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COMMENTARY

The Clinical Irrelevance of "Desistance" Research for Transgender and Gender Creative Youth

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In recent years, the suggestion that over 80% of trans and gender creative children will grow up cisgender has been strongly criticized in the academic literature. Although concerns over the methodology of these studies, known as desistance research, has shed considerable doubt regarding the validity of the reported number, less attention has been paid to the relevance of desistance research to the choice of clinical model of care. This article analyzes desistance research and concludes that the body of research is not relevant when deciding between models of care. Three arguments undermining the relevance of desistance research are presented. Drawing on a variety of concerns, the article highlights that "desistance" does not provide reasons against prepubertal social transition or peripubertal medical transition, that transition for "desisters" is not comparably harmful to delays for trans youth, and that the wait-and-see and corrective models of care are harmful to youth who will grow up cis. The assumed relevance of desistance research to trans youth care is therefore misconceived. Thinking critically about the relation-ship between research observations and clinical models of care is essential to progress in trans health care.

Public Significance Statement
The allegedly high rate of "desistance" among transgender youth has garnered public interest in recent years. This article explains why worries about trans children overwhelmingly changing their mind later are unjustified, showing that desistance research doesn't offer sound reasons to oppose or delay gender-affirming care.

Keywords: transgender children, transgender adolescents, desistance research, gender identity, transition

In recent years, the affirmation that 80% of transgender children will grow up to be cisgender adults—that is, adults who are not transgender—has grown common in the public sphere as well as some clinical circles. "How should we approach caring for trans youth?" has rapidly become one of the most politicized questions in the media, leading to a surge of interest in desistance research. Desistance research is a body of research that seeks to measure the percentage of youth referred to gender identity clinics who will or could grow up to be cis through similar, flawed methodologies and methods. In both the scholarly and popular literature, desistance research has played a central role in debates surrounding clinical models of care for trans youth (Bewley et al., 2019; de Vries & Cohen-Kettenis, 2012; Drescher & Pula, 2014; Ehrensaft et al., 2018; Evans, 2020; Griffin et al., 2020; Marchiano, 2017; Soh, 2015; 2020; Steensma & Cohen-Kettenis, 2011; Turban et al., 2018). The significance of desistance research was enshrined in the Standards of Care Version 7 of the World Professional Association for Transgender Health (WPATH), which cites desistance research as a factor to be weighed when deciding on prepubertal social transition (Coleman et al., 2012, p. 176). Implicitly or explicitly, the suggestion is that the high rate of "desistance" warrants conservatism about prepubertal social transition or peripubertal medical transition.

The argument for conservatism toward social and/or medical transition based on desistance research goes roughly as follows: (a) a majority of children referred to gender identity clinics will grow up cisgender and not pursue medical transition; (b) social and/or medical transition among youth who will grow up cisgender causes significant distress meaningfully comparable to the one experienced by trans youth whose transition is delayed;

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(c) therefore, professionals have reasons to delay social and/or medical transition—and perhaps even to actively discourage it, according to some (Bewley et al., 2019; Green, 2017; Marchiano, 2017; Soh, 2020; 2015; Steensma & Cohen-Kettenis, 2011). Premise (b) is often implicit but must be included insofar as the distress associated with retransition only gives prudential reasons to delay or discourage transition if it is meaningfully comparable to the distress associated with such delays or discouragement. One of the clearest expressions of the premise comes from Steensma and Cohen-Kettenis (2011; see also Soh, 2015; Green, 2017), who argue in favor of delaying social transition because "[i]t is conceivable that the drawbacks of having to wait until early adolescence (but with support in coping with the gender variance until that phase) maybe less serious than having to make a social transition twice." Drawing on the principle of charity, I have sought to word the premise in its philosophically strongest form.

I understand the argument for conservatism as an utilitarian one, that is, an argument that delaying social and/or medical transition leads to greater aggregate wellbeing for youth. This argument is unsound and cannot justify delaying or discouraging social and/or medical transition, undermining one of the theoretical foundations of the corrective and wait-and-see models. My article will be divided into four sections, first describing desistance research and then arguing in turn against premise (a), premise (b), and the inference from premises (a) and (b) to the conclusion (c).

In the first section, I define desistance research as a particular approach to studying the evolution of gender identity and transition-related desires and discuss its role in debates surrounding models of care. In particular, I explain the central role it plays in justifying the corrective and the wait-and-see models of care.

In the second section, I explain that the persistence percentages offered by desistance research do not meaningfully track the persistence of gender identity among prepubertal children nor the persistence of desire for medical transition among peripubertal youth. Because of the content and timing of assessments in desistance research, the reported persistence percentages are of little to no relevance in deciding between clinical models of care regarding prepubertal social transition or peripubertal medical transition and do not offer reasons to delay social and/or medical transition.

In the third section, I argue that the distress associated with social and/or medical transition among youth who grow up to be cisgender is not meaningfully comparable to the distress associated with delaying or discouraging transition. On the contrary, social and medical transition may be appreciated by many youths who grow up to be cisgender because of the opportunity for exploration that they provide.

In the fourth section, I argue that the corrective and wait-and-see models plausibly have harmful effects on youths who grow up cisgender even if social and medical transition is avoided, and that these harmful effects outweigh the distress associated with retransitioning.

For the purposes of this article, I suspend judgment on the nature of gender identity and gender development. I hold open the question of whether gender identity is fixed or fluid, as my arguments apply to both understandings and I do not wish to constrain my arguments to readers with specific theoretical views. Throughout the article, I understand as transgender (or trans) those people who express a gender identity (whether man, woman, nonbinary, or other) that does not correspond to the gender they were assigned at birth (St. Amand & Ehrensaft, 2018). I term cisgender (or cis) those who express a gender identity that corresponds to the gender they were assigned at birth. I also use the term 'gender creative' to refer to youth who show strong, ongoing behavior patterns associated with a gender other than the one they were assigned at birth but who may or may not be transgender. This latter term is most helpful for young children whose expressions of gender identity aren't always easily understood by adults because we do not speak the same language as children. In the literature on the corrective and wait-and-see models, gender creative youth have often been lumped together regardless of expressed gender identity or transition-related desires and described as confused about gender, despite many having a clear understanding of their gender identity. While acknowledging the fuzziness and impracticability of classifying every single youth as trans or cis, it is crucial for clinicians appreciate the diversity of gender creative youth in terms of identity, behaviors, and transition-related desires (Ehrensaft, 2018; St. Amand & Ehrensaft, 2018). For any given youth, social and medical transition may involve a wide-ranging constellation of changes including name, pronouns, clothing, hair, demeanor, social gender categorization, and bodily interventions (Ashley & Skolnik, 2021; Bradford et al., 2018). Trajectories of social transition are diverse and there is no one-size-fits-all (Kuper et al., 2019). Clinicians should be careful not to draw inappropriate inferences from one subgroup to another, as the argument I critique in this article does.

Given the flawed nature of the argument for conservatism based on desistance research, psychologists should reject the corrective and wait-and-see models and adopt a gender-affirmative model when working with trans and gender creative youth, as it is currently the most evidence-based and ethically-grounded approach (Ashley, 2019c; Hidalgo et al., 2013; Lopez et al., 2017; Rafferty et al., 2018; Telfer et al., 2018).

Desistance Research and Its Relationship to Models of Care

In this article, I understand desistance research as a body of research defined less by its interest in gender identity development than by its methodology and methods. Desistance research may be defined by three core features: (a) an initial prepubertal assessment, (b) a follow-up second assessment in adolescence or adulthood, and (c) assessments focused on clinical diagnoses and whether medical transition was pursued, often mixing the two (Drummond et al., 2008; Singh, 2012; Steensma et al., 2011; 2013; Wallien & Cohen-Kettenis, 2008). Neither the initial nor the follow-up assessment is centred on the person's gender identity. The basic structure of desistance research is as follows. Prepubertal children who satisfied the DSM criteria of gender identity disorder for Children[1] (GID, now Gender Dysphoria in Children) are invited to participate in the study later in adolescence or adulthood (American Psychiatric Association, 2000). They are reassessed to establish whether their GID remains and whether they pursued or are pursuing medical transition. In the affirmative, they are reported as having persisted. In the negative, they are reported as

[1] Including individuals who were below the threshold for a regular GID diagnosis, and were instead given a diagnosis of GID not otherwise specified.

having desisted. Those who refused to participate, did not respond to the invitation, or could not be traced are either excluded from the study or, more commonly, treated as a separate nonpersisting group. As a separate group, they are included in the denominator when calculating the overall persistence rate—which tends to lower it.

Not all studies looking at the evolution of gender identity or transition-related desires are included under the label of desistance research. I understand it as a specific approach to studying the evolution of gender identity and transition-related desires in youth. I do not take aim at studies that do not share the methodology and method identified in the preceding paragraph, and which may be better tailored to inform debates surrounding how to support trans and gender creative youth. At the heart of my criticism of desistance studies, developed in the next section, is that it is ill-tailored to debates about social and medical transition because it centres diagnoses instead of the evolution of gender identity or desire for medical transition from puberty onward. As Temple Newhook and colleagues (2018) have pointed out, the term "desistance" is borrowed from criminology and may suggest that growing up trans ("persisting") is deviant or undesirable. Studies that begin from the premise that all gender identity outcomes are equally desirable may wish to adopt a different terminology to avoid the negative connotations of "desistance" as well as distance itself from the flawed methodology and methods of desistance research.

Desistance research plays a central role in the theoretical apparatus of two clinical models of care, namely the corrective model and the wait-and-see model (de Vries & Cohen-Kettenis, 2012, pp. 307–308; Green, 2017; Meadow, 2018, pp. 80–81; Pyne, 2014b; Zucker et al., 2012, p. 375). The clinical goal of the corrective model is to reduce the persistence rate of gender dysphoria and thus discourage adult trans outcomes (Zucker et al., 2012). I term the approach 'corrective' following Jake Pyne (2014b); it is also known as the therapeutic or pathology response approach (Lev, 2019; Zucker et al., 2012). Because it seeks to reduce the persistence of gender dysphoria and discourage adult trans outcomes, many consider it a form of conversion therapy (Ashley, 2021; Madrigal-Borloz, 2020; Temple Newhook et al., 2018). Unlike the corrective model, the wait-and-see model does not actively seek to encourage identification with one's gender assigned at birth. However, it favors delaying prepubertal social transition out of fear that children who would grow up to be cisgender may socially transition (de Vries & Cohen-Kettenis, 2012, pp. 307–308; Steensma & Cohen-Kettenis, 2011). Children increasingly come to gender identity clinics having already socially transitioned; the wait-and-see model does not typically recommend retransitioning in such cases (Steensma & Cohen-Kettenis, 2018). The corrective and wait-and-see models may be contrasted with the gender-affirmative model (Ashley, 2019c; Hidalgo et al., 2013; Lopez et al., 2017; Rafferty et al., 2018; Telfer et al., 2018). The gender-affirmative model mandates respect for youth's expressed gender identities and allows prepubertal social transitions because they are reversible, relatively safe, and reduce the distress associated with the misrecognition of youth's gender identities (Ehrensaft et al., 2018). The approach emphasizes that gender identities, expressions, and pathways are diverse, that no gender identity or expression is undesirable, and that the best way to support youth is support them in living and expressing themselves in whatever gender feels most authentic or comfortable to them (St. Amand & Ehrensaft, 2018). While the gender-affirmative model is supportive of prepubertal social transition, it bears emphasizing that it is only supported for children who desire it. Not all children referred to gender identity clinics express a gender identity that differs from the gender they were assigned at birth, and nor do all wish to socially transition.

Increasingly, desistance research has been relied upon by clinicians and laypersons to argue more broadly against medical transition before late adolescence or adulthood, in favor of lengthier assessments, and in favor of conversion therapy (Bell v. Tavistock, 2020; Bewley et al., 2019; Evans, 2020; Griffin et al., 2020; Marchiano, 2017; Soh, 2020). Although desistance research emerges from gender identity clinics, it is often extrapolated to other populations such as transgender youth in general. In Canada, desistance research featured prominently in briefs opposing the inclusion of gender identity in the government's proposed ban on conversion therapy (Standing Committee on Justice & Human Rights, 2020). These positions share in the wait-and-see model's investment in delaying transition and/or the corrective model's investment in discouraging adult trans outcomes but extend them beyond their traditional focus on prepubertal intervention. Because they share similar philosophical foundations, I treat them as variants of the corrective and wait-and-see model for the purposes of the present article.

The percentage of 'desisting' children offered by desistance research has been roundly criticized in the scholarly literature (Hegarty et al., 2009; Temple Newhook et al., 2018; Temple Newhook, Winters et al., 2018; Vincent, 2018; Winters, 2019; Winters et al., 2018). However, few authors have turned their attention to the place of desistance research in the clinical arsenal. I take up this task and argue that desistance research should play little to no role in deciding between clinical models of care. The primary aim of this article is to rebut the argument that social and/or medical transition should be delayed because a large majority of trans and gender creative youth grow up to be cisgender. In line with this aim, I identified desistance studies from the references of known sources that deployed the argument I seek to rebut. Most citations were to five studies (i.e., Drummond et al., 2008; Singh, 2012; Steensma et al., 2011; 2013; Wallien & Cohen-Kettenis, 2008). These include the four studies that Temple Newhook and colleagues (2018) described as most commonly cited, in addition to the unpublished doctoral dissertation of Devita Singh (Singh, 2012). Studies conducted before 2000 were occasionally cited (Davenport, 1986; Green, 1987; Kosky, 1987; Lebovitz, 1972; Money & Russo, 1979; Zuger, 1978; 1984). Since references to these earlier studies were rare, I focus on the five more recent studies.

"Desistance" Does Not Give Reasons Against Prepubertal Social Transition or Peripubertal Medical Transition

In this section, I argue that the persistence rates reported in desistance research are not relevant to deciding between clinical models of care regarding prepubertal social transition or later medical transition because they do not track the evolution of desire for social or medical transition among children and youths to whom they are available.

First, the persistence rates reported in desistance research do not offer reasons to delay or discourage medical transition. "Desistance" almost always occurs before puberty, the time at which

medical interventions first become available (Brik et al., 2020; Coleman et al., 2012, p. 172; Steensma et al., 2011, p. 512; Zucker & VanderLaan, 2016, p. 226). On the contrary, youths who initiate hormonal treatments rarely discontinue them. In two studies, 96.5% and 100% of participants who had initiated puberty blockers sought hormone replacement therapy later in adolescence (Brik et al., 2020; de Vries et al., 2011). Because desistance research uses prepubertal assessment as a denominator when calculating the persistence rate and does not report the timing of "desistance" among its participants, persistence rates do not offer insight into the evolution of desire for medical transition among youths to whom medical interventions are available. As a result, desistance research is not relevant to deciding between clinical models of care regarding medical transition.

Second, the persistence rates reported in desistance research do not offer reasons to delay or discourage prepubertal social transition. Desistance research does not purport to observe the evolution of desire for social transition or gender identity, but rather whether children attending gender identity clinics desired medical transition during or after puberty (Steensma & Cohen-Kettenis, 2018, p. 227). Children in desistance studies may or may not have desired to socially transition or identified with a gender other than the one they were assigned at birth at the time of the first assessment. The first assessment instead tracks whether youths are given a GID diagnosis, which has been criticized for including a wide range of gender nonconforming behaviors (Temple Newhook et al., 2018; Winters, 2019). Youths and adults classified as having 'desisted' in desistance research may furthermore be trans and live socially in a gender role other than the one they were assigned at birth, as the category of "desistance" is predicated on pursuing or desiring medical transition—which many trans people do not want. Since desistance research focuses on the desire for medical interventions rather than on gender identity and social transition, they offer little insight into the decision between clinical models of care regarding prepubertal social transition. Puzzlingly, some authors of desistance research acknowledge this conceptual limitation while nevertheless relying on persistence rates to justify their conservative stance toward prepubertal social transition (de Vries & Cohen-Kettenis, 2012; Steensma & Cohen-Kettenis, 2011). To my knowledge, no explanation has been offered for this theoretical inconsistency.

Two counterarguments could be offered to my claim that desistance research is immaterial to deciding between clinical models of care regarding prepubertal social transition. According to the first counterargument, it is reasonable to believe that the stability of medical desire approximates the constancy of gender identity; persistence rates are therefore informative, if only as an approximation. According to the second counterargument, prepubertal social transition is undesirable because it encourages persistence. According to this counterargument, persistence is undesirable because it may delay reidentification with one's gender assigned at birth until after medical transition is initiated, or because being trans is inherently undesirable. Read through this lens, desistance research is indicative of youths who may have been prevented from initiating a medical transition before they would retransition or from growing up trans altogether. In the remainder of this section, I explain why neither counterargument is convincing.

Let us consider the first counterargument, namely that continued medical desire rates approximate the rate at which youth continue in their gender identity. This counterargument fails because we have good reasons to believe that reported persistence rates do not accurately track long-term desire for medical transition—undermining the suggestion that we know continued medical desire rates—and because we have good reasons to believe that desire for medical transition does not approximate gender identity.

Desistance research is overinclusive at the time of the first assessment. Many participants likely neither expressed a gender identity differing from the gender they were assigned at birth nor expressed interest in future medical transition. Participants were assessed for GID under the criteria found in the *DSM–III* to *DSM–IV–TR*. The diagnostic criteria for GID are overinclusive, especially in the *DSM–IV* and *IV-TR* including subcriteria such as preference "for wearing only stereotypical masculine clothing," "preferences for cross-sex roles in make-believe play," "intense desire to participate in the stereotypical games and pastimes of the other sex," and "strong preferences for playmates of the other sex" (American Psychiatric Association, 2000). None of the subcriteria expressly relate to bodily desires or desire for medical transition, strongly undermining the suggestion that desistance research accurately tracks the evolution of desire for medical transition. In addition, the desire to be or insistence that one is of "the other sex" is relegated to a single subcriterion which does not need to be met for a diagnosis. Gender nonconformity often suffices for a diagnosis (Gray et al., 2012; Pyne, 2014a; Temple Newhook et al., 2018; Winters, 2019). The overinclusiveness of desistance research at first assessment is further reflected in the fact that many participants in desistance studies were subthreshold of the DSM criteria for GID, instead receiving a diagnosis of GID NOS, "not otherwise specified" (Temple Newhook et al., 2018, p. 215). In some studies, as many as 40% of the participants were given a diagnosis of GID NOS (Drummond et al., 2008). Indeed, one of the clinics associated with desistance research has reported that fewer than 10% of children at the clinic expressed a gender identity different from the gender they were assigned at birth (Olson, 2016; Zucker et al., 1993, p. 449). Expressing a gender identity different from one's gender assigned at birth in childhood is believed to be correlated with future gender identity and desire for medical transition (Steensma et al., 2013, p. 588). While the importance of this factor should not be overemphasized and many children who do not express their gender identity in such clear terms may well grow up to be trans and pursue medical transition, it is striking that so few children attending clinics, i.e., participating in desistance research, had voiced a trans gender identity, further emphasizing the overinclusion of children in these studies. Desistance research tracked neither gender identity nor desire for medical transition at first assessment.

Besides being overinclusive at the time of first assessment, desistance research is underinclusive at the follow-up assessment and underreports persistence whether understood in terms of desire for medical transition or gender identity. The follow-up assessment occurred relatively early, requiring only that participants have reached 14 to 17 years of age depending on the study (Temple Newhook et al., 2018). In the Wallien & Cohen-Kettenis study (2008), for instance, participants were 19 years old on average at follow-up. Classification as having persisted was predicated on meeting the complete diagnostic criteria for GID in Adolescents or Adults and having applied for medical transition at the clinic (Wallien & Cohen-Kettenis, 2008). Some trans participants

may still have been unsure as to whether they wished to medically transition and classified as having desisted for that reason. Among trans adults, 22% are undecided about or do not wish to initiate hormone replacement therapy; 23–24% are undecided about undergoing vaginoplasty and orchiectomy; and 31–37% are undecided about undergoing phalloplasty and metoidioplasty (James et al., 2016, pp. 99, 101–102). While these statistics are not specific to those who attended gender identity clinics in youth, they serve as a reminder that medical transition is not one-size-fits-all and that some trans people may take longer to make a decision regarding transition-related interventions. In a study by researchers of the VUmc Amsterdam clinic who published desistance research, a nonbinary participant who identified as bigender was classified as having desisted, further highlighting the lack of correspondence between gender identity and desire for medical transition (Steensma et al., 2011, p. 512). Around a third of trans adults identify primarily as nonbinary (James et al., 2016, p. 45). The persistence rates reported in desistance research cannot be used to approximate the rate at which children continue in their gender identity since it classifies individuals who may medically transition later and who are trans and/or nonbinary but do not wish to transition as having 'desisted'—subgroups of a potentially significant size.

Desistance research may also underreport persistence because of the impact of clinical models of care on follow-up assessments (Temple Newhook et al., 2018, p. 219). The Canadian clinic where the Drummond et al. (2008) and Singh (2012) studies were conducted was closed in 2015 following allegations that they engaged in conversion practices. An external report concluded that their corrective model was contrary to currently recognized professional norms (Zinck & Pignatiello, 2015). While the director of the clinic later obtained an apology notably for misattributed statements, the home institution reiterated its conclusions that the approach failed to meet the needs of trans and gender creative youth (Rizza, 2018). It is plausible that some trans participants repressed their gender identity due to the corrective model employed by the clinic, only for it to resurge later in life. Due to its implicit negativity toward transition, the wait-and-see model may have similar but less pronounced effects (Ashley, 2019a, 2019c; Ehrensaft, 2014, p. 579).

The unrepresentativeness of persistence rates is further worsened by desistance research's treatment of individuals who refused to participate, did not respond to the invitation, or could not be traced. In some studies, these individuals were included in the denominator for the reported persistence rate. Instead of being deleted from the cohort as is common with nonparticipants, as the Drummond study did (2008), they were treated on par with the desisting subgroup to calculate persistence. In the Wallien & Cohen-Kettenis study (2008), 30% of contacted youth could not be reassessed at follow-up. Had this group been deleted from the cohort, the persistence rate would have been reported as 39% instead of 27%. Since theirs is the only gender identity clinic for children in the Netherlands, the authors reasoned that it was unlikely that any of those who were not reassessed at follow-up were "persisters" (Wallien & Cohen-Kettenis, 2008). They confirm their reasoning by pointing to the lack of statistically significant difference in gender-related test scores between this group and the 'desisting' subgroup at first assessment (Wallien & Cohen-Kettenis, 2008; Zucker et al., 2018). Both reasonings are problematic. First, just because the difference in scores between the two subgroups is not statistically significant does not mean that such scores can be assumed to be the same. All it means is that there is at least a 5% chance that the scores are the same.[2] This is a very low bar to meet and it may still be more likely that those who were not reassessed substantially differ from the 'desisting' subgroup. Second, it is problematic to assume that all youths who stopped attending the clinic 'desisted' just because it is the only clinic in the Netherlands. We know that many youths are frustrated by the wait-and-see model, which is employed at the Dutch clinic, because its assessments are perceived as unduly lengthy and labyrinthine or because they see the approach as unduly negative toward transition (Ehrensaft, 2014, p. 579). Some youths may not wish to stay in contact with the clinic, even if it means waiting until later to transition or going to another country to obtain services. In Dutch community circles, Belgium is known as a viable alternative for obtaining transition-related medical services. Treating individuals who were not reassessed at follow-up akin to the 'desisting' subgroup is theoretically questionable and biases calculated persistence rates.

The disparity between persistence rates reported in desistance research and those reported using other methodologies and methods lends credence to the argument that desistance research is not a reliable proxy for the rate at which youth continue in their gender identity. The persistence rates reported in desistance research vary substantially depending on the study, ranging from 2% to 27% (Drummond et al., 2008; Green, 1987; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995, pp. 283–287). These rates not only vary significantly within desistance research but stand in stark contrast with those revealed by methodologies that more narrowly focus on gender identity. At the Royal Children's Hospital Gender Service in Australia, 96% of youths continued to identify as transgender, whether binary or nonbinary, into late adolescence. The study was not published in a peer-reviewed journal and did not only include participants who were first assessed before puberty (In re: Kelvin, 2017), making it impossible for us to infer the rate specific to prepubertal children. Nevertheless, the sheer disparity between persistence rates in desistance research (which focuses on medical transition) and percentages more narrowly tied to gender identity is striking. At the very least, it offers reasons to doubt that desistance research can be used to approximate the constancy of gender identity. Since reported persistence rates are not reliable indicators of desire for medical interventions and since we have serious reasons to doubt that medical desire at puberty approximates gender identity, desistance research does not justify delaying social transition until after puberty among children who wish to socially transition.

I now turn to the second counterargument, which states that prepubertal social transition should generally be discouraged because it may encourage persistence. Under this view, persistence is undesirable because it may delay reidentification with gender assigned at birth until after medical transition is initiated, or because being trans is inherently undesirable and should be avoided if possible. The preoccupation that supporting prepubertal social transition may encourage persistence has been raised a few times in the literature, including more recently by Kenneth Zucker (2018, p. 237).

[2] More precisely, it means that there is at least a 5% chance that at least this large a score difference would be found despite the subgroups being the same.

At this juncture, it is worth emphasizing that the gender-affirmative model only encourages social transition for children who desire it and favors developing a positive environment within which it is always possible to socially retransition without judgment (Ashley, 2019c). Participants in desistance research who do not wish to socially transition would not be encouraged to do so. Recent studies on gender development have shown that social transition is associated with prior gender identification, that gender identification does not meaningfully differ before and after social transition, and that trans children are similar to cis children of the same gender identity (Gülgöz et al., 2019; Rae et al., 2019). By contrast, there is little evidence that children classified as 'desisters' would have socially transitioned under the gender-affirmative model or that such social transition would delay reidentification to the gender they were assigned at birth until after initiating medical transition.

The second counterargument is better understood in light of the developmental and biopsychosocial perspective theorized by Zucker and colleagues, which understands gender identity as malleable before puberty and frequently describes trans and gender creative children as confused (2012). Even if this theory were true, however, we have no clear reason to believe that a higher rate of persistence would lead more people to regret medically transitioning in adolescence and adulthood. While the evidence base is limited, clinics operating under a gender-affirmative model do not appear to report elevated rates of retransition or regret and generally report positive mental health outcomes (Blasdel et al., 2018; Ehrensaft et al., 2018; In re: Kelvin, 2017).

Since the developmental and biopsychosocial perspective views gender identity as largely fixed upon reaching puberty, the concern may be less that youths would reidentify with their gender assigned at birth after initiating medical transition and more that they would grow up to be trans at all. However, we do not have reasons to believe that being trans or transitioning is inherently undesirable, such that persistence should always be discouraged if possible. While trans adults often evidence poorer mental health than the general population, negative mental health outcomes are strongly correlated with lack of access to medical transition as well as stigma, discrimination, and violence (see e.g., Bailey et al., 2014; Bauer et al., 2015; McLemore, 2018; Olson et al., 2016; Tebbe & Moradi, 2016; Timmins et al., 2017). There is no evidence that poor mental health outcomes are inherent to being trans, and it would be ethically questionable to justify preventing people from being trans and/or transitioning on the basis that they may experience transphobia. Such reasoning should be rejected on three counts: it is a form of victim-blaming, would justify a wide range of unethical practices such as gay conversion therapy,[3] and furthers the transphobic aim of eliminating trans people from social life. Trans people are an integral part of human diversity, and their existence should be valued as such.

Even if we agree that children's gender identity is flexible and that the gender-affirmative model leads to higher persistence rates than the wait-and-see and corrective models, it does not follow that prepubertal social transition should be discouraged. Being trans is not bad in-and-of-itself. Youths who may otherwise have grown up to be cisgender may nevertheless have good mental health and high life satisfaction. Short of evidence that allowing prepubertal social transition leads to ethically significant, negative outcomes for an identifiable subgroup, the second counterargument holds no sway.

Since desistance research does not track gender identity or desire for social and/or medical transition among youths to whom they are available, the persistence rates it reports are immaterial to deciding between clinical models of care regarding prepubertal social transition or peripubertal medical transition.

Transition for 'Desisters' Is Not Comparably Harmful

In this section, I argue that the distress associated with social and/or medical transition among youth who grow up to be cisgender is not meaningfully comparable to the distress associated with delaying or discouraging transition. By meaningfully comparable, I mean that the aggregate distress associated with social and/or medical transition among youth who grow up to be cisgender must be at least approximately as large as the aggregate distress from delaying or preventing transition for youths who desire it. If it is not meaningfully comparable in this sense, then the distress of trans youth would outweigh it. For the purposes of this section, I presume that the persistence rates reported in desistance research are accurate. We have reasons to believe that transition for those who grow up to be cis is not comparably harmful for two reasons. First, much of the distress associated with social retransition appears tied to gender nonconformity, independently of whether one's name, pronouns, and social gender categorization are changed. Second, many youths who grow up to be cis or discontinue medical transition are not distressed and, on the contrary, express gratitude for the opportunity to explore their gender through transition.

In a 2011 letter to the editor, Thomas Steensma and Peggy Cohen-Kettenis justified their conservative approach to social transition by pointing to two young girls who, in a previous study, had expressed difficulties and distress retransitioning after an initial social transition (Steensma et al., 2011; Steensma & Cohen-Kettenis, 2011). Cited in the WPATH Standards of Care Version 7, the letter to the editor is frequently used as evidence of the risks of prepubertal social transition. However, the experiences of the two girls have limited implications for whether and how youths should be supported in socially transitioning. The two girls were gender nonconforming, wearing short hair and clothing perceived as masculine, but neither had changed their name or pronouns nor, it would seem, how they were socially categorized for, for example, sports or bathrooms (Ashley, 2019b; Steensma et al., 2011, p. 503). The authors explain that they identified as boyish girls and it is unclear whether they wanted to change their name, pronouns, or how they were socially categorized. Trajectories of social transition are diverse and there is no one-size-fits-all (Kuper et al., 2019). However, it is significant that the two girls' negative experiences related to changes in appearances rather than a change in name, pronoun, or social categorization. We do not know whether their difficulties and distress with retransitioning would have been significantly higher had they also changed their names, pronouns, and social categorization—which are often the most controversial aspects of social transition. Their experiences only allow us to draw conclusions regarding changes in appearances such as hair and clothing. However, it would be unacceptable to prevent youth from being gender nonconforming simply because they attend gender identity clinics when the same nonconformity is common and often

[3] Pushed to its extreme, it could be deployed to justify eugenics and genocide.

allowed in the rest of society. Short hair and traditionally masculine clothing such as large t-shirts and pants are common among young girls. Opposing or preventing gender nonconformity in youths assigned female at birth is objectionable on feminist grounds. Since it is unethical to discourage gender nonconforming appearances and since we do not know whether changes in name, pronouns, and/or social categorization would have led to greater distress, Steensma and Cohen-Kettenis' letter to the editor cannot be used to support delaying or discouraging social transition, regardless of what it involves for the particular youth. No studies currently provide evidence supporting the suggestion that a change of name, pronouns, or social categorization among children who grow up cis causes significantly more distress than changing one's gender expression from nonconforming to conforming, let alone of a significant enough degree to compete with the distress of delaying social transition for those who desire it.

Recent case studies suggest, on the contrary, that transition may be beneficial and appreciated by some youths who grow up to be cis. The composite case of Jamie, described by Jack Turban and Alex Keuroghlian (2018) illustrates this phenomenon. For 13 months, Jamie took testosterone, used the pronoun "he" and wore traditionally masculine clothing. After 13 months, however, Jamie informed the clinical team that, upon reflection, she understood herself to be a queer woman and wished to cease testosterone. Despite retransitioning, Jamie did not regret initiating testosterone nor the physical changes it brought. Instead, "[s]he was adamant that without being allowed to socially transition and experience testosterone therapy, she would not have settled into her identity [as a queer woman]" (Turban & Keuroghlian, 2018, p. 452). Exploring her gender through social and medical transition had been integral to her identity formation, and she was grateful for the opportunity to undertake them. A similar attitude was reported in a person assigned male at birth who eventually settled into a nonbinary identity and discontinued estrogen and puberty blockers (Turban et al., 2018). In a study of 88 minors who initiated hormone therapy at the Callen-Lorde clinic in New York City, both youths who discontinued hormone therapy denied having regrets (Blasdel et al., 2018). While retransition may come with significant regret and distress, it cannot be assumed that growing up to be cis after having socially and/or medically transitioned is necessarily a negative outcome. This observation rings doubly true in the case of peripubertal use of puberty blockers, which are far more reversible than testosterone and estrogen and, indeed, endogenous puberty.

While clinicians working under the wait-and-see model often see retransition as an ill to be assuaged by extensive assessments and delaying transition (Wren, 2019), we must ask ourselves whether certainty is a good for the child or whether its primary function is to appease the anxieties and discomfort of parents and clinicians. As the examples given by Turban and colleagues show, some youths do not see retransition as a negative and do not mind transitioning even if they are not certain as to whether it will suit them. Parents may fear being judged by others should their youth retransition in the future and clinicians may experience a patient's retransition as a failure on their part. However, these are not goods for the child and their relevance to deciding between clinical models of care is questionable.

Scholars and clinicians should interrogate the importance of attaining certainty before allowing transition rather than presuming it, as many individuals may benefit from exploring their gender through transition. The gratitude of youths who eventually realize that medical transition is not for them and/or who settle in a gender identity corresponding to the gender they were assigned at birth can be explained by the fact that transition provides a uniquely fertile opportunity for gender exploration (Ashley, 2019c). For some, social and medical transition will play an indispensable role in exploring their gender and arriving at a decision regarding what best suits them. Experiencing gender euphoria, for instance, may confirm that transition is right for them. Conversely, not experiencing gender euphoria could lead the person to the opposite conclusion. Without transition, youths may have taken much longer to settle into their identity—if at all. Transition is experienced positively by some youths who grow up cis. By contrast, it seems unlikely that a significant number of youths who grow up trans would be grateful for delays and barriers to transition, that is, for being forced to live in a gender role and/or body that does not correspond to their self-understanding of core aspects of their personal identity. Accordingly, we have reasons to doubt that it is comparably harmful to delaying social and/or medical transition for youths who desire them.

The Corrective and Wait-and-See Models Have Harmful Effects on Youths Who Will Grow Up Cis

I have thus far targeted the soundness of the premises of the desistance argument. Even if (a) and (b) imply (c), we cannot infer (c) if either (a) or (b) is false. In this section, I turn to challenge the inference between the premises and the conclusion. Even if it were the case that most youth would grow up cis and that retransition causes significant and proportionate distress, it would not follow that the wait-and-see and corrective models are justified. These models are harmful to some children who will grow up cis, and their harm plausibly outweighs the distress associated with having to retransition.

Sociologist Karl Bryant has discussed multiple times the negative impact that the practices of the UCLA Gender Identity Research Clinic under the direction of Richard Green had on him (Bryant, 2006; Kohli, 2012; Schwartzapfel, 2013). Although he grew into an identity as a cisgender gay man, the approach has negatively impacted his life: "The study and the therapy that I received made me feel that I was wrong, that something about me at my core was bad, and instilled in me a sense of shame that stayed with me for a long time afterward" (Schwartzapfel, 2013). Dr. Sé Sullivan, a nonbinary professor who was a patient at the UCLA clinic, reports similar traumas (Sullivan, 2017). The approach of the UCLA clinic under Green's direction was in many points similar to the current corrective model (Kohli, 2012; Pyne, 2014b; Sullivan, 2017, p. 17; Williams, 2017; Zucker et al., 2012).

This strong negative impact can be explained by the sense of psychopathologization (for the corrective model) or of negativity toward transition (for the wait-and-see model) that is communicated to the child through their respective practices. Whether it is by attempting to change gender nonconforming behaviors or by preventing the child from freely expressing their gendered inclinations, both models tend to teach the child that gender creativity is negative, which engenders shame and the degradation of attachment relationships (Wallace & Russell, 2013). Shame is linked to

high risks of depression and other mental health problems (Cheung et al., 2004; Wallace & Russell, 2013).

The engendering of shame is not limited to youth who persist in their gender identity or medical desires. Shame is linked to various components of gender including gender nonconformity, which often motivates clinical referral. Many cis queer adults who showed gender creativity in childhood report being shamed and humiliated for their behaviors (Ehrensaft et al., 2018, pp. 264–265). As Diane Ehrensaft et al. explain (2018, p. 265):

> Shaming children never leads to a positive outcome and has been shown to have adverse effects on mental and physical health, especially if that shaming is done by a child's family. Thwarting a social transition is the perfect recipe for such shame. Facilitating a social transition, if possible, that centers the child's developing self-knowledge is the perfect preventive measure against such shame.

Negative messages about gender identity impact youth who grow up cis as well. Sending the message that one's child will only be fully accepted if they identify with their gender assigned at birth communicates conditional acceptance surrounding sexual orientation, gender nonconformity, and gender exploration, which can have negative impacts on various aspects of parent–child relationships. Pressures to conform can also foreclose gender expression, which may impede pleasure and flourishing, if not cause distress (Hegarty et al., 2009, p. 897). Wearing dresses, for a cis man, can be very enjoyable!

In sum, even if it were the case that social and/or medical transition likely had a negative impact on youth who will grow up cis, it would not mean that the corrective and wait-and-see models are justified since we have sufficient reasons to believe that they would be even more harmful. On the opposite end, youths who underwent prepubertal social transition as part of the gender-affirmative model are mentally healthy, with anxiety and depression rates that are comparable to their cisgender peers (Durwood et al., 2017; Ehrensaft et al., 2018; Olson et al., 2016; Rae et al., 2019). We have theoretical, empirical, clinical, and anecdotal reasons to believe that the gender-affirmative model is superior to both the wait-and-see and corrective models. This approach was also endorsed by groups such as the American Academy of Pediatrics, the Australian and New Zealand Professional Association for Transgender Health, the Pediatric Endocrine Society Transgender Health Special Interest Group, and the Transgender Health Research Lab (Lopez et al., 2017; Oliphant et al., 2018; Rafferty et al., 2018; Telfer et al., 2018).

Conclusion

In this article, I have argued that desistance research is of very limited relevance in debates surrounding clinical models of care for transgender and gender creative youth and fails to provide support to the wait-and-see and corrective models. The conservatism of those two models vis-à-vis prepubertal social transition is not supported by desistance studies. Not only do we have good reasons to doubt the accuracy of reported persistence rates, but these observations are disconnected from the clinical decisions health care professionals face surrounding models of care. Moreover, transition for those who would grow up cis does not appear comparably harmful to delaying transition, and both the corrective and wait-and-see model pose significant risks of harm.

Thinking critically about the relationship between research observations and clinical models of care is essential to progress in trans health care. Research on the trajectories followed by trans and gender creative youth should be tailored to the clinical debates it seeks to inform. When studying prepubertal social transition, researchers should tailor their methods to reflect gender identity and the diversity of social transitions. When studying medical transition, methods should aim to reflect the evolution of desires regarding medical transition at the relevant time in their life span (e.g., when puberty blockers and/or hormone therapy are offered) and acknowledge the diversity of medical transitions. In both cases, research should strive to include quality-of-life outcomes and collect data about retrospective preferences (e.g., youths' perspectives on how they would have been best supported). Youths' trajectories are diverse and retransition does not necessarily indicate a harmful, regretted, or regrettable outcome. When selecting a model of care, psychologists should ensure that they rely on trajectory statistics tailored to the type of support being contemplated, consider the relative benefits, harms, and risks of facilitating versus delaying or discouraging social and/or medical transtion, and take into account the harms that some models of care may have on youths regardless of whether they grow up to be trans.

The arguments presented in this article offer additional support to the gender-affirmative model by undermining one of the major arguments in favor of the wait-and-see and corrective models of trans youth care. Psychologists play a central role in supporting trans and gender creative youth and their families, offering psychological and social support as well as conducting assessments for medical interventions (Coleman et al., 2012). Throughout their work, they should adopt a gender-affirmative model that views being trans as a matter of human diversity that should not be discouraged or curtailed (Ashley, 2019c; Hidalgo et al., 2013). This approach is best supported by the available evidence and is promoted by leading clinical guidelines (Lopez et al., 2017; Oliphant et al., 2018; Rafferty et al., 2018; Telfer et al., 2018). Rather than focusing on predicting clients' future gender identity, psychologists should strive to best support them in the here-and-now. That means respecting youths' expressed gender identity, supporting children who wish to socially transition, and facilitating access to medical transition among adolescents.

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