Gender Dysphoria? If yes, how so? How are Gender Dysphoria and gender euphoria related? What can the ordering of gender euphoria tell us about what *good* transgender health care entails?

Expanding the possibilities of ordering is important because, as we have seen, the question of *what* Gender Dysphoria *is,* is a question that is and will remain open-ended as the object changes within every practice that is concerned with it. The way Gender Dysphoria is ordered is not just an effect of the way health-care settings are organised but is also due to Gender Dysphoria being a 'moving target' (Hacking, 2006, p. 1). Gender Dysphoria is multiple in its ontology. At the same time, this multiple ontology is never stable due to changing clinical, personal and societal understandings of gender, identity and distress. As we have shown, different modes of ordering imply different norms and thus have different effects on *what* Gender Dysphoria, or the object of transgender health care, *is.*

Particular norms are reproduced in clinical practice. This might be done via the 'present absence' of Gender Dysphoria as a pathological category, or via the tendency to enact Gender Dysphoria as a continuing category that existed in the past and will exist in the future as well. In these ways, gender identities are continuously done and redone in clinical encounters. Understanding which modes are operative in clinical and non-clinical settings and which norms they imply might help better understand which modes are wished for by clients, clinicians and researchers, and which are not. Understanding how Gender Dysphoria is ordered in a variety of medical and non-medical contexts can thus help us to further understand the 'goods' and 'bads' of transgender healthcare.

CONCLUSION

This article is, first and foremost, an *intervention* into Gender Dysphoria and transgender health care. As Law (2004) emphasises, methods do not describe realities *out there.* Instead, they help to create realities. Our approach thus does its own ontologies: Gender Dysphorias that are ordered as a matter of diversity or as a matter of the future, that are isolated and narrated. In doing so, we enacted another ontology: a particular Gender Dysphoria that is opened up through social science. But what for?

Researchers before us showed how the practices of transgender health care carry and reproduce particular cultural norms, norms that shift over time. These norms may be hidden but have very material consequences, such as denying or granting a treatment wish. Therefore, they must be made visible, time and again.

As transgender health-care practices change, so too do the objects these practices are concerned with. Different doings make for different ontologies that carry different normative assumptions. We have illustrated how material semiotics offers a lens through which to untangle and make these practices, ontologies and norms visible. This visibility can help health-care professionals and other stakeholders to become more aware of aspects and consequences of their practices. This visibility, in turn, might help contribute to understanding what *good care* should entail in transgender health care. In the end, the task for transgender health care and its research is not to strive for closure, solidification or well-roundedness, but instead, to stay with the struggle of doing their object of care, that is to say, staying with its fluidity and open-endedness.

AUTHOR CONTRIBUTIONS

Wolter de Boer: Conceptualization; methodology; formal analysis; investigation; writing – original draft; writing – review & editing. **Bert C. Molewijk**: Conceptualization; funding acquisition; investigation; methodology; supervision; writing – review & editing. **Marijke A. Bremmer**: Conceptualization; funding acquisition; investigation; supervision; writing – review & editing. **Baudewijntje P. C. Kreukels**: Conceptualization; funding acquisition; investigation; supervision; writing – review & editing. **Eileen M. Moyer**: Conceptualization; methodology; supervision; writing – review & editing. **Karl Gerritse**: Conceptualization; formal analysis; funding acquisition; investigation; methodology; project administration; writing – original draft; writing – review & editing.

ACKNOWLEDGEMENTS

We thank all the participants who spent time talking with us about their clinical practice. Besides, we want to thank the researchers of the Center of Expertise on Gender Dysphoria and the participants in the Research Seminar of the Platform on Diversity in Sex and Gender from Radboud University, where we both extensively discussed the findings presented in this article. Lastly, we wish to thank the Amsterdam UMC Actor-Network Theory reading group members for providing valuable comments on the text.

CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

To ensure the anonymity of our interlocutors, the original data for this research is not available.

ETHICS STATEMENT

Not applicable.

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ENDNOTE

[1] Throughout this article, we refer to Gender Dysphoria with capitals to indicate the object with which transgender healthcare is concerned. To be clear: while individual experiences of distress might also be referred to as gender dysphoria, here we are concerned with Gender Dysphoria as a *diagnostic object*.

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How to cite this article: de Boer, W., Molewijk, B. C., Bremmer, M. A., Kreukels, B. P. C., Moyer, E. M., & Gerritse, K. (2024). Doing and undoing transgender health care: The ordering of 'gender dysphoria' in clinical practice. *Sociology of Health & Illness*, *46*(4), 644–663. https://doi.org/10.1111/1467-9566.13727