AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychology of Sexual Orientation and Gender Diversity

ISSN: 2329-0382

https://doi.org/10.1037/sgd0000504

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.

ublic 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 unjusti ed, showing that desistance research doesn t offer sound reasons to oppose or delay gender-af rming care.

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

In recent years, the af rmation 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; Grif n et al., 2020; Marchiano, 2017; Soh, 2015; 2020; Steensma & Cohen-Kettenis, 2011; Turban et al., 2018). The signi cance 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 signi cant distress meaningfully comparable to the one experienced by trans youth whose transition is delayed;

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I thank Julia Temple Newhook, the journal s editor M. Paz Galupo, and the article s anonymous reviewers for their helpful feedback.

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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, rst 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 rst section, I de ne 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 xed or fluid, as my arguments apply to both understandings and I do not wish to constrain my arguments to readers with speci c 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- ts-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-af rmative 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 de ned less by its interest in gender identity development than by its methodology and methods. Desistance research may be de ned 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 satis ed 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 af rmative, 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 speci ed.

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 speci c 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 identi ed 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 identi cation 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-af rmative model (Ashley, 2019c; Hidalgo et al., 2013; Lopez et al., 2017; Rafferty et al., 2018; Telfer et al., 2018). The gender-af rmative 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-af rmative 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; Grif n 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 identi ed desistance studies from the references of known sources that deployed the argument I seek to rebut. Most citations were to ve 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 ve 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