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Abstract

Studies suggest that the majority of gender diverse children (up to 84%) revert to the gender congruent with the sex assigned at birth when they reach puberty. These children are now known in the literature as ‘desisters’. Those who continue in the path of gender transition are known as ‘persisters’. Based on the high desistence rates some advise being cautious in allowing young children to present in their affirmed gender. The worry is that social transition may make it difficult for children to de-transition and thus increase the odds of later unnecessary medical transition. If this is true, allowing social transition may result in an outright violation of one of the most fundamental moral imperatives that doctors have: first do no harm. This paper suggests that this is not the case. Studies on desistence should inform clinical decisions but not in the way summarised here. There is no evidence that social transition per se leads to unnecessary medical transition; so should a child persist, those who have enabled social transition should not be held responsible for unnecessary bodily harm. Social transition should be viewed as a tool to find out what is the right trajectory for the particular child. Desistence is one possible outcome. A clinician or parent who has supported social transition for a child who later desists will have not violated, but acted in respect of the moral principle of non-maleficence, if the choice made appeared likely to minimise the child’s overall suffering and to maximise overall the child’s welfare at the time it was made.

The importance of being persistent.

Should transgender children be allowed to transition socially?

Studies suggest that the majority of young gender diverse children do not become transgender adolescents and adults.[1-5] These children are now usually referred to in the literature as 'desisters'; the others are called 'persisters'. According to one study, "[f]eelings of gender dysphoria persisted into adolescence in only 39 out of 246 of the children (15.8%) who were investigated in a number of prospective follow-up studies" (p.500). [1] Although studies give different results, [6-11] all seem consistent in suggesting that the majority of pre-pubertal gender diverse children will at some point desist. Earlier studies suggested that the vast majority of desisters had developed homosexual sexual orientation, and a minority had reverted to the gender congruent with the sex assigned at birth without developing homosexual sexual orientation. [8]

In light of the high desistence rates reported in the literature, it has been recommended that doctors and parents should be cautious in choosing how to clinically manage gender diverse children. [12] The problem with the so called 'social transition' (ST) is that once children present themselves to the outside world as being of a different gender it can be difficult to 'de-transition'. ST may thus increase the odds of later medical transition. If this is true, doctors who begin early treatment may violate one of the most fundamental moral imperatives underpinning medical practice: first, do no harm. They would unnecessarily lead children towards a path of gender affirming medical interventions, which may involve invasive surgery, life long medical treatment and social difficulties¹. [28]

¹ These may include hurdles in adopting a different gender, in obtaining legal recognition, but also later discrimination in employment, or even risk of harassment, verbal and physical abuse

I will argue that there may be reasons to allow ST in children even where the psychosexual trajectory that the child will take is uncertain. Desistence is one of the possible outcomes of early clinical management (including ST), not an indication that treatment has been provided unnecessarily. I will also argue that an ethical approach should aim at minimising the most likely and significant harm, and an individualised balancing exercise between current and perspective risks and benefits needs to be at the heart of clinical decisions.

Before discussing the early clinical management in childhood, I will clarify how the terms are used in this paper.

Terminology used

Terminology in this field is ever evolving. Terminological problems concern all identities, not just gender diverse identities (I have discussed epistemological issues around gender elsewhere). [35] In this section I will give an outline of how terms are most commonly used in the literature (readapted from Telfer et al, 2018). [29] I will also anticipate my use in this paper. Some conceptual issues around these terms will be discussed in the course of the paper, where relevant.

Gender identity: a person’s sense of being male, female, a blend of both or neither.

Sex assigned at birth: usually the classification of male and female following genital morphological examination at birth.

Gender expression: the external presentation of the individual, as expressed in the person’s choice of play, name, clothing, behaviour, hairstyle and so on.

Transgender: a term that refers to people whose gender identity is not congruent with the sex assigned at birth.

Gender incongruence (also at times named 'variance'): Gender incongruence refers to gender expression that is 'nonconforming' to or 'incongruent' with what is expected based on the sex assigned at birth in the society or culture of belonging. The ICD-11 has adopted this term, replacing 'gender identity disorder' (GID) used in the previous version of the ICD [30].

Gender dysphoria: a term that refers to the distress associated with the sex physical features. Not all gender diverse children experience gender dysphoria.

Non-binary: A term to describe someone who doesn't identify exclusively as male or female.

Gender fluid: A person whose gender identity varies over time.

A-gender: A person who does not identify either as male or female.

Cisgender: A person whose gender identity and expression are congruent with the sex assigned at birth.

Gender diverse children: children who do not conform to the social and cultural expectations for males and females.

Because the presentation, expression, strength and degree of the diversity are variable, I will privilege in this paper the notion of 'gender diverse children' over all others (gender variant, incongruent, transgender). 'Gender diverse' includes both binary and non-binary outcomes. No suffering (dysphoria) is necessarily experienced by children who are gender diverse, but some may experience discomfort with their physical features and/or their social roles. When puberty approaches, even those children who have not experienced dysphoria in a pre-pubertal phase are likely to experience some degree of discomfort with the developing secondary sex characteristics. [15]

Persisters/desisters: these are defined as either 1. gender diverse children whose *feelings of gender dysphoria* persisted/desisted into adolescence [1] or 2. gender diverse children who *have/do not have a desire for medical gender affirming treatment* after they enter puberty [27]. (I will discuss some of the potential issues relating to the terminology of persistence/desistence later on).

Social transition² (ST): Allowing a child to choose play, clothes or roles, or a name and pronoun, that they feel congruent with their affirmed gender, either in the domestic environment or also outside (in school for example). ST may take different forms, and these will be discussed in the course of the paper.

Methodological concerns

As mentioned in the Introduction, desistence studies give different results, [6-11] partly because of the demographics of the research participants, [16] and partly because desistence rates are likely to be influenced by the social context in which the study takes place and by the samples examined. [27] Although I will not debate the methodologies used, it may be worth noting that Temple Newhook et al [25] have identified four broad methodological issues with some desistence studies:

First, the studies included a broad spectrum of gender diverse children. The broad inclusion of these studies, according to these authors, carries a risk of inflation of the actual desistence rates.

The second concern relates to the variability of expectations around gender. What is regarded as a ‘normal’ or ‘typical’ gender identity development is

²Earlier this was called ‘real life experience’.

likely to vary in different social and historic contexts. Therefore the results, they argue, are not easily generalizable. Moreover, the studies are limited to those children whose parents brought them to the attention of the clinicians (parents who obviously were concerned about their children's difference). Many may not wish to or may be unable to access clinical treatment, and these numbers are unlikely to be captured by the published estimates.

A third methodological concern relates to the timing of follow up. The mean age of follow up was between 16.04 and 23.02 years. However, the authors note, many individuals transition later in life. The desistence rates shown at follow up, thus, are not definitive. [36]

Finally, a number of original participants cannot be located, and not all of those located will agree to the follow up. This problem, inherent in many longitudinal studies, and known as attrition, has been resolved in some of these studies by including the non-respondents in the category of desisters. The problem with this is that not all those who identify as gender diverse or transgender will seek medical transition (see later); therefore the desistence rates may vary if it includes those who no longer have feelings of gender dysphoria (as in desistence definition 1) or if is limited to those who do not seek gender affirming treatment (as in definition 2). Moreover, it needs to be clear what those who enter the statistics of 'desisters' are desisting from, whether from seeking help through standard routes, or from seeking help at all, or it is instead their gender trajectory that has shifted. People may be unwilling to proceed with gender affirming treatment at one clinic because of poor experience of the healthcare services, for fears of family rejection or employment security or other pressure. Children and youth who have died (including those who have committed suicide) have not been included in the studies, or have inflated the category of desisters. Steensma and Cohen-

Kettenis have subsequently provided a detailed response to these concerns, [27] and I refer the interested readers to their original paper.

I will not discuss here what the most accurate estimate is, or how we can get the most accurate estimate, but what the seeming high desistence rates (whatever the most accurate number is) can tell us about the clinical management of gender diverse children.

Early treatment in childhood

Clinical management of gender diverse children involves two main decisions: one is how to respond to the child’s gender expression; the other is whether to administer ‘blockers’ at some point after the onset of puberty. Usually a child will be assessed by a multidisciplinary team, and will be offered psychological support.

In this paper I will focus on ST. ‘Blockers’ are usually not prescribed before Tanner Stage 2 or 3 (that is, after puberty starts, and this is so because the reaction to puberty is assessed clinically). [14] Therefore in principle the current desistence estimates should not affect the prescription of these medications, as these are prescribed only when it is highly likely that the child is a ‘persister’. However, it is worth noting that some have argued that the high desistence rates should also caution against the use of ‘blockers’. These medications, it has been argued, may represent a step towards more radical medical interventions. [12] Moreover, physical maturation obviously varies. Tanner Stage 2, for example, may occur in natal girls at any point between the age of 8 and 15, and Stage 3 any time between 10 and 15. [31] As we are going to see in what follows, some clinicians suggest that a full ST should be discouraged in children younger than 10 years; one question that arises is

how pubertal suppression would be managed in those children who accrue Tanner Stage 2/3 before or around the age of 10, if they have not been able to experience their gender outside the domestic environment. It is therefore possible that delaying ST may have a knock on effect on the provision of 'blockers'.

Broadly speaking there are three treatment models for gender diverse children (see table, readapted from Ehrensaft, 2017). [13]

Gender affirming³	Live in your skin	Watch and wait
The goal is to allow the child to express the affirmed gender. The child may freely choose toys, clothes, plays, peers, or a name. The child is not labelled as 'transgender': it is for the child to express their gender and their identity. Social action may be necessary to ensure the external environment is 'fit' to embrace the child's affirmed gender. This approach is based on the evidence of the psychological short and	The goal is to dissuade gender nonconforming behaviour. Significant others ⁴ reward gender conforming behaviour. Presentation in the affirmed gender, particularly outside the domestic sphere, is deferred to after puberty. This approach is based on two grounds: 1. desistence rates of pre-pubertal children 2. postulation of high brain plasticity in young children. [4]	The goal is to allow a child to develop safely and optimally. [14] Significant others will not attempt to manipulate the child's gender expression, but if possible full ST (presentation to the outside world in a way that is consistent with their gender identity) is discouraged before puberty. This recommendation is based on the high desistence rates of pre-pubertal children. If in adverse social settings,

long-term suffering exhibited by children who feel unsupported. [32]		transition is recommended at home only, for safety reasons.
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I will not discuss primarily what model clinicians and parents have most reason to adopt; rather I will focus on whether desistence rates can help us to answer that question (as shown in the table, two of the three models summarised above are partly motivated by the desistence rates).

The importance of desistence studies

Wallien and Cohen-Kettenis wrote: “If one was certain that a child belongs to the persisting group, interventions with gonadotropin-releasing hormone (GnRH) analogues to delay puberty could even start before puberty rather than after the first pubertal stages, as now often happens”. (p.1413-14). [8] Suppressing pubertal development early enough would spare people extensive surgical gender affirming treatments (mastectomy, feminizing

surgeries and many others), and the physical outcome would in likelihood be significantly more satisfactory. [15]

Identifying which children will persist may equally help to decide about ST: if one was certain that a child was going to change gender, one could straightforwardly allow that child to express their identity and implement the measures that would enable this to happen.

However, whereas predicting persistence could straightforwardly suggest that early medical care and ST are indicated, predicting desistence may not equally straightforwardly suggest that early medical care and ST are counter-indicated. This is so because early medical care may also benefit those who will eventually desist (see later).

But there is an additional problem: desistence studies tell us how many, among the population of those observed within a certain clinical study have transitioned later, and tell us about the psychosexual trajectories taken by those who agree to follow-up; however they do not tell us how likely it is that any of the individual children will later transition or what their psychosexual outcome is going to be. Therefore it is not clear how, knowing that many will desist, can help making clinical decisions with regard to any individual child.

This did not escape the attention of some of the researchers. Steensma et al pointed out that desistence studies aim not only at establishing statistics of persistence and desistence. They also aim at understanding the developmental trajectories open to gender diverse children, and which factors may be taken as indicators of the likelihood of persistence. [1, 2]

Steensma et al found that one predictor of persistence is the *identification* with the other gender, rather than *the wish to be* of the other gender. A child who insists that she or he *is* of a certain gender is more likely to persist than one who merely says she or he *wishes to be*⁵ of a certain gender. [1] In an earlier study Wallien and Cohen-Kettenis noted that it is likely that “only children with extreme gender dysphoria are future sex reassignment applicants, whereas the children with less persistent and intense gender dysphoria are future homosexuals or heterosexuals without GID [gender identity disorder]” (p.1414). [8] Persisters in their study were more likely to meet all the DSM criteria for GID, and they presented more severe cross-gender behaviour and gender dysphoria. However, they noted that “none of the follow up studies have as yet provided evidence for this supposition” (p. 1414). [8] In order to be able to predict which children will persist it may be necessary to identify which features (biological or behavioural or both) were manifested in childhood by the persisters and not by the desisters.

One could argue that even in absence of reliable predictors of persistence, high desistence rates justify (or require) that clinicians adopt a precautionary attitude towards early clinical intervention. However, it is not clear what this precautionary attitude should involve, and whether enabling or limiting self expression, and to what extent, is the best way to be prudent. In what follows I will discuss the reasons that have been adduced in the literature to caution against ST with young children.

⁵ It is interesting that this difference was noted. However, it should not be inferred that persistence/desistence can be necessarily predicted on the grounds of how children express verbally. Young children may not have the conceptual and linguistic skills to express their feelings in an accurate way. A child’s ‘wishes’ may well be an indication of their sense of self. I thank Terry Reed for this comment.

Social transition is psychosocial treatment

Some argue that, whereas ST is usually presented as simply being understanding and supportive of the child, it is instead a serious psychosocial treatment and it has consequences.

Zucker writes: “I would argue that parents who support, implement, or encourage a gender social transition (and clinicians who recommend one) are implementing a psychosocial treatment” (p.237) [16], and “encouraging social transition is itself an intervention” (p.236) [16].

According to this argument, because ST is psychosocial treatment, and because of the high desistence rates, clinicians and parents should be careful in implementing it.

To this concern, we should respond that ST may reasonably be regarded as ‘an intervention’; however, all approaches are interventions. There is no easy way to differentiate interventions from non-interventions (philosophers have debated for a long time whether it is possible to differentiate conceptually acts and omissions). The ‘live in your skin’ is as much as a treatment than ‘affirmative approaches’ (and some may say, more of a form of treatment – akin to conversion therapies). But even if one could differentiate interventions from non-intervention/non-treatment, the latter is not necessarily the morally right or even a morally neutral choice. [17]

Enabling a child to express their feelings is not a neutral choice, whatever form it takes, whether it is limited to play at home or goes all the way to presenting as the other gender in school. So is dissuading a child, and so is dissuading only in certain contexts (say, allowing self-identification at home and dissuading it outside the house). None of these are neutral choices, and

neither one would have a moral reason to prefer a neutral choice (admitting that this were possible).

ST may thus be regarded as a form of treatment, but this, in itself, is not an objection to it. Whether an intervention is ethically defensible requires a different type of analysis, and not an analysis of whether one is more or less of an intervention than the other.

The other perhaps more serious concern is that ST leads to medical transition.

Does social transition lead to medical transition?

It has been argued that ST increases the likelihood of later transition. [12, 16] Here the high desistence rates become obviously very relevant to the clinical and ethical decision-making. Even those who regard gender diversity not as pathology will probably admit that gender affirming therapies may involve life long medical treatment with associated risks and often various forms of invasive surgery.

So one could argue that inducing someone to submit to those treatments when they would have not otherwise is to be at least partly responsible for the decision to submit to unnecessary medical treatment. This can be seen as a straightforward violation of a fundamental moral imperative: first do no harm.

However, currently there is little evidence that ST *per se* increases the odds of later medical transition. Whereas there appears to be a correlation between childhood ST and persistence [2], it is not clear how this correlation can be explained; it is possible for example that persisters are more likely to transition socially more fully earlier on. There might be other relevant factors

1
2
3 too in place, having to do with the circumstances in which ST takes place.
4
5 Some parents need to invest a great deal of energy and emotion in the ST of
6
7 their child; some need to deal with difficulties in the external environment. In
8
9 other circumstances it might be easy to remain open to whatever the child
10
11 expresses regarding clothing, play or transition. ST might therefore be a
12
13 significantly different experience for children in different environments.⁶
14
15

16
17 Perhaps large-scale follow-ups (which as of today have not been conducted)
18
19 might tell us what impact a liberal or more restrictive environment has had
20
21 on adults who showed gender variance in childhood. It will then be necessary
22
23 to reflect on the clinical implications that these data should have.
24
25

26
27 One further question is how ST might affect gender identification. As we saw
28
29 earlier, Steensma et al found that children who *identify with* the other gender
30
31 are more likely to be persisters, compared to those who express their *wish to*
32
33 *be* of the other gender. [2] If ST 'steered' cognitive representation of gender in
34
35 one direction, then one might argue that ST might indeed increase the odds of
36
37 persistence. The possible impact of the ST itself on cognitive representation of
38
39 gender identity or persistence have never been studied. [2] (p.588). It should
40
41 also be noted that cognitive representation of gender is likely to depend on
42
43 many factors that interact in unique ways in different individuals, [37] and so
44
45 it might be difficult to assess the independent influence of one specific factor.
46
47 The concern perhaps is not primarily how *ST might contribute to the cognitive*
48
49 *representation*, but whether ST might inhibit a child's freedom to change their
50
51 mind, thus *influencing a child to acquire a gender identity that is not authentic*.
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53
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59 ⁶ It should also be noted that the starting age of ST has indeed not been included in
60 the studies. I thank Peggy Cohen-Kettenis for pointing this out.

ST however involves listening to and validating a child’s expression and needs. The goal is (or should be) precisely the opposite of restricting a child’s options. If enabling a child to explore turned out to thwart their ability to explore and express themselves, then one might ask whether other factors, not ST *per se*, might trigger this seeming paradox.⁷ I will return to this problem in the next section.

Social transition causes distress at desistence

Steensma et al observed that many gender diverse children are currently brought to their clinical attention only after full ST (p.229); [27] they noted that “some girls, who were almost (but not even entirely) living as boys in their childhood years, experienced great trouble when they wanted to return to the female gender role” (p.514). [1] On this basis, they recommend that “parents and caregivers should fully realize the unpredictability of their child’s psychosexual outcome. They may help the child to handle their gender variance in a supportive way, but without taking social steps long before puberty, which are hard to reverse. This attitude may guide them through uncertain years without the risk of creating the difficulties that would occur if a transitioned child wants to revert to living in his/her original gender role” (p.514). They suggest caution in allowing full ST in young children, particularly younger than 10 years of age. [1]

Here it is important to note that what Steensma et al observed in that study was not the same as saying, neither does it imply, that ST increases the odds of persistence. Whereas the two issues may seem linked (that is, if a child is

⁷ Again I thank Peggy Cohen-Kettenis for this observation.

distressed at the thought of de-transitioning, they may continue in the path of transition), they are in fact not.

For the psychological distress to impede 'de-transition', the psychological distress would have to be greater than the psychological distress and the physical distress involved in transitioning. Or the child would have to have no means for dealing with the distress; for example inadequate support from families or healthcare professionals.

There are thus two separate issues here: one empirical and one is ethical. The empirical issue is whether or not ST does cause distress or trouble for desisters. The ethical issue is what the ethical grounds are for allowing ST, if we can predict that desisting may be troublesome. The ethical issue is related, but only partly, to the empirical problem.

With regard to the empirical problem, the only way to resolve it is by way of a research study, specifically limited to desisters, in the attempt to understand the extent and nature of the distress experienced during the de-transition. Here one should also consider how ST and de-transitioning were handled.

This would be important, because it is arguably not ST that causes distress, but the de-transition⁸. Of course one could hypothesise that it may be less troublesome for adolescents to de-transition if they have only transitioned at home. Whereas this is plausible, it is not clear that this would be so for all children – it may be that for some children the main problem is revealing the changes to the close family. It would be interesting to know more about the context in which ST and de-transition occurred in the instances reported (for

⁸ I wish to thank the anonymous reviewer for this observation; the ensuing consideration follow from this.

example how the family reacted to the changes, to what extent these children were aware of different possible outcomes, the degree of acceptance by peers and so on). Likewise, it would be interesting to understand in what ways de-transitioning was troublesome: one thing is to fear rejection at school; another is to experience it; another is to be distressed by own confusion; another is to feel embarrassment or shame, and yet another is to feel guilt towards those who supported the transition earlier on (elsewhere I have discussed the issue of shame and guilt in transgender individuals). [33] In restrictive environments ST (even in moderate forms, even just in the domestic sphere) can be problematic, and in these environments de-transitioning might be even more so.⁹ With better understanding of the predicaments suffered by adolescents during the de-transition, we may be in a better position to answer the question of whether it was ST to have caused trouble, or rather other factors, and thus we may be in a better position to assess whether limiting ST, rather than mitigating those other factors (if possible), might be an effective way to prevent the potential distress of de-transitioning.

Perhaps future research will tell us more about the experience of de-transition, and this may give us a better idea of the merits of the three clinical models schematized earlier. However, if and when these data will be collected, generalizable conclusions need to be drawn very carefully. Let us suppose that data showed that the majority or even all of the desisters who had full ST experienced not just trouble (as Steensma et al report –see earlier) but significant distress. Suppose that only those who fully transitioned experienced this distress, and not others. Let us also further suppose that it appears clear the distress is to a relevant degree *caused by* (not just correlated to) ST (that is, that over and above any other concomitant factors, including

⁹ I wish to thank Peggy Cohen-Kettenis for helping me to understand these issues

family reaction, peer reaction, guilt and so on, the distress is one that the child would have not experienced without ST). However meaningful, data of this kind would only provide a part of the answer to the moral question of how children should be managed clinically, or should have been managed clinically in those specific instances. Before answering those questions, we would need to ask what these children would have experienced, if they had not been allowed to socially transition. It may be that, on balance, the trouble experienced at the stage of desisting is for those children more bearable than the trouble that they would have experienced if they had not been allowed to transition socially.

The potential difficulties of de-transitioning must be balanced with the real difficulties of presenting in the gender consistent with the sex assigned at birth, and with the long term foreseeable consequences of feeling ostracised or supported. One could again hope to find help in this moral exercise of balancing risks and benefits in empirical data; maybe we could attempt to evaluate whether the trouble at de-transition tends to be greater than the past distress of presenting in the gender consistent with the sex assigned at birth.

However, it is uncertain whether empirical studies could provide reliable data that can inform the moral decisions in this particular area. Firstly, the trouble of de-transitioning is likely to depend on the circumstances: the causes or levels of trouble experienced by one child may be significantly different from those experienced by another, and it would be difficult to extrapolate data that may be generalizable. Moreover, people tend to overestimate current distress and underestimate past distress, because current pain is something we feel, and past pain is something we only remember, and because there are well known defence mechanisms in the memory of trauma and suffering. [18]

The reverse is also true: we may give more weight to current distress and minimise the importance of the future distress, because the future distress is only imagined and the current one is experienced; therefore thinking things through with the child, and warning them that they may experience future trouble at de-transition may not fully resolve the doubt of whether taking the risk of that future distress is currently the best bet. Of course knowing that there are different possible outcomes and that the current experience of gender may change may be helpful in exploring what the extent of ST should be with the child. However the child may be unable to fully appreciate the difficulties of later de-transition, and may understandably give priority to their currently experienced distress at presenting in the gender congruent with the sex assigned at birth.

All that the parties involved can do is to evaluate the degree of current distress and the degree and likelihood of future distress, reassuring the child that de-transitioning may well happen and remaining open to the various possible outcomes.

What we have reason to prefer

What makes an intervention clinically preferable over another, and ethically justified, is that it is either more likely than the alternatives to yield benefits (on beneficence grounds), or more likely than the alternatives to prevent harm and suffering (on non-maleficence grounds).

When benefits and risks have to be balanced against one other not only in the present time (or in the short term) but over time (that is, when a present benefit has to be balanced against a future risk, or when minimizing present

harm has to be balanced against the risk of future harm), the likelihood and magnitude of the future harm will also have to be factored in.

Other things being equal, one has greater reason to prefer minimizing the likelihood of imminent and certain harm than to minimise the likelihood of only future and theoretical harm. Of course, preventing current trivial harm is not worth taking a highly probable and grave future risk.

In some cases it appears obvious that the current harm is trivial compared to the future risks – that is why bringing our children for a blood test will normally not raise any particular concern: the current relatively small harm caused by the needle is worth taking considering the risks that not taking the blood may procure.

In other cases things are not so obvious. Studies report that children thrive when they are allowed to live in the gender that is most authentic to themselves.[34] Those who are unable to affirm their identity, or who cannot access early treatment, are much more likely to suffer anxiety and depression, compromised school performance, suicidal ideation and carry out suicide attempts than those who are in supporting environments. [19] [32]

This is clinically significant risk of serious, imminent, and likely harm: this provides a clear moral and clinical reason, grounded in non-maleficence, to adopt a supportive attitude.

In light of this, a clinician or a parent who enabled transition when there is reason to believe that doing so minimises current harm and suffering and promotes long term welfare would not have to feel moral blame if a child desisted, even if the process turned out to be psychologically burdensome for

the child and others involved. Clinicians and parents who were in this position would have not violated, but acted according to the moral principle of non-maleficence.

Clinical implications of desistence rates

What has been said so far does not imply that desistence studies are unhelpful. It is important to understand better the psychosexual trajectories taken by gender diverse children. In fact, it would be interesting to look beyond gender diverse children, and understand more broadly the psychosexual trajectories open to all children. In fact, cisgender children who become transgender adults [20] can also be considered ‘desisters’.

Desistence studies can also help parents and clinicians to give the right weight to a child’s gender expression: if my 3 or 4 year old child shows gender nonconforming behaviours, desistence studies can tell me that it is likely that this will subside over time. If these feelings are very strong and persist in adolescence, these studies tell me that it is more likely that later on my child will seek gender-affirming treatment. This in itself can be important for everyone involved.

These studies also complement the information (scarce and sometimes conflicting) currently available on gender identity development. Gender development studies indicated that sex typing¹⁰ usually is complete by the age of 6 or 7. [21] Desistence rates suggest that one can expect significant gender fluidity in older children too.

¹⁰ Self-categorisation congruent with conventional perception of what is typical for each sex.

Desistence studies also suggest that hitting puberty is an important milestone for gender identity development. The fact that many gender diverse children after puberty discover homosexual sexual orientation may suggest that the achievement of puberty, perhaps the endogenous production of sex hormones, and perhaps also the exploration of one's sexuality, may help the child in understanding their gender identity. Desistence rates may thus also warn parents and clinicians of being particularly attentive and sensitive during that developmental stage.

Desistence rates may caution against initiating irreversible or partly reversible medical interventions, such as masculinising and feminising hormones or surgery, before the psychosexual trajectory of the child is clear. Deferring these treatments until after the first stages of puberty is common practice.[22]

However, desistence rates do not tell us whether an 'affirmative approach', a 'watch and wait' or a 'live in your skin' approach should be preferred. Even if those rates were compounded with clearer information relating to indicators of persistence, clinicians should still be wary of using desistence rates, and even indicators of persistence, to make clinical judgment about which model to adopt.

As we have seen earlier, Wallien and Cohen-Kettenis pointed out that if we knew for certain which children were persisters, it would be possible to provide puberty suppressant medication even before the onset of puberty; this would prevent a number of later invasive surgical interventions, improve bodily satisfaction and facilitate psychosocial adjustment. [8] But whereas it is likely that a perspective persister will benefit from early medical care and ST, it does not follow that a perspective desister may not equally benefit from that care.

Accepting a child’s self-expression may mean creating the context that the child may need in order to elaborate serenely their gender and psychosexual identity. Desisters may thus benefit from early clinical intervention as much as persisters. One of the goals of early treatment, it was noted, [23] is improving the precision of the diagnosis and helping in identifying children who are false positives. [24]

The decision to enable ST should not be based on the likelihood that a child will ‘persist’. It should be based on the likelihood that it overall serves the child’s interests, that it minimises current distress, that it promotes long-term self-acceptance, that it encourages trust in the significant others, that it promotes a sense of being accepted and validated by healthcare professionals and the family. Desistence rates and indicators of persistence should thus not overcloud considerations around the overall welfare of the child.

This also means that desisters who have been managed clinically with an ‘affirmative approach’, or with a ‘watch and wait approach’, or who have been given blockers, have not necessarily received *unnecessary* treatment; they may have not been *unnecessarily* exposed to the risks inherent to the treatment provided, even if they experienced some adverse side-effects (psychological distress at de-transition, for example).

Final considerations on persistence, desistence and ST

The terms ‘desisters and persisters’ suggest that being gender diverse is something that has specific features, which can be observable and measurable. Indeed, diagnostic criteria shape perhaps inevitably that perspective. However, in the same way as being a woman or a man, a boy or a girl, is likely to be different and mean different things for different people,

at different stages of their life and in different socio-cultural contexts, people may be 'gender diverse' in many different ways too. Some children for example may express a desire to 'cross-dress' at home (this is written here in inverted commas, because at least for some of the children concerned wearing clothes may not be 'cross-dressing' - from their point of view they may be dressing congruently with their sense of self); some children may wish to be called with a chosen alternative name; some others may express a desire to affirm their gender in school or outside the home environment; some may be distressed by the external phenotypical appearance and so on. There is no single way in which a child can be gender diverse.

The conceptual categories of desistence and persistence risk obscuring the variability and complexity in psychosexual developments [25] (albeit, as noted earlier, some of the authors of these studies recognise such variability and complexity and acknowledge that the terminology of desistence/persistent may be inadvertently binary). [27] Because of this, these categories remain, and are bound to remain, vague and potentially confusing. We could ask whether the 'persistence' category should encompass those who have full gender affirming treatment and surgery, or those who have legal gender change (regardless of whether they have undergone medical treatment), or also those who do not have legal change or medical treatment but identify as gender diverse, or also those who identify as a-gender or bi-gender. Similar questions may be asked about all other categories, including the cisgender categories¹¹. [26] Without answers to these questions, these

¹¹ Attempts at classifying humans in sex and gender categories have met significant epistemic problems. We may recall here how the International Olympic Committee has struggled to define who should be classed as a woman and who as a man, in light of the complexities inherent in sex differentiation and gender identity development.

categories lack the epistemological clarity that is necessary, if they are to be used for clinical and research purposes.

Because each child’s gender expression is likely to vary, what it means to ‘enable’ a child to express themselves is also likely to take many different forms. As DeVries and Cohen-Kettenis note, wholesale advice about ST cannot be realistically offered.

They write:

“For example, if a young boy likes to wear dresses in a neighborhood in which aggression can be expected, [parents] could come to an understanding with their son that he only wears dresses at home. In such a case, it is crucial that the parents give their child a clear explanation of why they have made their choices and that this does not mean that they themselves do not accept the cross-dressing” (p.309). [14]

They point out that the goal of the parties concerned should be to create an environment in which a child “can grow up safely and develop optimally” (p. 308) [14].

It is difficult to imagine that a child can develop safely and optimally if they do not feel accepted and validated by the significant others. But of course that validation can and needs to take many different forms, and is likely to change over time. What a child may experience as sufficient validation may at another point in the development feel like hostility and *viceversa*, because the needs of the child, their understanding of the family and social environment, and those of the significant others evolve and change.

Conclusions

Desistence estimates can tell us something important. They can provide a context in which to evaluate a child's gender expression; they can tell us that gender can fluctuate significantly at least until puberty (but sometimes after too).

However it has been argued that these studies should caution us against the use of ST. This way of proceeding, which urges caution, may be thought to be in respect of one of the most important moral imperatives of the medical profession: first, do no harm.

This way of using desistence rates, I have suggested, risks to inadvertently violate that very moral and professional obligation which one may believe it respects.

Even if we had a better understanding of gender identity development, and were able to identify desisters and persisters, this still would not tell us which clinical model one should prefer. ST may still be clinically and ethically the best option, even for perspective desisters. Decisions should be made on the basis of what is most likely, given the available information, to prevent the greatest and most likely harm and to yield the greatest overall benefit for the child. The nature and degree of current harm needs to be balanced against the nature and degree and likelihood of potential harm.

There are problems in defining what it is to 'dissuade' or 'encourage' a child. This, I have suggested, is partly a function of the epistemological difficulties involved in defining discrete categories of 'boy/girl' 'cisgender' 'gender diverse' 'desister' 'persister'. A parent may feel that she is 'more than supportive', and yet a child may feel not validated. What it is that makes a

child feel encouraged, validated or ostracised cannot be determined in any other way than by responding sensitively and attentively to what the child says and expresses, and by being open to the developmental changes of children, particularly as they enter adolescence and adulthood.

Any approach can procure some distress. ST may procure distress at de-transition; but it may procure some distress for persisters too. It is possible that a child who, for example, decides to present in the other gender for the first time at a family gathering for Christmas may feel a mix of relief and anxiety, joy and fear. The anticipation of how self-identification will be received by significant others or by others at large may not match with the response received, and this can cause some degree of distress. These are reasons to be sensitive to a variety of factors, to support parents in understanding and meeting the children's needs and protect children from third parties' subtle, unintentional, or overt discrimination and abuse.

Another consideration needs to be made. Some of these studies, such as those conducted by Steensma et al, are geographically located in areas that are notoriously liberal. In less liberal settings, urging caution may translate in hurdles with acceptance and barriers to medical care for gender diverse youth. Thus what may be recommended in one country as a note of caution may acquire significantly different meanings in a different country.

ST should not be viewed strictly speaking only as 'treatment'. It should also be viewed and used as a tool to allow the child and the meaningful others, including the clinicians, to determine what is the right trajectory for the particular child.

A clinician who has supported ST in a child who will later persist will not have been responsible for unnecessary bodily harm, as there is no evidence that ST per se leads to medical transition. A clinician who has supported ST in a child who will later desist will have violated no moral principle of non-maleficence, if the choice made appeared likely to minimise the child's overall suffering and to maximise overall the child's welfare at the time it was made.

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