Article

Thinking an ethics of gender exploration: Against delaying transition for transgender and gender creative youth

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Abstract

Youth explore their genders – both theirs and those of others. Exploration is not only a vessel of discovery and understanding but also of creation. Centring the notion of gender exploration, this article inquires into the ethical issues surrounding care for transgender youth. Arguing that exploration is best seen not as a precondition to transition-related care but as a process that can operate through transitioning, the article concludes that the gender-affirmative approach to trans youth care best fosters youth's capacity for healthy exploration. Unbounded social transition and ready access to puberty blockers ought to be treated as the default option, and support should be offered to parents who may have difficulty accepting their youth.

Keywords

Transgender youth, gender-affirmative care, therapeutic ethics, ethics, gender variance, gender diversity

Introduction

Youth explore their genders – both theirs and those of others. Exploration is not only a vessel of discovery and understanding, but also of creation. It is not only about unearthing a pre-existing truth, but also making that truth for ourselves. Even though I experience gender dysphoria vis-à-vis my beard, my conscious decision not to continue with electrolysis has allowed me to develop a stronger sense of myself as a person outside the binary – although I remain well shaved most of the time. In her article in the present issue, Wren claims that clinicians 'are obliged to consider whether more time for exploration is needed by any child or family before embarking on a medical intervention, given the impacts of (partly) irreversible treatments years after they were initiated' (Wren, 2019).[1]

A golden thread running through Wren's article is the view that exploration, as a process, must precede transition, because transition forecloses future life possibilities (Wren, 2019).[2] In this article, I will argue that such a conception of exploration is mistaken and propose an alternative view

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of exploration. My article will centre an ethics of exploration in rethinking what it means to transition, socially and medically, for trans and gender creative youth.[3] An ethics of exploration, in this context, is the process of deliberately centring our ethical thinking around the notion of exploration to try and see how it can shed a different light on an ethical issue. An ethics of exploration can be put in contrast to an ethics of prediction, which centres the question of how the child will evolve. Prediction, like exploration, is subject to multiple elucidations: it could mean centring the prediction of future gender identity (Temple Newhook et al., 2018), but also of whether a choice will be found to be regrettable in the future (Wren, 2019).

An ethics of exploration does not provide us with absolute answers since exploration is not the only relevant factor to ethical choice. Still, it can serve as a heuristic, an additional tool in our ethical vocabulary through which we can further our thinking on moral questions.

Leaving behind prediction altogether, the present article proposes an ethical conceptualisation of transition that takes exploration at its word and, in doing so, is more in line with the gender-affirmative approach (Hervey, Hervey, & Hervey Birrell, 2018; Hidalgo et al., 2013). In contrast to Wren's view that exploration precedes transition, I will venture to spell out how taking up a vision of the self as dynamic and relationally constituted, as Wren does, leads to the conclusion that exploration is not prior to transition but operates through and alongside transition. Although many trans and cis people experience gender, in whole or in part, as something that is discovered and affirmed, many of us also see it as constituted by exploration. Under this lens, gender is tentative: it is always provisional and improvisational. If that is so, then transitioning, both socially and medically, is an integral part of exploring ourselves as autonomous gendered beings. Delaying transition to facilitate exploration, then, would make little sense.

Views of exploration, views of self

Who we are is not something that is given to us in totality. Some parts are given – our body, though it changes – but most parts are not. Few of us are spawned into the world already enjoying art. We learn to enjoy art by learning about it and by enjoying it with others. An integral part of my enjoyment of Brutalist architecture is how it provokes in me endless daydreaming of socialist utopias. Scotch whisky is something I enjoy with my father, with long discussions of its flavour profile, with scented hints of caramel and honey, in the suburban backyard of my childhood home. Now that I have moved to the city, my enjoyment of Scotch has diminished.

Whether we view gender as a component of the self that is given to us or not has significant implications for how we view exploration and its role in relation to desire and assent to social transition, puberty blockers and hormone replacement therapy. If we see gender as a given, as Wren notes, then the role of the clinician is to determine whether expressions of gender are authentic with sufficient certainty and, once this certainty is attained, to provide requested treatment (Wren, 2019).[4]

Wren disagrees with this view of gender as given. As Wren highlights (Wren, 2019),

> 'Who someone is' can also comprise perspective, outlook or viewpoint, i.e. their more considered wants and desires, cares, concerns, standards, values and commitments. This is a characterisation of autonomy as a complex process of interpretation and negotiation, determined by multiple developmental influences combining to provide a sense of identity. On this model, a sense of self builds up from experience, from a person's earliest choices and motivations. It is a model that implies that for children and adolescents their deepest values and concerns may not be fully clear or delineated until they confront a wider diversity of types of situation than most children and young adolescents face.

This vision of gender as dynamic and relationally constituted is reminiscent of feminist metaphysics, which have highlighted the social construction of gender and the relational nature of the

self (Hanslager & Ásta, 2018). Although the gender-affirmative approach to trans youth has frequently been associated with the view of gender as given, it has been explicitly rejected by many theorists of the approach (Hidalgo et al., 2013, p. 288; Temple Newhook et al., 2018). Of course, rejecting the view that gender is a given and that trans people are 'born this way' does not mean that gender at any specific point in time is not relatively stable and resistant to change (Ehrensaft, Giammattei, Storck, Tishelman, & Keo-Meier, 2018, p. 260).

The contrast between theorisations of gender-as-given and gender-as-dynamic is related but distinct from various modes of trans embodiment. In my previous work, I have proposed three distinct types of relationship to the body, which may lead trans people to seek transition-related care: gender dysphoria, gender euphoria and creative transfiguration (Ashley & Ells, 2018). Gender dysphoria refers to a negative, distressing experience of the body as differing from our gendered self-image. Gender euphoria is its positive homologue, is an experience of 'distinct enjoyment or satisfaction caused by the correspondence between the person's gender identity and gendered features associated with a gender other than the one assigned at birth' (Ashley & Ells, 2018). Creative transfiguration, however, is wholly other. Putting a name to this experience which I saw in the experiences of many trans people and the precious work of transmasculine theorists (Horncastle, 2018; Preciado, 2013; Spade, 2013), I spoke of the irreducible creativity of gendered embodiment for some trans people (Ashley & Ells, 2018):

> Trans embodiment can be irreducibly creative. Creativity is one of the manifold ways in which we may assert ownership over our bodies, transforming them into an art piece that is truly ours out of previously alienating flesh.

Gender dysphoria and gender euphoria could be recast as a form of theatrical gender subjectivity, as opposed to improvisational. There is a sense in which finding our gender through dysphoria and/or euphoria *feels* like unearthing a pre-constituted image of the self, and this even if we acknowledge and realise that they are both dynamic and relationally constituted. Transition, then, may be metaphorically compared to an actor reciting lines from script written uniquely for them. It is the actualisation of a pre-written and coherent vision of the self.

If gender dysphoria and euphoria can be cast as theatrical, then creative transfiguration brings out more of a metaphor of improvisation. Unlike theatrical gender subjectivity, which may not feel dynamic and relationally constituted even though it is, creative transfiguration feels creative through and through. There is no sense of unearthing a pre-constituted image of the self, but a sense of actively creating ourselves, like someone creating a character that best represents them in a video game – yes, I *know* I'm not an elf but somehow an elf character seems to best capture my spirit.

By understanding trans people's experiences of gender as not only rooted in gender dysphoria but also in gender euphoria and creative transfiguration, we can better make sense of how trans people experience their gender sometimes as given, sometimes not, while also remaining committed to a view of the self as dynamic and relationally constituted.

Commitment to either a view of gender-as-given or gender-as-dynamic bears significant implications for the role exploration should play in a clinical context. For Wren, '[t]he ethical picture is complicated if we give weight to the real possibility of a child or young person's identification continuing to evolve over time and their levels of distress in relation to identity/body incongruence fluctuating (with and without medical intervention)' (Wren, 2019).[5]

Unfortunately, Wren mistakenly takes the need for more curiosity and exploration as warranting further delaying of transition, generating a tension between the perhaps unwarranted need for caution and the undesirability of clinicians who, paralysed by uncertainty, endlessly defer transition

(Wren, 2019).[6] As will become clear in the next section, understanding exploration and curiosity as something that occurs through transition instead of primarily before it allows us to resolve this apparent tension.

On the contrary, the best form that this curiosity and exploration can take is the bracketing of the question of authenticity. If the self is fundamentally dynamic and relational, then asking whether a person's experience of gender is authentic makes little sense (Bettcher, 2009, p. 110ff). No one would say that my enjoyment of art is inauthentic because I learned to like art by visiting museums with my best friend. No one's experience of gender is free from social influences; to think that they make gender less authentic would be to mistake gender for something that is not fundamentally dynamic and relational. Although there is room for confusion about gender – anyone who claims to have a clear understanding of gender is a liar, liar, pants on fire – supporting someone through confusion and helping them understand themselves is completely different from assessing authenticity. Gender identities are not authentic or inauthentic. They simply are. If we are committed to the view that gender is dynamic and relationally constituted, then our answer to Wren's question of 'how do we assure the authenticity of any young person's choice of treatment?' (Wren, 2019)[7] is that we simply do not.

Before moving on to the next section, I want to draw a further implication of gender as dynamic and relational. Tey Meadow's recent book on trans youth eloquently questioned the relationship between trauma and gender (Meadow, 2018, pp. 90–91):

> If it is possible to understand gender as 'an improvisational possibility within a scene of constraint', relational and produced through the interaction of individuals, it's not a huge leap to imagine that some forms of gender could be made of scar tissue, produced as much by trauma as by tenderness. But it's a quick and dangerous slide from thinking about gender deviance as compensatory and thinking it pathological. And if gender deviance is a maladaptation, then those of us with atypical gender presentations are, in fact, damaged goods. [. . .] How do we disentangle gender from the many complex interacting factors that produce it? And is there a way to take seriously the question of gender as an adaptation without understanding it as pathology? [. . .] All gender is an adaptation, a call for recognition. The mistake lies in thinking of it as somehow less real, less constitutive of selfhood, less central to psychic life.

A corollary of the belief that gender is always already socially influenced and in flux is that the sort of social influence – so long as it remains influence rather than coercion or manipulation – does not matter. Gender identities born out of trauma, out of scar tissues, are no less legitimate than any other gender identity born out of the manifold intersections of biology, learning, attachment, cognition, transference, and so on. Significant controversy exists over etiology, over which factors influence gender identity. Pathologising accounts of gender variance have frequently foregrounded trauma and co-occurring mental illness as causes (Kuhl & Martino, 2018; Pyne, 2014b). Once we understand gender as normally dynamic and relationally constituted – like many other elements of the self – then such pathologising accounts must be rejected. This concords with the intuition shared by many clinicians that etiology is not determinative of treatment ethics (Vrouenraets, Fredriks, Hannema, Cohen-Kettenis, & de Vries, 2015, p. 369). Selves born out of trauma are no less selves.

Ethical role of exploration

Favouring choices that least restrict children's future options is wise. Because Wren believes that steps taken towards transitioning foreclose future options and fail to give due weight to how delaying transitioning is also an act of foreclosure, she sees exploration as a step prior to transition.

This stance is hard to reconcile with her commitment to gender as dynamic and relational. Since gender is not something given that we need to unearth, but something that remakes itself – the same or anew – over and over again as we gather new experiences of the world, the moment of transition is not ethically special from the standpoint of exploration. Transitioning is just another way we explore our gender.

We can see this most clearly in older adolescents and adults. Earlier in their transition, my partner expressed uncertainty regarding which name and pronouns they felt most favourable towards.[8] We decided to try different combination of names and pronouns over a period of weeks. The resulting choice was not final, and they later changed their name a second time. The same partner later began to take low doses of testosterone. They stopped a few months later only to later resume taking testosterone as they realised that they were more comfortable on it. They are uncertain as to how long they will continue to take it, an uncertainty with which they are perfectly comfortable and see as an integral part of their exploration of gender embodiment. Although experiences like theirs have been suppressed in the clinical world because of narrow views of gender exploration – non-binary identities are still routinely invalidated by clinicians – changing names and pronouns and undergoing transition-related interventions are routinely used by trans people in an exploratory manner, largely to positive effect (Bradford et al., 2018; Turban, Carswell, & Keuroghlian, 2018; Turban & Keuroghlian, 2018).

Exploration is not prior to transition. It comes before, during and after it. Once we admit that gender is dynamic and relational, then there is no reason to see exploration as something that must ethically come before clinically significant choices. That transitioning might influence gender identities is not by itself reason to delay transition, since identities are just as susceptible of being foreclosed by delaying transition than by allowing it. Youth's identities are arguably more fixed by an approach to transition that imply a desire for gender stability than one that allows them to fluctuate back and forth across boundaries of identities as they please.

Halberstam, whom Wren cites, perhaps has some reasons to worry that gender variance can be prematurely stabilised into a fixed trans identity that casts their gender as 'something clear and true' (Wren, 2019).[9] Although the problem they describe pales in comparison to that of lack of support, it should be noted that many non-binary people who initially identified in a binary manner anecdotally report pressures to retain those initially expressed identities (Bradford & Syed, 2019). Many others report being forced into a certain relationship to their gender – I remember my mother telling me that I shouldn't wear certain clothes 'since I'm a woman now' and have heard too many butch trans women lament the constant invalidation of their identities they face on the part of people who see themselves as supportive.

The dilemma between naturalising trans identities and offending those identities by subjecting them to endless doubt is best resolved not by finding a means between 'too quickly' and 'too slowly' but by rethinking how we understand transition and exploration. By refiguring transition as a form of open exploration of gendered feelings and moving away from viewing it as the solidification or entrenchment of the child's identity, we can leave ample room for curiosity and exploration and avoid foreclosing future possibilities without delaying transition.

Transition-as-exploration

Narrowing future possibilities, whether through difficult-to-reverse bodily changes – including ones that occur on their own during puberty – or pressures to commit to a specific gender identity, often binary, is antithetical to exploration, all other things being equal. This is not to say that well-defined identities are bad. But if gender is dynamic then we need to take into consideration the

ever-present possibility that making certain bodies and identities more difficult to inhabit will cause to distress and a disconnect between self-identified and other-identified gender – often experienced as gender dysphoria.

Interventions such as social transition, puberty blockers and hormone replacement therapy should not be unduly delayed solely on account of fear of uncertainty and a vague risk of distress. Gender creative youth's actual distress is very real, and future uncertainty is an inescapable reality of gender: it is not a bug, it is a feature.

Most clinicians assume that the clinical starting point should be the absence of transition, with deviation from this starting point requiring justification. In other words, any step towards transition must be justified by showing that the child is sufficiently trans or gender creative to warrant it. Short of justification, the default is no-transition. This assumption is predicated upon a social organisation that centres cisgender ways of being as the default. In an alternate society that used the pronouns of the child's choice on any given day, the idea of changing pronouns as part of a social transition would not be perceived as an intervention that must be clinically justified; it would be the default, the status quo, and it is instead discouraging social transition that would be perceived as interventionist.

Judging the adequacy and timeliness of each possible step of transition will depend upon the role they can respectively play within gender exploration. The ethical considerations involved with social transition are not the same as for puberty blockers and hormone replacement therapy. Although I will discuss each in turn, they need not come in that order, nor is any mandatory. Any combination of social transition, puberty blockers and hormone replacement therapy, in any order, temporarily or permanently alike, can be considered a successful exploration of gender if it is done at a pace and in a fashion well adapted to the child.

Social transition

From the perspective of exploration, flexibility in the usage of name and pronoun, and acceptance of varying gender expressions appear most warranted. When done in a sufficiently flexible and accepting environment, allowing people to try on and off different ways of referring to themselves enables and enhances the exploration of gendered feelings. A flexible and inviting atmosphere is crucial.

Within a mind-set of promoting exploration, an ethical approach to social transition should avoid sending the message that changes of name, pronouns or gender expression are necessarily a form of long-term commitment. Although difficulty accepting and affirming the child's gender identity is by far the bigger problem, this is nonetheless of concern in families, often more conservative, who seek to reconfigure their narrative of family life in a more palatable manner by projecting onto their children a static and essentialised view of trans existence under which trans people's gender identities are unchanging, binary, and seek to approximate the bodies of cisgender people. Practitioners and parents must be attentive to potential overcorrection, as parental affirmations of their child's gender can lead to a perception in the child that they will only be accepted if they continue to be transgender, to identify with that specific gender or to express it in a specific way, which notably risks hampering the natural development of some youth's non-binary identities and non-conforming gender expressions. Although these teachings are routinely mentioned as integral to the gender-affirmative approach and are adopted by many parents, they bear reiterating.

A policy of respecting youth's latest expressed verbal and expressive preferences no matter what they are or how often they change, coupled with occasional re-assertion that the future is open and that current choices do not preclude different future choices appears to best facilitate exploration. This means respecting everyday gendered life as a matter of course: youth should be allowed

to dress however they want, use whichever pronouns they want and use whichever name they want. Parents and clinicians – if possible, *everyone* – should respect those wishes. Social transition facilitates rather than inhibits gender exploration.[10]

Puberty blockers

Puberty blockers delay hormonal puberty. Discussion of the ethics of puberty blockers has largely centred the question of reversibility. Although reversibility plays a distinctive role with regard to the foreclosing of future opportunities, few authors extend their foray past it. Although taking puberty blockers is a form of medical treatment, it certainly facilitates exploration significantly more than letting puberty run its course; whereas puberty strongly favours cis embodiment by raising the psychological and medical toll of transitioning, puberty blockers structurally place transgender and cisgender hormonal futures in approximate symmetry. Youth who take puberty blockers have their options wide open, their bodies unaltered by either testosterone or oestrogen. Although much remains unknown about the long-term effects of puberty blockers, limited empirical evidence and clinical experience make us more than justified in assuming that whatever risks puberty blockers have do not foreclose future life paths as much as undergoing puberty does.

The neutrality of puberty blockers as opposed to unmitigated hormonal puberty should evacuate any hesitancy towards initiating gonadotropin-releasing hormone (GnRH) analogues for youth who desire them. From the premise that facilitating exploration should be our starting point in caring for trans and gender creative youth, puberty blockers must be seen as the default position, to be readily prescribed since they leave the largest space for future identity development and negotiation. Clinician hesitancy as well as the belief that a considerable amount of prior gender exploration must be undertaken before prescribing puberty blocker appear to be unjustified and uncritical, whether it is rooted in psychological inertia or subtle prejudices towards trans lives.

Hormone replacement therapy

Whereas the role of social transition and puberty blockers is unequivocal within an ethics of exploration – they are elements of transition that plainly favour, enhance and facilitate identity exploration, negotiation and development – hormone replacement therapy's explorative character is more ambiguous. To the extent that exploration does not just uncover gender but also constitutes it, hormone replacement therapy can be an integral experience for trans and gender creative individuals who are still negotiating and navigating the gendered world. It is not uncommon for older trans teenagers and trans adults to begin hormone replacement therapy tentatively, knowingly uncertain about whether they will prefer their altered body to their current one but hoping and expecting that as their body changes they will gain a more enlightened understanding of how they relate to their body's gendered features.

At the same time, the fact that the body changes in part irreversibly does mean that after a certain amount of time on hormone replacement therapy, users of hormone replacement therapy will never be able to inhabit an uncomplicated cis identity. They will always have a body that needs to be explained to intimate partners. Hormone replacement therapy stands in tension as both a process of exploration and as a mode of foreclosure of future possibilities. That tension must be resolved or dissolved, but the notion of exploration cannot give us a ready-made answer. The tension lies beyond the limits of exploration, although understanding how hormone replacement therapy is in and of itself a form of exploration can help us resolve that tension more fruitfully.

Although I do not propose any resolution or dissolution to this tension – a thorough discussion of the ethics of hormone replacement therapy is beyond the scope of this work, although I believe

an informed consent model best guarantees well-being (Ashley, 2019b; Blasdel, Belkind, Harris, & Radix, 2018; Cavanaugh, Hopwood, & Lambert, 2016; Hale, 2007) – a few comments can be contributed towards an answer. Restricting future possibilities is a matter of degree, and the ills associated with hormonally altered bodies for people who may eventually opt to live in the world in concordance with the gender they were assigned at birth are easy to overstate. Bodies that are hybrid, which fall outside of the cisnormative view of the body as falling within one of two sets of gendered traits, are often perceived negatively by clinicians, parents and members of the general public. However, such attitudes may not be shared by the people to whom those bodies belong. Butch lesbians who seek out mastectomies and cis men who find pride in labelling themselves eunuchs provide us with clear examples of people whose gender identity corresponds to the gender they were assigned at birth, and yet find no shame in having bodies that deviate from cisgender norms of embodiment (Ashley & Ells, 2018; Villarreal, 2018; Wassersug, 2007).

Unsurprisingly, many people who have undergone transition-related interventions and later came to identify with the gender they were assigned at birth do not regret the interventions but are instead grateful for the opportunity it provided them. In an attempt to help clinicians understand gender creative youth who discontinue hormonal interventions, Turban and Keuroghlian provided the following composite case example (Turban & Keuroghlian, 2018, p. 451):

> Eventually, Jamie informed her care team that after the trial of testosterone and much reflection, she had come to understand her identity as a queer woman and wished to discontinue hormone therapy. Jamie reported being pleased about the hormone therapy trial, because this allowed her to clarify her gender identity. She did not regret her social affirmation or any physical changes that occurred during this process, such as fat redistribution and minor facial hair growth, in the context of otherwise being healthy.

They later explain that:

> Gender exploration, including a period of testosterone therapy, was an important part of her identity formation, and she was grateful that her psychotherapist carefully facilitated her process of introspection through her transition period. She is now medically and psychologically healthy. Although it is possible that she could have arrived at the same conclusion through a period of social transition alone, she responds that the changes to her body from testosterone therapy were only cosmetic, and she does not regret them.

Bodies that are read as transgender carry a social meaning of monstrosity (Stryker, 2013, p. 245). In ethical practice, it is necessary to acknowledge that such bodies need not be figured as monstrous – clinicians surely should not contribute to perpetuating those harmful ideas, even subtly – and that, even if they are, many people do wish to be monstrous. The figure of the monster has been a recurring theme in trans literature, much like the figure of the villain has been re-appropriated in queer spheres (Stryker, 2013, pp. 246–247):

> I want to lay claim to the dark power of my monstrous identity without using it as a weapon against others or being wounded by it myself. I will say this as bluntly as I know how: I am a transsexual, and therefore I am a monster. [. . .]
>
> Hearken unto me, fellow creatures. I who have dwelt in a form unmatched with my desire, I whose flesh has become an assemblage of incongruous anatomical parts, I who achieve the similitude of a natural body only through an unnatural process, I offer you this warning: the Nature you bedevil me with is a lie. [. . .] I call upon you to investigate your nature as I have been compelled to confront mine. I challenge you to risk abjection and flourish as well as have I. Heed my words, and you may well discover the seams and sutures in yourself.

Poetic as it may be – I know that poetics is not always fully appreciated in the clinical world – it speaks to an understanding of the desirability of hybrid bodies, of bodies that differ from those assumed in a social world organised around the assumption of cisgender life. Assuming that hybrid bodies should be discouraged or at the very least less readily accepted and accessible reflects a negative evaluation of trans embodiment, which has no place in trans health care, and which is deeply dangerous to intersex youth (Ashley & Ells, 2018; Bastien-Charlebois, 2015; Holmes, 2002; Kessler, 1990).

Avoidance of negative judgements towards trans embodiment has further implication when considering the relationship between exploration and hormone replacement therapy. In the context of youth care, hormone replacement therapy frequently comes following the use of puberty blockers. When assessing readiness for hormone replacement therapy in youth, the fact that their body has not yet undergone hormonal puberty in either direction is of high significance. As was mentioned in the previous subsection, puberty blockers structurally place transgender and cisgender hormonal futures in approximate symmetry. Both ceasing puberty blockers to resume puberty and beginning hormone replacement therapy similarly impact future options, since they alter bodies in a more-or-less bimodal manner although testosterone is more conducive to low dosages and thus limited masculinisation, a treatment modality that is frequently favoured by non-binary people who were assigned female at birth (Richards et al., 2016; Vincent, 2018, p. 165ff).

To require more of youth who wish to begin hormone replacement therapy than of those who wish to cease puberty blockers, if they have not gone through puberty, would be a questionable double standard. Similar thresholds should be applied to both and, given that years-long use of puberty blockers should satisfy clinicians of the relative stability of transition-related desires, both options should be easy to access.[11]

The clinician's role in facilitating exploration

Setting exploration as an ethical good, we must move away from attempting to assess the truth and authenticity of assertions of gender identity. As a pamphlet developed by Canadian trans youth enjoins (Hudson, Kaeden, Lindsey, & Sky, 2018): 'Stop assessing us!'

Wren questions how assessments of children's gender narratives can be ethically justified suggesting a need to balance 'between the respect due to the seriousness and importance of a child or young person's identification and the respect due to the time and effort needed for full participation in the careful business of ethical decision making' (Wren, 2019).[12] She further suggests that a view of the self as dynamic and relational 'is consistent with a higher threshold' for prescribing treatment.

This stance is more reminiscent of a logic of prediction or interrogation than an ethics of exploration, despite her references to exploration. This is precisely what leads her to attempt to justify assessing trans and gender creative youth's gender narratives, thereby positioning the clinician in an oppositional rather than supportive dynamic to the child's navigation of gender. These oppositional dynamics have negative impacts on youth (Ehrensaft, 2014, p. 579; Hervey et al., 2018; Schwartzapfel, 2013). On the contrary, clinicians should see their role as supporting and facilitating. The goal should be not to assess the child's gender but provide them with tools to explore their gender subjectivity, tools which they may not have at their age.

Unfortunately, gender is multifaceted and endlessly complex. Gender subjectivity carries a certain amount of ineffability, making it difficult for trans people to justify or explain their gender identity. Even after years thinking about gender identity in both scholarly and lay contexts, my own gender identity remains largely unintelligible (Ashley, 2018a). Would cis people be able to explain

theirs with ease? Imagine how distressing it is for youth to be asked to explain and justify their gender identity by people who have power over whether they can access treatment, when they lack the maturity and access to theoretical paradigms which adults benefit from. Clinicians support exploration not by mandating it, but by making space for it on the child's own terms. If they do not wish to explore their gender with clinicians, then that is the end of the matter – though everything we do is a form of exploration insofar as it builds a bank of experiences upon which we relationally constitute ourselves, it would be inappropriate for clinicians to impose a specific manner and time for exploration. Supporting exploration does not mean asking youth to constantly justify their gender or constantly talk about it. It means making space.

Clinicians should come before each child with the assumption that they carry certain cisnormative biases. Clinicians are not exempt from societal biases, and most of those biases appear natural to those holding them. Above all, a critical openness to being wrong about assessments of the clinical indicability of treatment because of underlying beliefs and attitudes about gendered lives and bodies is the mark of an ethical clinician. In assuming that their clinical recommendations do not reflect the pervasive cisnormativity of our societies, clinicians are doing a disservice to their patients and inhibiting their gender explorations, which may take them through transition. As Wren mentions, knowledge is socially situated (Wren, 2019).[13] That we are all inescapably moulded by our social context does not imply that all knowledges are equivalent, however, and much of the feminist epistemology has been dedicated to demonstrating that marginalised groups' knowledge of their own marginalisation is more than often superior. Clinicians should adopt a stance of humility towards trans communities and scholars' critiques and work to integrate them within their work. A common fear is that social transitioning and puberty blockers will make children more likely to grow up trans; that may be true, but why would that be a bad thing unless we believe that it is bad to be trans? Clinicians should ask questions like these and invite the input of trans communities as holders of privileged knowledge about transitude.[14]

It may be difficult for clinicians to engage with those questions, but moral discomfort and distress is not necessarily an indication that something is wrong. One of the first things I learned in bioethics was that oftentimes the best possible solution leaves us uneasy and unsettled. Emotions are unruly and do not readily submit to reason. Discomfort is an unfortunate but integral part of professional practice and something which practitioners may have to get used to. But discomfort also provides us with an opportunity for both moral and personal growth. Patients are not the only ones who are exploring their gender in a clinical setting. We all are.

Given what was said about social transition in the previous section, clinicians will have to play a supportive role not only to children but also to parents (Ashley, 2019). Understanding why and how parents are struggling with their children's gender is crucial to fostering a healthy environment for their gender-creative kids. Some parents may experience a disruption in their life narrative. Clinicians can help them reconfigure their life story in a healthy manner by adopting the teachings of narrative ethics (Brody & Clark, 2014; Frank, 2014; Montello, 2014). Many parents will have difficulty adopting a fluid and open-ended attitude towards trying names, pronouns and gender expressions as part of gender exploration. Reiterating that gender creative young people will be loved and accepted however they come to identify, and that they are allowed to try out different names, pronouns and clothing styles without committing to them will inevitably be challenging for some families. This should be done carefully, as reiterating it too often or at the wrong moments can have the effect of unintentionally communicating a preference for cis outcomes. Clinicians should support parents in navigating those difficulties and work alongside support groups for parents of trans and gender creative youth. In parallel, those support groups should ensure that they are helping parents foster fluid and open-ended environments for their children.

Conclusion

Beginning from the view, which I share with Wren, that gender identity is in constant evolution and is constituted through our relation to others and to the world that surrounds us, we come to the inescapable conclusion that exploration is not a step that precedes transition, but a process that operates through transition. It is impossible to conceive of a degree of exploration that would make us certain that transition will suit future identity development. Guaranteeing the stability of the self is neither possible nor desirable. Instead of interrogating youth, providers should play a supportive role.

Once we recast transition in those terms, many of the moral quandaries faced by clinicians are resolved. As was shown, unbounded social transition and ready access to puberty blockers ought to be seen as the default, and it is deviations from them that warrant justification. The mere fact that transitioning might influence gender identities is not an a priori reason to delay transition, since identities are just as susceptible of being foreclosed by delaying transition than by allowing it. Social transition and puberty blockers – and, to an extent, hormone replacement therapy – facilitate exploration and prevent the foreclosure of identities brought on by delaying transition. Their availability should not be predicated on interrogation or the mandatory performance of exploration for health care providers' benefit, but instead should be made readily available to all those who wish for them. Together we must recognise that exploration is best fostered not by delaying transition, but *through* transition.

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Notes

1. Clinicians cannot predict what young people will feel in ten, twenty or thirty years, but they are obliged to consider whether more time for exploration is needed by any child or family before embarking on a medical intervention, given the impacts of (partly)irreversible treatments years after they were initiated. (Wren, 2019)
2. We need to ask, for example, how we recognise that enough exploration of the young person's understanding has been done, that enough of the known and unknown risks have been elaborated, that enough consideration has been given to the possibility of a change of heart about the timing and extent of bodily alteration desired-in the knowledge that complete and specific consent is an illusion. (Wren, 2019)
3. Various terms have been proposed to refer to children who exhibit ongoing behaviour patterns associated with a gender other than that they were assigned at birth. These terms suspend judgement as to whether the children are trans and/or will grow up to be trans (Pyne, 2014a, p. 27). I have opted to use the terminology of 'gender creative' to situate myself in the lineage of Diane Ehrensaft, who coined the term, and pay homage to the organisation Gender Creative Kids Canada. Other common terms include 'gender variant', 'gender diverse', and 'gender independent'.

4. ‘They are not attitudes and do not lend themselves easily to being chosen or given up. Gender diverse young people often project this sense that their gender identity is phenomenologically a “given” in an intensely embodied way (whether stable or fluctuating)’ (Wren, 2019).
5. The ethical picture is complicated if we give weight to the real possibility of a child or young person’s identification continuing to evolve over time and their levels of distress in relation to identity/body incongruence fluctuating (with and without medical intervention).
6. ‘Or might caution and uncertainty at times paralyse the clinician who endlessly defers the decision to medically treat?’ (Wren, 2019).
7. ‘In this context, how do we assure the authenticity of any young person’s choice of treatment?’ (Wren, 2019).
8. My partner consented to having their experiences shared in this article.
9. Halberstam (2018) writes about the “noble goals” of families who champion their trans child’s rights, yet worries that ‘this activism has prematurely stabilised the meaning of the trans* child’s gender variance and put protocols in place for the normalisation of his or her gender’, shaping their gender into ‘something clear and true’. (Wren, 2019)
10. As I have previously argued, the current arguments levied against pre-pubertal social transitions fail to establish that it poses ethically significant risks to gender creative youth (Ashley, 2018).
11. Of course, we are here talking about clinician assent and recommendations, as clinicians rightly may not be legally allowed to prevent patients from ceasing puberty blockers.
12. ‘We must mark a distinction between the respect due to the seriousness and importance of a child or young person’s identification and the respect due to the time and effort needed for full participation in the careful business of ethical decision making’. AND ‘The other sense of “who one is” – a self as a developmental achievement built up through myriad experiences, with deep values and commitments developing over time – is consistent with a higher threshold’.
13. ‘As a psychologist and family therapist in the UK, I am inevitably situated, not a free-floating moral agent’.
14. Transitude refers to the fact of being trans and implies a non-medicalised perspective.

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