THE UNIVERSITY OF CHICAGO

PRACTICING GENDER: THE MEANINGS AND USES OF GENDER AFFIRMING CARE FOR YOUTH IN THE UNITED STATES

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE DIVISION OF THE SOCIAL SCIENCES
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

DEPARTMENT OF COMPARATIVE HUMAN DEVELOPMENT

BY
PAULA JOANNE MARTIN

CHICAGO, ILLINOIS
AUGUST 2022

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGMENTS

This project would have gone nowhere fast without the willingness of the patients, staff, and providers at the Trans Youth Clinic to let me, a stranger with a lot of questions, in to their worlds. The administrative support of Megan and Luis (who got a me a desk and a key card) and the gentle friendship of Beau, Alex, Nina, and Dr Y, were especially essential, as they introduced me to patients, helped me network with other providers, and engaged me in critical reflections both on and off "the record." Dr M, who could have been a social scientist in her own right, was a stauch ally, and her formal sponsorship of this work let everything else fall into place. I am grateful for her willingness to take a risk on me and my scholarship, especially at such a delicate time for trans care. Most of all, I am humbled by all of the young people and parents who trusted me to observe their care, and so generously shared the experiences and insights that make up the core of this dissertation.

Throughout the long years of graduate school, I have been the recipient of numerous forms of support, financial and otherwise, from institutions in and outside of the University of Chicago. I am deeply appreciative of Larry and Susan Giannino, whose financial support has enabled numerous professional development opportunities I would not otherwise have been able to participate in, and funded crucial aspects of my research and writing up. My early research benefited from a Society for Psychological Anthropology/Robert Lemelson Fellowship, and my fieldwork was generously funded by the Wenner-Gren Foundation. Holding a residential fellowship at The Center for the Study of Gender and Sexuality has also given much needed space and financial support, and my final year of writing has been funded by a Social Science/Mellon Dissertation Fellowship.

To turn towards the explicitly autobiographical, I am grateful to my family, for always letting Goodrich Drive and the F/V Twocrack be a home to return to, and for supporting me even when I have made choices that were very different from theirs. Particular thanks go to my parents, Pam and Mick, and my sister Bonnie, whose path to graduate school paved the way for my own.

My years at the Evergreen State College fundamentally shaped who I am as a researcher and, now, as a teacher. David Marr, Rachel Hastings, Krishna Chowdary, and Eric Stein all deepened my curiosity about how the world works, and their teachings are reflected in how I approach texts and problems. Most of all, I certainly would not have had the confidence to attempt to write a dissertation without the steadfast early mentorship of Sam Schrager, who not only taught me about social science, but received and read some of my most vulnerable writing, and never once made me feel foolish.

I first started at the University of Chicago as a graduate student in social work, where I benefited immensely from the guidance of E. Summerson Carr and Beth-Anne Jacobs, who offered both intellectual and pragmatic support in the very earliest stages of this project. At the Crown School I found my first Chicago community, and I owe much to the friendship of Lily Camp and the rest of the cohort six wine club for being incredible thinkers and practitioners.

It would be nearly impossible to overstate the significance of my internship at the Illinois Caucus for Adolescent Health in developing both this dissertation and my self. Serving as the youth development intern exposed me to the tenets of reproductive justice and the complex world of adolescent medicine, including gender affirming care, from the perspective of youth organizers and advocates visioning worlds that could be otherwise. I will be eternally grateful for all that the members of the Youth Leadership Council taught me, and for the life-sustaining friendships with Aisha Chaudri, Jenni Kotting, and Nik Zaleski that originated there. You three have taught me more than I can say about how to trust, to recognize insight (wherever, however it shows up), and to access pleasure, even when it would otherwise feel impossible, in the first decade of our friendship; I can only imagine what the next decade will bring.

The Department of Comparative Human Development has been a wonderful environment in which to do this work, and it is the people who make CHD all that it is. Emily Wilson, Lorna Hadlock, Sarah Cashdollar, Helen Lee, Carly Bertrand, Aron Marie and countless others have offered feedback and essential support at many stages, particularly the early ones. Professors Jennifer Cole and Michele Friedner provided key provocations at critical times, and their work as Department Chair and DGS during my final years of writing, along with the administrative labor of Janice Pavel, have kept CHD running even in the midst of a pandemic.

No dissertation is written alone, and I am in deep debt to several writing communities that have inspired me and kept me afloat. Co-working became ever more critical during the isolation of Covid-19, and I would not have managed half so well as I have without the consistent zoom sessions with Agatha Slupek, Jordan Johanssen, and Dylan Bellisle, or the grounding friendship of Aron Marie. The Workshop on US Locations, the Gender and Sexuality Studies Workshop (and Working Group), and the Medicine and Its Objects Workshop have all been necessary sites of experimentation, critique, and collaboration. I am exceptionally grateful for the sharp insights of Hilary Strang, Josh Franklin, stef shuster, Jade Wong, Helen Gremillion, and Rebecca Ewert, whose engagements with various drafts and chapters, both in and out of those workshops, have improved the project in innumerable ways.

To the fieldwork group that became a writing group, the Midwives, I can only offer sincere, heartfelt gratitude. Alejandra Azuero-Quijano, Briel Kobak, Hannah Eisler Burnett, Soni Grant, and Talia Gordon have been with me every step of the way. I am especially grateful to Soni, for an accountability practice which has steadied me even in the most turbulent times, and to Talia, whose creative partnership in writing is so integral to my life that I cannot image a future without it (and I am glad I do not have to). Your collective fingerprints are all over this dissertation, and I wouldn't have it any other way. Four down, two to go, right?

The mentorship and support I have received from my committee has far surpassed any expectations I had at the beginning of my graduate program. Collectively, Eugene Raikhel, Eric Plemons, Joe Masco, and Kristen Schilt have provided me with hours of meetings, reviewed drafts, grants, reading lists, and course proposals, all while teachings courses that forever shifted my thinking, and writing the kinds of texts that I, too, wanted to write. I am especially grateful to Eugene's steady confidence that I would find my way, for Eric's encouragement to make arguments mine, for Joe's investment in my process and growth as a writer, and for Kristen's visionary ability to help me see outside whatever problem I was stuck in.

No graduate student should go without a good therapist, and Linda Bartoli has been a great one. She has witnessed me along this entire process, supported me as I practiced being present with struggling youth, and celebrated my successes even when I could not see them as such. I am also grateful for Haymarket Co-op, where I have boarded for several years, which has often been a wellspring of meals, encouraging voices, and collective belief in the value of my work.

Finally, the last word goes to Lily Ye, my wife. If all I got from graduate school was the change to entangle my life with yours, it would have nonetheless been worth it. You (and Blossom) provided the companionship, humor, joy, and recognition I could not have managed without. Thank you for being who you are, and for sharing my commitments with me. Our project of meeting the future, together, is the one I am most invested in.

ABSTRACT

Practicing Gender is an ethnographic account of how gender affirming medical care is provided to young transgender people in the United States. Gender affirming care broadly refers to interventions which work to align a person's social and bodily presentation with an internal sense of gender, when that gender identity differs from the gender they were assigned at birth. The dissertation shows how anticipated futures—of individual youth, of medical practice, and of our understanding of gender itself—shape the treatments available to young people in the present. Drawing on months of clinical observations, attendance at research team meetings and case conferences, participation at national conferences, and over 75 interviews with young people, parents, providers, and other experts, *Practicing Gender* articulates the temporal and epistemic logics grounding gender affirming interventions.

Since the 1990s, gender affirming care has been increasingly available to young people in the United States in the form of early social transition, treatment with puberty delaying medication, and access to hormones like estrogen and testosterone. Though this care has often been treated as one cohesive model, the dissertation distinguishes between what I call the logics of "prevention" and "potential" present within the broader umbrella of "gender affirming care."

I argue that many current practices of care emphasize the risk of future outcomes that must be prevented, whether these outcomes are associated with withholding affirmative care or with providing it too broadly. Preventative logics thus are characterized by a concern with two exemplary futures, each which discursively emerges to counter the other; the future marked by suicide and the future shaped by regret. I show what holds these two initially oppositional perspectives together is the way both appeal to anticipated future harms that providers and parents are responsible for preventing. Preventative logics thus encompass very different material outcomes but tend to similarly re-inscribe youth as in need of protection from themselves, and to value gendered care primarily through the ability of that care to reduce unwanted future outcomes. However, I also attend to the ways in which some forms of practice invoke a logic of “potential” alongside or in contrast to that of prevention. While similarly attuned to the future, potential logics manage risk by highlighting the inevitable uncertainty inherent within attempts to know the future, and to know gender. I argue that forms of care which focus on recognizing youths ability to shape their own futures and emphasize the value of gendered embodiment itself are therefore rooted in potential, and suggest pivoting away from prevention towards potential offers more opportunities for gendered medical care to be a part of crafting more livable worlds.

The dissertation identifies the clinic as a key node in the web of cultural meaning-making around gender identity, without claiming transgender as an inherently medicalized category. Instead, I forward the clinic as a site which consolidates multiple meanings of gender, drawing attention to its porosity and ethnographically illustrating the mechanisms by which contemporary clinical interventions contribute, and respond, to broader notions about the gendered possibilities of the future. Across five chapters, I show how young people and providers manage the pervasive ontological and epistemic uncertainties of gender—the continued questioning of what gender is, as well as how we should know it—by exploring the possible futures enabled through the use of gender affirming interventions. Ultimately, the dissertation shows how medical practices can be a part of building a more affirming world, and offers insight into the relationships between fantasies of the future, scientific knowledge, and the uncertainties of gender.

CHAPTER 1

POTENTIAL AND PREVENTION

What We Don't Know

Before we see our first patient, I ask Dr M how long *this usually takes.*

As long as THEY NEED.

This approach might occasionally delay her appointments for the rest of clinic, but she thinks people understand because they know, if one day they are the one who needs the extra time, they'll get it.

I don't know who I'm expecting to walk in the door, but I know that when Simon showed up, holding a nondescript grey stuffy, I was surprised. He's eight, in second grade, ruddy cheeked, with unruly curls, and answers most questions with a soft, singsong,

I
don't
know

before Mom fills in details. Dr M asks Simon how things have been, *in the year since she last saw him.*

good

but not really good.

People are still calling me my old name.

Simon's mom is concerned that she isn't even hearing about all the incidents that could be happening at school, partially because she knows Simon often chooses to engage, instead of avoid, a particular group of young boys. Simon confirms.

I want to hang out with them,
and
I'm trying to change their attitude!

A social justice warrior in the making, *according to Dr M.*

Patients as young as Simon are a rarity in the clinic. If they are engaged in care they generally appear annually until they begin to get close to puberty, at which point they might start coming in sooner, depending on how far away they lived. Given the lack of specialty gender care in many areas, even in California, it wasn't uncommon to see patients, like Simon and his mom, who travel for hours on either end to get to their appointment with Dr M or one of her colleagues.

Dr M asks Simon,

What's going on around puberty for you, friend?

I
don't
know

nothing . . . .

NO CHEST DEVELOPMENT?
NO ODOR?

Dr M shifts her question to include Mom, which allows Mom and Dr M to start to joke about how they would find out, raising their arms, talking about giving a smell, until Simon says, with a little smile,

I don't really wanna find out!

Dr M and Mom are both aligned in that they really want to make sure he gets blocked in time, particularly motivated to preserve Simon's freedom to swim shirtless given how important the water has been for Simon as a source of activity and joy. As Mom says about their summer plans, I think we're going to do a lot of swimming.
There is some uncertainty around if there is a genetic history of early puberty, because, as Mom tells us, they used an egg donor.

This contributes to Mom's need to stay

vigilant

to remain on the look out for any bodily changes, that could emerge at any time; because

we
don’t
know.

We don’t know.

***

The Next Generation

The onset of puberty for many youth like Simon, who identify with a gender other than the one they were assigned at birth, is one of many expected future events that structure how contemporary gender affirming care for youth is practiced and understood. As as set of interventions that work to align a young person’s embodiment with, and enable their social recognition as, a gender other than the one they were assigned, affirmative care is currently the object of much social concern in the United States and across the globe. Yet this current cultural obsession with the meaning and impact of interventions for gender offered in childhood, interventions understood as significant through their power to shape the gendered future, has not always been the primary thrust of transgender health care. Rather, the conditions of possibility necessary for interventions that take as central the importance of identifying, predicting, and acting upon the future self were set, in part, by generations of activists and health care organizers who did not always feels like the future was able to be an object of attention.

“From my generation, the future was something that we were not even thinking about. It was about surviving. It was about getting by.” Mirabel, the woman who told me this, is a community activist and trans woman who came to the US from Guatemala about twenty years before our 2019 interview. Over the course of our conversation she described to me how few resources she felt were available when she first came to California all those years ago, outlining some of the many layered barriers that prevented individuals from even starting to think about “the future”. Housing, employment, access to basic healthcare, immigration resources, providing alternatives to sex work—these were the issues Mirabel first worked on addressing, and which her organization continues to work on to this day, providing a vital space for legal advocacy and support to those who often continue to struggle with surviving, with “getting by”.

From another perspective, the possibility of the emergence of a form of trans health care that centers the promise of a future is also deeply indebted to the history of work that has pushed the ability of health care providers, insurance companies, and institutions to take seriously the needs of trans people. Grant, a White[1] trans man, who had also been involved in organizing during the time period Mirabel described, told me that “if you got, at the time, any group of trans people together and asked what the primary issues were, they were struggling with—health care came up almost always as number one.” He told me, “many of the places that would provide hormones or specific transition related care were either for people who were wealthy and had private insurance,” or for people who were able “just to pay out of pocket”. On the other hand, limited community resources like the ones Mirabel was involved in amplifying, were often specifically intended for trans women diagnosed with HIV. For most people, access not only to gender affirming care, but to basic health care provided in a culturally competent way, which affirmed rather than pathologized gender, was scarce. So how do we then arrive, a handful of years laters, at a moment where the most visible form of trans care might be care for young people and where the major investment of that care is in predicting, cultivating, and protecting the possibilities of the gendered future?

Many have argued that trans youth have become increasingly visible in the US only in the last several decades since the 1990’s, as a part of larger social shifts which increased the visibility of gender diversity. Whether named as *The Trans Generation* (Travers 2019), a *Gender Revolution* (Meadow 2018b), or the *Transgender Tipping Point* (Steinmetz 2014) the perception of a new frontier in the understanding of gender identity carried by young people

---

[1] For now, I capitalize White as a racial category following the scholarship of Eve Ewing (2020) and others who argue that such a move helps challenge the continued presumption of Whiteness as defined primarily through neutrality or absence.

and those who care for them has saturated public consciousness. This increase in visibility has been met with an increased availability of affirmative services for youth, including a dramatic rise in the number of specialty gender clinics attached to some of the largest academic children's research hospitals in the country. So, too, has come the backlash, efforts to shore up the hegemony of binary gender, and create state investments in cisgender status, which looks like, in policy, attempts to restrict the provision of medical interventions, to ban trans youth from sports, and to punish parents and providers who choose to facilitate, rather than hinder, expressions of gender which fail to align with the gender a child was assigned at birth.

This dissertation is concerned with understanding how practices of gender affirming care operationalize, identify, and reckon with the future. It examines a form of trans health care that is not set on reconciling youth with the gender they were assigned at birth, but rather, with orienting towards the possibility that youth could both know, and embody, their gender at earlier ages, and might use the tools of medicine to do so. As an ethnographic study of a clinic and, at times, "elsewhere" (Meyers 2013), I use data gathered from observations of clinical consultations, case conferences, research team meetings, and conferences, as well as interviews with youth, parents, and experts to describe practices of gender affirming care as strategies for managing pervasive uncertainties—about gender, about the future, and about young people themselves—in a climate that so often challenges youths' capacity to survive. Ultimately, I argue that we might better understand what holds together approaches towards both knowing and treating gender in youth by understanding the logics of what I articulate as *potential* and *prevention.*

I use these concepts to highlight the "anticipatory" (Adams, Murphy, and Clarke 2009) logics within the care of gender, which respectively identify the significance of the bad future that must be prevented (characterized most frequently by regret and or death) as well as the importance of current action in manifesting the possibility of the future that is desired;[2]

---

[2] Though the question of whose fears, and desires, shape the orientation towards the uncertain future is

Simon's vulnerability to the undesired changes of puberty, or being called *his old name*, and the future where he can continue to swim shirtless. Potential and prevention are not opposites, and I do not propose them in order to inscribe yet another binary, one liberatory, another conservative, even as there are ways in which I map these logics onto practices of knowing and treating gender in order to argue for the kind of futures such practice enable or foreclose. After all, binary thinking itself, which shapes how gender and gender care is made legible (through distinctions such as the ones made between male and female, sex and gender) is as analytically insufficient here as it is in those other cases. Thus, I often pair potential and prevention, describing them together, as entangled and co-constituting conceptual threads, that nonetheless can, and should, be distinguishable at the point of their enactment.[3] Potential and prevention are useful because they help name how youth are interpolated as subjects in relation to those who are tasked with securing the future on their behalf, as well as how failures in care are conceptualized in clinical care and in clinical research. I do not suggest these are entirely new phenomena, but instead, trace the sustained lineage of preventative strategies within the field alongside the emergence of tactics primarily concerned with the potential for living a good gendered life, demonstrating how multiple co-existing, sometime conflicting, orientations are currently shaping the field of affirmative care.

The (Re)Birth of the Gender Clinic

The Trans Youth Clinic (TYC) where I did most of my fieldwork in 2019 is a California based outpatient clinic with a caseload of over 1000 patients in active care. I first encountered this clinic, and the particular model of care most often associated with its medical director, Dr

---

often questioned

[3] I also understand this to be, in part, the difference between theorizing a broad normative claim towards how all trans health care should be done, and theorizing from a position of ethnographic specificity, which allows for, and assumes, the existence of contradiction, the need for coordination, and the multiplicity of objects.

M,[4] at a conference in Seattle where I was doing fieldwork in 2018. When I first approached Dr M to explore the possibility of observing her clinical practice, I had only a few tenuous connections—my hello at the conference, and a generous email introduction from Dr A, a Chicago based physician I had previously interviewed. Dr A I knew only thanks to the grace of a classmate who had connected me with her roommate, a medical student who did a rotation under Dr A's supervision and offered to introduce us. Thus, I made my way from the Midwest to California, thanks to the kindness of many along the way.

The Trans Youth Clinic is one of now many gender clinics attached to pediatric research hospitals. Major clinics exist in Boston, Seattle, Chicago, San Diego, Los Angeles, Philadelphia, Cincinnati, San Francisco, Minneapolis, Providence, and Washington D.C., to name just a few at the moment. The Gender Multispeciality Service at Boston Children's Hospital, often identified as the first named pediatric center in the US to offer gender affirming services, began providing gender care as a part of their endocrine speciality in 1998, with the GeMS clinic specifically opening in 2006 (Spack et al. 2012; Tishelman et al. 2015). Boston was the first US site to begin translating a model of care developed in Europe, which drew on interventions such as puberty suppression and gender affirming hormones for youth in their teenage years, into the context of the US. In its simplist form, the basic tenets of this model include the possibility that youth can identify with a gender other than the one they were assigned at birth, and that rather than simply waiting until adulthood to undergo any gen-

---

[4] Nearly all of my study participants are described using pseudonyms, with the exception of some professionals who have consented to the use of their real names, which I sometimes suggested in instances where I wanted to describe some of their public facing work in conjunction with interviews I conducted, or to credit them for their intellectual and academic labor that I draw upon. However, given the more vulnerable position of some of the employees at the TYC, I have chosen to refer to all participants there under pseudonyms, and I urge readers to resist any desire to reveal the "true" site of the TYC. As anthropologist Lily Ye (2021) has written regarding her own fieldwork with interlocutors who are difficult to disguise in the field of education research, such desires make it increasingly risky for sites to let potential ethnographers into their spaces. Particularly in worlds where shared language and access to academic publications means our informants, too, may choose to engage with our work, maintaining possibilities for remaining anonymous may be critical in order to better foster opportunities for "studying up". Furthermore, like education, medicine is also a world where self-reflection is highly valued. The willingness of my clinical participants to permit ethnographic access speaks to how open they were to examining their own clinical practice in this way, and I see my own efforts as essentially aligned with theirs in our commitments to witnessing and improving care for trans and gender expansive youth.

der affirming services, one could begin exerting intentional control over the gendered traits of the body as early as puberty.[5] For the very small number of youth who both identify and are supported in a gender expression other than the one they were assigned at birth before puberty, like Simon, this could mean treatment with medication that prevent the development of unwanted bodily characteristics, like breasts, or facial hair, that would appear should they go through their endogenous puberty, and later, treatments that promote the development of traits they do desire.

The emergence of hospital based clinics, this time for youth, at best can be considered a re-emergence in light of the history of trans medical care in the US.[6] Much of this historical scholarship on trans medicine has often, if not exclusively, focused on the role of trans adults, highlighting the clinical practices of Harry Benjamin, Robert Stoller, and John Money as pioneering the conceptual development and eventual treatment of gender at a category distinct from sex. As historian Jules Gill-Peterson (2018, Chapter Three: Sex in Crisis) argues,

---

[5] For consistencies sake, and to more accurately reflect the language used in the field, I attempt to consistently use "gender" and "the gendered traits of the body", rather than reinstating sex as a separate bodily category, except in my discussion of historical or other scholarship that utilizes the language of sex. Gender itself has, of course, been theorized many ways since its conceptual invention, perhaps most recognizably as "performative" (Butler 1988, 2006) and as a "doing" (West and Zimmerman 1987), both which situate gender in relation to the repeated acts of making oneself legibly gendered, or "recognized" as (Plemons 2017) in social life. Other theorists have taken up gender as a "social construct" (Haslanger 2000; Kessler and McKenna 1985) that is made meaningful primarily through relations of social oppression (Rubin 1975), while in anthropology, gender has been recognized as an integral part of social life (Mead 1928; Ortner 1996; Strathern 1988). Anthropologists have also focused on describing the specific positions and experiences of those who live outside the categories of "man" and "woman" (for example, see Kulick (1998), Boellstorff (2004), Valentine (2007), and Newton (1972), demonstrating the narrowness of current assumptions in the US and elsewhere that take gender to be a natural binary between man and woman. In this project, I take gender to be one of my ethnographic objects, so rather than offering a neat articulation of gender via an existing theoretical framework, I attempt to hold off on anything that would concretize it, except to note how the concept of gender as a category that is distinct from, yet inevitably entangled with, characteristics of the body often named as sex, critically enables the development of a field of care that attempts bring a sense of internal identity into alignment with physical traits and social perception. In many senses the concept of gender I am most aligned with is that of what is better named "gender/sex", following social neuroendocrinologist Sari van Anders (2015), which calls upon the way that the popularized dichotomy drawn between gender as the cultural meaning of sex fails to account for how sex "itself" (Richardson 2013) is made meaningful through teleological references to cultural ideas of gender (Shrage 2009). Nonetheless, the experience of gender as distinct from the characteristics of the body (whether those characteristics are named as "sex" or not), particularly when then this distinction is a source of distress, is often taken to be one of the hallmark experiences that provide people with the information that they are transgender, or trans, as I will use throughout this text.

[6] See Meyerowitz 2009; shuster 2021; Stryker 2017

gender emerges at this time within the practice of endocrinology as a concept which can shore up the increasingly unstable category of sex, giving justification for interventions that can concretize sex characteristics among young people with ambiguous traits by appealing to the social importance of clear and stable gender categories. This marks one beginning for the uptick in interest and clinical care for gender, which reaches a pinnacle during what Susan Stryker calls the "'Big Science' period of transgender history", (2017, p. 117) a time from the mid 1960's to the late 1970's which stef shuster (2021) has also identified as a moment where providers were actively working to develop a knowledge base that would legitimize their course of treatment. This "Big Science" period included the publication of endocrinologist and sexologist Harry Benjamin's book *The Transsexual Phenomenon*(1966), the opening of John Hopkin's site for surgery in 1966 as the first clinical site for gender affirming surgery in the US, and the start up of a handful of other clinical and research sites (perhaps most prominently at Stanford, as discussed by Sandy Stone (1992). Yet, all of these clinics would eventually close by the late 1970's (Fritz and Nat 2021).

Gender clinics of the 1960's starting closing in the decade after, which these scholars have attributed at least in part to the emergence of studies which claimed to show the failure of surgical intervention to provide successful outcomes (whether that success was defined by self-reported degrees of satisfaction or culturally normative outcomes such as rates of marriage and employment). Furthermore, there was the pragmatic difficulty of running a surgical program where procedures would not be covered by insurance, and which may have largely relied on research funding to stay operational. While it is difficult to document the exact rationale of each specific closure, the notable exception remains the clinic at Hopkins, which was very publicly closed by psychiatrist Paul McHugh after he came into a leadership position in 1979. McHugh maintains, both then and now, that gender affirming surgery is not indicated for gender dysphoria, which he describes as a mental pathology (McHugh 1992). McHugh's power over the clinic as a psychiatrist was linked to what shuster (2021) describes at the "legitimacy wars" between psychologists, psychiatrists and other providers of the time, an epistemic tug-of-war that ultimately gave rise to "team based" approach that most often integrates mental health care providers as gatekeepers; that is, as those who determine who should have access to care.

In a notable exception to the historical focus on adult care, Jules Gill-Peterson's (2018) work excavates a lesser known history of trans youth as present far before the 1990's and 2000's so often named as the era of the trans child. She troubles any narrative that constructs trans youth as new, and argues that trans youth were already present at John Hopkins and in the practices of notable gender care professionals like Harry Benjamin, sometimes already living as their identified gender (and with varying levels of openness). Gill-Peterson makes a compelling case for understanding the critical role that the "plasticity" of youth—the capacity to be formed into appropriately gendered bodies—had in the development of treatments for gender. Her scholarship, along with that of Meyerwitz, shuster, Stone, and others have furthermore emphasized how the clinics model of success were predicated on the ability of their patients to conform to gendered expectations, showing how patients were often accepted only after demonstrating their capacity to embody gender in a way that upheld, rather than disrupted, expectations of legibility within the gender binary. This capacity, which in the material sense makes up the notion of "plasticity" that Gill-Peterson argues is at the core of gender care, was also linked to the proximity trans people had to Whiteness. As she argues, even as medical practice based on plasticity conscripted White children into a highly determined forms of a gendered future, other youth were denied even that small form of affirmation, and instead more likely to be shunted towards mechanisms of carceral control and surveillance (2018, p. 197).

When youth gender clinics started to appear on the scene in the 2000's, they most often emerged from one of two directions. The first is the trajectory that builds out the discipline of endocrinology (Gill-Peterson 2018), as at Boston Children's Hospital. Largely run by endocrinologists specialized in treating intersex conditions in children and adolescents, these programs started expanding their service to include other youth coming to their practices looking for care for gender. Often relying on psychological professionals to determine which youth were appropriate for treatment, such programs nonetheless note how rapidly their caseloads grew once they explicitly began accepting referrals of youth seeking out gender affirming care without any other diagnoses (Spack et al. 2012). The second trajectory that maps onto some of the contemporary youth clinics in the US, including the site of most of my work, emerges from the HIV/AIDS epidemic and the development of programs for the health needs of adolescents in community settings, rather than in hospitals. This trajectory is best illustrated through the description of the Trans Youth Clinic. But before getting to the clinic in practice, a brief detour into the clinic not as a historical place but a theoretical site, is crucial for social scientific understandings not only of gender but of many of the trademarks of modern life; in other words, the clinic, in theory.

The Clinic (in Theory)

The Dutch scholar Annmarie Mol, in her ethnographic study of arteriosclerosis, writes in reference to Foucault's *Birth of the Clinic* (1973) that

> The medical question par excellence is no longer the question Foucault pointed out as such: "Where does it hurt?" Instead, it has becomes this other one: "What is your problem?" This is a question about whether you, the patient, are still able to live a good life, or whether you have *a problem* with that. The problems one is faced with are not conditions of the body. They pertain to one's body, but they are situated elsewhere: in one's life. With this comes another shift: that of the subject of normativity. The professional, or professional knowledge, is no longer able to differentiate between what is and isn't a problem in a persons' life. *Is this a problem* for you, *Mrs. Sangers*? This is the new trope: that patients are being elicited to articulate norms about and for themselves. (2002, p 128)

Mol's analysis aptly reflects much of the care that I track in this dissertation, with the two important clarifications. The first is that the YOU was often multiplied, such that youth were required to speak both to their current state, as well as to their imagined future states, and that problems of others around them—parents, providers—were so often centered in their care. *Is this a problem*, for you, *or* YOU, *or* them? The second is that in the context of medical anthropology, the question of what is or is not a problem for someone in their life has often been posed as an individualizing response to social or structural problems, which has special significance when it comes to the relationship between medical practice and gender.

The biomedical is but a form of the cultural, as social scientists and other theorists have long demonstrated. Scholars have produced multifaceted arguments about the relationship between sickness and the social world (see Young (1982) for a review of the early literature), and shown how medical institutions often frame responses to diverse social conditions in the diagnostic languages of mental health (Fanon 1968; Kleinman 1988; Nichter 1981; Obeyesekere 1985). Medical anthropology has been able to foreground the inseparability of experiences as varied as addiction (Garcia 2010; Meyers 2013; Raikhel and Garriott 2013), psychosis (Davis 2012), and cancer (Livingston 2012) from the contexts of their emergence and embodiment. This has often looked like, in theory, tracking the "biopolitical" (Foucault 1977) in its many manifestations, qualifying how conditions become known or treated as "pathological" (Benedict 1934a; Canguilhem 1978), and attuning to new forms of subjectivity that emerge through mechanisms of classificatory "looping" (Hacking 2007). Furthermore, scholars have described how technological developments, enmeshed as they are in systems of global capital, can shape how the self is understood (Dumit 2012; Rose 2003), or be freshly deployed to new effects in different settings (Koch 2013).

The clinic may function in many ways as a "technology of inscription", as Sandy Stone (1992) wrote, which in the context of care for gender can be seen as a site of enactment where, as she argues, "we can locate an actual instance of the apparatus of production of gender." Yet, theorists have also argued that clinical medicine enacts not a singular or even coherent object, but instead, reflects "situated" biologies (Niewöhner and Lock 2018)and enacts "multiple" bodies (Mol 2002), which are not always commensurable across times or locations. That is, any critique of the clinical treatment of gender which generalizes too broadly, or attends merely to theories of practices, rather than practices as they are done, misses the opportunity to see how gender affirming care can enact multiple forms of gender and other objects.[7] This is particularly important given the historical context of theorizing the relation between gender and medicine that has, on occasion, reduced the dynamics between patients and providers to one of unilateral ideological imposition which leaves little room for agency or motivation other than the normalization of gender (see, for example, Bernice Hausman (1995)). Furthermore, medicine itself is far from uniform, meaning scholarship on medicine (including practices of gender affirming care) must attend to specifics of practice, rather than provide a perfunctory critique of the "medicalization" (Rose 2007) of gender that ends with the notion that medical practices are deeply implicated in our understanding of what it means to live a gendered life, rather than begins there. With this in mind, I turn to the clinic as it is, in practice: a specific site, where specific practices produce opportunities for insight into the logics of gender affirming care for youth, which as I will argue, are not simply about gender but about the possibility of imagining and securing the future.

The Clinic (in Practice)

Most places don't let the little kids come see the medical doctor. Dr M and I had recently seen a patient only four years old, whose parents had been surprised that they met with her, an adolescent and pediatric physician, rather than a psychologist or a psychiatrist. It was true that for most patients, their first point of contact at the clinic would be a social worker, who would walk them through an intake process that asked about domains of life such as their home, education, employment, as well as the typical areas of concern for youth: eating, sexuality, suicide, drugs, self image, along with asking about their desires and intentions in coming to a gender clinic for care—the answer to the perpetually posed question, *what*

---

[7] This is also not just about attempting to categorize different models of gender care, as Ann Fausto-Sterling (2012) did in an her effort to extrapolate theories of the origins of gender from published essays by providers at several key clinics at the time. Instead, to again reference Mol, this is about locating "knowledge primarily in activities, events, buildings, instruments, procedures, and so, on. Objects, in their turn, are not taken here as entities waiting out there to be represented but neither are they the constructions shaped by the subject-knowers. Objects are - well, what are they? That is the question." (32) See also Prentice (2012).

are we here for? But for the very young ones, this intake was less of a concern, especially given they were years away from any medical intervention. Families (and it would always be some legal decision maker, at this early age, who brought their child into the clinic) were therefore more likely to have a consultation with one of the primary medical providers, who would talk with them about their child's experience, describe what could be a trajectory of care (identifying key moments of possible intervention, like puberty) and connect them with community resources and supports.

The TYC takes a team-based approach to treating youth, largely drawing on the disciplines of adolescent medicine, pediatrics, social work and psychology. Their program does not include an endocrinologist, and I never met the psychiatrist, in my year of attending weekly team meetings and shadowing providers. Rather, the TYC was a clinic that built its trans health program out of their work serving youth who were diagnosed with or at risk of HIV in the 1990's. Housed in the Division of Adolescent Medicine, an outpatient branch of the hospital, the TYC is perhaps best known for being a program which has moved from a strong reliance on mental health providers to assess youth as appropriate candidates for care to the model of informed assent/consent they advocate for today. This model is an effort to give supportive care in the "least restrictive" environment possible, which most closely aligns with a shift towards informed consent care in adults.[8] In this way, this is a site that is not exactly representative of the most widely shared model of care at this moment, but instead a place that is actively, and visibly, developing a mode of care that others are increasingly seeking to emulate, as evidenced by the strong presence of the TYC providers

---

8. Informed consent takes the responsibility for determining whether or not someone is *really trans* more or less off the table, instead relying on the possibility of people to determine whether or not they want to take on the risks of hormonal therapies. This is still not the case in many places, and is not the case when it comes to surgical intervention, where most patients need to produce one or two "letters of readiness" for surgery, usually from a mental health provider and another doctor, that affirm in expert language the appropriateness of surgical intervention, the stability of a patient's gendered desires, and the anticipated capacity of patients to comply with the surgical aftercare procedures that promote safe healing and desirable outcomes. However, "informed consent" in trans care has been differently operationalized by practitioners, whose individual practices may veer away from what would generally be considered informed consent in other settings (shuster 2019).

as trainers and amongst those shaping published protocols. In other words, the Trans Youth Clinic is a place that enables careful examination of practices that might be reshaping trans medicine, pulling the field in a different direction; one less concerned with the instantiation and correction of misaligned gender than with orienting towards both aspired for and feared future outcomes for youth, and which emphasizes the value of responding to the desire to live a gendered life.

Dr N, who was the Director of the Adolescent Medicine Division, saw his first trans patient in 1992, as he recollected to me one time. She had AIDS, so as he said to me, *why wouldn't I give her what she wanted?* Teasing me a bit, as we waited between patients, he described the information circuits that he travelled given that *believe it or not, there was no internet.* In his telling, he called up an old medical school professor, who he knew was working at a clinic downtown, who in turn told him the amount of estrogen to give, and reassured him that with all of the labs and monitoring that they were doing for her care already, it would be fine. Eventually, Dr N said, they got the *brilliant* idea they could begin treating people *before* they got HIV. After securing grant funding, they then began community outreach and providing affirmative hormonal interventions as a part of HIV prevention.

The Adolescent Medicine Division (AMD) itself has always been more embedded in community care than the main hospital, which I found surprising upon my own arrival at the clinic. According to the annual report in 2019, the hospital itself, which consistently makes it into national rankings of the top children's hospitals across the country, had operating expenses over 1.2 billion dollars, with finances available for "reinvestment in the mission" at over 1.3 billion. Yet the AMD functioned more like a scrappy nonprofit most of the time I was there, with tensions that felt resonant with my past experiences as a social work intern. Like other, much smaller organizations I had worked with, the Division was also living and dying by the grant cycle to keep therapists on staff, community programs running, and resources like the food pantry stocked, as well as managing occasional conflicts between the values of the organization as they were claimed and as they were practiced, and dealing with the reality of burn-out by staff expected to see their work as a "calling".

The AMD was founded in 1963, and first was designed to provide training to adolescent medicine fellows, specifically emphasizing the care of youth who were in hospital care for either acute or chronic illness. In the 1980's the Division shifted focus from providing care to current patients who happened to be adolescents, to adolescents living in community who had unmet health needs, expressly youth experiencing homelessness, pregnant and parenting youth, youth who used substances, were at risk of or diagnosed with HIV, or those at risk of violence. The TYC emerged as a part of this work, and was further consolidated and named at a part of the hospital during a strategic planning process in 2002.

As Dr N and many who work at the TYC describe it, for a long time THE MAIN HOSPITAL as it was generally called, or just THE HOSPITAL was disinclined to outwardly name that they were doing this care. But, since Dr M took over as head of the TYC, with her robust schedule of conferences presentations, trainings, media publications and guest speaking stints, alongside culture shifts and popular media visibility[9], THE HOSPITAL have become *very supportive.* The Clinic is no longer one of only a handful of big programs, but nonetheless continues to add upwards of 250 new patients a year, who range in age from four to 25 years old.

It was frequently referenced how the TYC, in a far cry from its origins, was now known as a site that mostly served White, teenaged, transmasculine people, a sense that did hold up when examining the intake data on new patients the year I was in residence (see Table 1).[10]

Most of my understanding of how the TYC and the AMD fit together in the context

---

[9] Namely the Barbara Walter's show that thrust Jazz Jennings (now television star of many years), then age six, into the public spotlight and Catelyn Jenner's very public transition

[10] I follow the TYC in using transmasculine, transfeminine, and nonbinary to most broadly gloss the different people who might come to the clinic seeking care in a way that does not rely on re-asserting the category of sex assigned at birth. However, whenever I refer to specific individuals in the text, as much as possible I use the words they used for themselves, and only resort to these categories when attempting to convey some more generalized sentiment or feeling.

Table 1: New Patients 2019

Gender Identity	New Patients	**Race and Ethnicity**	New Patients
Nonbinary or Gender Diverse	25	African American	7
Transfeminine	86	Asian Pacific	12
Transmasculine	180	Declined	8
		Latino/Latina	66
		Multiple Ethnicities	37
		Native American	5
		Other/Unknown	10
		White	146
Total	291	Total	291

of THE HOSPITAL came through my weekly attendance at “Huddle”, a space for the interdisciplinary team to come together, provide programatic and business updates and debrief about patients new and old. Community-based outreach workers would provide quick updates on their sexual health education groups, update the team on major events coming up and collaboration offers, while researchers might drop in to pitch the latest study they were recruiting into, or share a new publication. My fieldwork took place among both clinical and research teams, as I was interested in the practice of doing gender affirming care, and in understanding clinical research efforts as an integral part of that practice.

During my year on site there were four primary clinical providers (three medical doctors and one nurse practitioner) as well as one full time nurse, a program manager, three (and then two) social workers who did intakes, individual therapy, and ran groups, and a clinical psychologist. There were also four (and then three) community or youth advocates, who worked on grant funded projects (like running drop-in sexual health education groups or providing support for the process of legally changing name and gender markers), AMD financial support staff who helped negotiate insurance, and a set of social work or public health interns. In the research meetings I attended, I would often see a slightly different set of faces, including data and research program managers, a health psychologist and statistician, and research specialists, all with varying percentages of their time dedicated to the HOPE study amongst the other projects or clinical work they did.[11] As a teaching and research hospital, many people held multiple roles both officially and not, which looked like finding time for research projects as well as conducting patient facing work, or offering extra support to the drop-in spaces for trans identified folks, and hosting a perpetually revolving door of trainees and visitors (myself included).

The TYC and others programs that evolved from HIV/AIDS prevention and treatment programs co-exist with programs that developed out of endocrinology, and are often more similar rather that different when it comes to orientations and approaches towards intervention.[12] It is not meant to be a simple distinction, but one that can continue to complicate how the contemporary clinic, the clinic reborn, should be understood in relation to the historical site of the clinic. While much of the historical scholarship that I have overviewed shows how medical practices have been used to normalize and concretize gendered embodiment, I also argue that while these ideologies may persist, they are perhaps less pressing than how, as historian Beans Velocci writes, “informal evaluative practices rooted in anticipation of bad outcomes became standards of trans care” (2021, p. 463). Drawing on letters and archival materials of Harry Benjamin and his colleagues, Velocci argues that concerns about passing, that is about being able to move about in social life “recognized” (Plemons 2017) as one’s gender, was less about making (in particular) “transsexual” women into “real” women (which Benjamin and his colleagues asserted they would never be) but about assuring a future in which the possibility of regret was minimized. The clinical focus on minimizing regret is linked to an understanding of trans people as risky subjects, once who could neither be trusted to be happy with their future outcomes, or on some level, to know their selves or their desires (shuster 2021; Velocci 2021). It is this understanding which I argue is so

---

[11] In total, I consented 26 staff members and interns into my study, all who permitted me to observe them in their daily work, and many of which completed individual interviews with me about their professional and personal histories.

[12] For example, all these programs offer the same interventions, like puberty suppression and hormonal therapy, for youth under age 18, though they might differently justify their decisions or call upon different norms for determining who should get access to care, and who shouldn’t. Much of the distinction is around the role of assessments, as I will describe in Chapter 3.

relevant to the practices of gender affirming care for youth today, and which I follow into the clinic. There, I ask how orientations towards the future shape possibilities for gendered embodiment, and use the concepts of potential and prevention to name some of the distinctions present in what is usually glossed together as affirmative intervention.

Potential and Prevention

In a general training from the World Professional Association for Transgender Health I attended in 2019, a presenter asked the dispersed crowd, *how do you project forward, ten, twelve years?* Subsequently, he suggested that it is a *huge problem in medicine*, that as a discipline, it relies on *the miracle of science, on a pill, or surgery* to *make everything* ALRIGHT. Embedded in this comment is not only an critique of the assumption that medicine thinks it can make everything ALRIGHT through intervention into the body, but the persistent return to the success or desirability of intervention as linked to the *projection* of the future self.

Scholars have described how the development of expert standards of evaluation, of attempting to do the work of casting forward *ten, twelve years*, was often tied to the fear of legal or other harms that would befall professionals due to the regret of some imagined future patient (shuster 2021; Velocci 2021). In the TYC, REGRET was a major concern, if not always of providers, certainly of parents.[13] Yet, at least at the time of my writing, in California providers rarely linked that concern to any fear of future legal punishment.[14] Instead, there were meetings about safety planning after alt-right news outlets published information that included details about some of the clinic's providers, and a strange adult had attempted to access the clinic by signing in as one of those providers. When it came to

---

[13] As discussed most directly in Chapter Five.

[14] This is continually being challenged - see Interlude Two: LEGISLATION, which excerpts selected legislation attempting to restrict or outlaw the provision of gender affirming care to youth in the US in 2021. 2022 is set to have as many, if not more, legal attempts to ban care and restrict the inclusion of trans youth in public life, particularly in the realm of sports and other sex or gender segregated activities (Lavietes 2022; Travers 2019).

their legal liability, Dr M only told me once, WE'VE *never been sued.*

Dr M contrasts this to a situation at a different clinic, telling me about a parent who sued a hospital after her trans son died by suicide. Kyler Prescott had been taken to Rady due to his experiences of suicidal ideation and self-harming behaviors, but at the hospital was repeatedly misgendered by the staff and eventually discharged early. In the case, which was settled in fall of 2019, Kyler's mother asserts a relationship between the misgendering experience at the hospital and the eventual death of her child (Lesbian Rights 2016; *Prescott v. Rady Children's Hospital-San Diego* 2017). Though Kyler had been in care with the gender clinic at Rady, and even though this case was not about the treatment chosen by Rady providers to support Kyler through his gender transition, it presents the other future that providers, parents, and sometimes youth attend to and attempt to prevent—suicide.

This dissertation articulates two orientations or aspects of contemporary gender affirming care that shape how interventions are conceptualized, provided, and taken up. These two orientations are temporal in nature, embedded within the context of medical care, and name how practices of gender affirming care are situated in relation to the well-being of young people. I call these *potential* and *prevention.*

Potential and prevention identify "chronopolitical" formations existing within practice of gender affirming care, a term drawn from queer theorist Elizabeth Freeman that describes how "some groups have their needs and freedoms deferred or snatched away and some don't" (2005, p. 57). As I will argue, it is not only the twin threats of regret and suicide that structure practices of affirmative care, but also the possible future of gender—not necessarily a psuedo-utopic future, where gendered intervention is rendered meaningless due to the complete eradication of the link between gender and the body, but one where people are free to desire and seek experiences of gendered embodiment using the myriad medical and social tools available to them, without subsequently being tasked with the responsibility to either refuse or reify existing gender categories. This dissertation therefore develops crucial historical arguments by putting them in the context of contemporary youth care, where intervention is necessarily shaped by multiple layers of speculative projection and yet also tied to the present as the only actionable moment; where actions might be read not merely as attempts to guarantee a pre-determined future, but attempts to foster the potential of it.

As a form of "low theory" (Halberstam 2011), if you will, I am not seeking a grand theory of gender (or of medicine) but instead trying to stay with the pressing need to find, name, and amplify ways of caring that can "see trans children's growth and flourishing as ends in themselves" (Gill-Peterson 2018, p. 206). As such, I do not intend to suggest that either potential or prevention are explanatory models or exist in pure ideological forms in the field. These are not emic phrases that I observed in use. Rather, potential and prevention are flexible designators that I argue point to critical differences in how risk, uncertainty, and the possibilities for knowing the gendered self and the gendered future are managed, which emerged from critical ethnographic engagement. It was through my observations of clinical practice with young people—the daily work of caring for patients, of soothing parents, of filing insurance claims and of discussing medications dosages, policy changes, and all else that goes into operating a clinic—that I came to identify these as analytics which could be useful for articulating how the practices of gender affirming medicine are currently used and understood.

Furthermore, while the temporality of this form of care, which is consistently asked to account for the future even as the present circumstances of youth demand engagement under conditions of uncertainty, at a moment of particular significance. Though such a temporality is perhaps always constitutive of medicine itself,[15] and is historically implicated in the treatment of gender, recent emphasis on the gendered experiences of early adolescents in the form of the spread of treatments that target the developmental trajectories of youth and proposed phenomena such as "rapid-onset gender dysphoria" (Littman 2018), heighten the importance of understanding the multiple ways that treatments for gender hinge upon

---

[15] As anthropologist Gregory Mitchell helpfully pointed out in his response to a conference talk I gave in 2017.

particular invocations and enactments of the future.[16] Potential and prevention are two ways of grappling with those invocations, which build on the observations of others who have so keenly mapped out the dynamics of knowledge and power that shape this kind of care, and allow me to ask: What kind of (gendered) future are is being worked towards? What counts as good (gender) medicine? How does one know if this (practice, standard, approach) is it? And will it produce a world desired by those who these practices treat?

Configuring Risk, Knowledge, and Temporality

Potential and prevention, as I am using these concepts, index orientations towards risk, knowledge, and temporality that structure contemporary life. Risk itself I take to be "a joint product of knowledge about the future and consent about the most desired prospects" (Douglas and Wildavsky 1983, p. 5), where possible futures become sources of risk only as they are able to be identified and compared to the future that is desired. Broadly speaking, the concept of risk saturates theorizations of what it means to live in the contemporary world, in particular, how the future is felt and oriented towards. In sociology, Ulrich Beck famously claimed that we are living in a "world risk society" (2006), while Anthony Giddens wrote that "modernity is a risk culture" (1991, p. 5), and Niklas Lurhmann has suggested that "the more we know, the better we know what we do not know, and the more elaborate our risk awareness becomes" (1993, p. 28). The latter point—that our awareness of the unknown is amplified and revealed through ever proliferating techniques of gathering knowledge and formulating predictions—helps further illustrate the essential relationship between the perception of risk and the capacity to know, which in the context of gender affirming care, is a question about both scientific regimes of evidence and the understanding of young people as incomplete subjects, unable to access knowledge of the future self.

Anthropologist Joe Dumit has argued that health itself in the United States "is defined by

---

[16] Victoria Pitts-Taylor has theorized "rapid-onset gender dysphoria" itself as a "scientized and medicalized construct of gender untimeliness" (2020, p. 15).

this double insecurity: never being sure enough about the future—always being at risk—and never knowing enough about what you could and should be doing." (2012, p. 1) Potential and prevention, as speculative, "anticipatory" (Adams, Murphy, and Clarke 2009) attunements are, I argue, ways of entering into this reality, which though both characterized by this "double insecurity" nonetheless differently approach the assurance of knowledge and the possibility of disaster.[17]

In the more concrete articulation, risk is identified in the clinic, among families, and in scientific discourse through a logic of *prevention*, that is, through focusing on the possibility of the bad future—the one that will show, with crystalline hindsight, how decisions made on false understandings have brought about circumstances now felt to be unbearable. As I have already described, the two most powerful representations of this bad future are the twin outcomes of regret and of suicide.[18]

The risk of regret and of suicide are tied together such that regret is attributed to the possibility that youth will, in some unspecified future time, come to see themselves as the gender they were assigned at birth, and thus regret any intervention they underwent to align themselves with a different gender. This is particularly palpable when there are effects on the body—things like the removal of breasts or penile tissue, or the utilization of a course of hormonal treatments that eliminates the opportunity to parent biological children—but also affix to the imagination of suffering from youth who will have to "re" or "de" transition socially and therefore combat many of the same social biases that harm trans people who are transitioning for the first time. Counter to that, affirmative providers attempt to balance the risk that left without care, youth might choose to end their life, feeling the embodiment

---

[17] Much of the scholarship on risk has attended to subjects such as the magnitude of disaster and catastrophic uncertainty that characterizes the nuclear age (Masco 2013; Petryna 2013) and later, the war on terror (Masco 2014), as well as to the predictive capacities of technologies that operate on scales ranging from the fetus (Rapp 2004) to the modern security state, (Amoore 2013).

[18] This is in affirmative care, which stands apart from models of care known as "reparative" that simply attempt to prevent transgender futures. However, the assumption of a trans future as an abject or undesirable one compared with a cis future remains present in the ways that care practices narrate risk, as I will illustrate in the coming chapters.

of an inappropriate gender as too destructive to their sense of self and their happiness to be worth living through.

Gender affirming care as it currently stands balances these two preventative needs, often turning to severity of suicide to supersede the fear of regret. But focusing on the outcomes that need to be prevented requires a particular stance towards the prospect of knowing gender, and knowing the future. In these cases, youth are expected to evidence their clear relation to the threat of suicide, or in some cases, their intense feelings of distress, such that the prevention of that distress becomes more important than the prevention of future regret. The prevention of these risks is approached through projects of knowledge gathering—the historical narrative that begins in childhood as a way of showing etiological purity (distinct from the fragile identity claims of adolescence), and assessments that rule out other possible explanations for gendered distress. Risk prevention is also materialized in a legal apparatus (the age of consent) that constructs youth as incapable of taking on risk themselves, which compounds the ways that adults, like providers and parents, are understood as taking on epistemic and moral authority on behalf of children.

Potential, on the other hand, appears when providers like Dr M talk about approaching youth without requiring certainty, or when her colleague Dr Y explains to me that he tells parents that “we have to be kind of comfortable with uncertainty,” but that uncertainty doesn’t mean inaction, given that “what we know—what we have to do—is support people’s identities now.” As a way of identifying a different orientation towards the management of risk, potential names the willingness to consider the other side of the question; of what else happens when you focus on the uncertainty of the future to the detriment of seeing the person who exists today. It is a logic of complexity, that is open to the possibility for knowledge that may only be obtainable if one is willing to *take* risks, and that might see risk as opening up not just the possibilities for failure but for thriving. Potential is embedded in the notion that, as social workers Aydin and Darlene say, if you *open the door* to gender diversity, some youth *might take you up* on it—and couldn’t that be good?

Medical anthropologists have argued that "as a conceptual apparatus, potentiality does complex work: to imagine or talk about potential is to imagine or talk about that which does not (yet and may never) exist. [...] In some respects, potentiality can be understood as the partner to, or flip site of, 'risk'—also defined as a set of possibilities—though it has yet to be theorized in the same way" (Taussig, Hoeyer, and Helmreich 2013, S4). In queer theory, potential appears most often in relation to the speculative horizon of the future, an understanding of queerness itself that Jose Muñoz argues is "a work of not settling for the present, of asking and looking beyond the here and now" (2009, p. 28). In Muñoz's reading of Agamben's reading of Aristotle, he draws a critical distinction between potential and possibility, writing that "unlike a possibility, a thing that simply might happen, a potentiality is a certain mode of nonbeing that is eminent, a thing that is present but not actually existing in the present tense" (2009, p. 9). And as Agamben argues, what makes potentiality meaningful is how it conceptually articulates a capacity to bring about a state, or a thing, which nonetheless is always paired with the power to *not* do so, what he calls "impotentiality" (1999). This is an important distinction that showcases how, unlike theorizations that tie potential to inherent biological plasticity, potentiality is not uniformly distributed or available. In other words, not all youth have the potential to be trans, and some potentially trans youth will never *be* trans. [19]

Turning towards potential as an analytic enables a critical appraisal of the ways that structures, like that of medicine, can support youth who desire a gendered embodiment that is not yet present, even if that future is also uncertain, risky, and imperfect. In this dissertation I want to draw on potential as a way of holding together the prospect of "hope" not "*only as emotion*", but "*more essentially as a directing act of a cognitive kind*" (Bloch 1995, p. 12)(emphasis in the original), along with a refusal of the "chronopolitical" (Freeman 2005) imperative, so often delivered to young people, to defer processes of living until a future

---

[19] Though as I have already described, in Gill-Peterson's theorizing of plasticity she is careful to describe how not all youth are determined as sufficiently plastic, or capable of embodying gender other than the one they were assigned.

that might never arrive. It is a task that I take seriously, to consider the future as "kid stuff", where as Lee Edelman argues, the figure of the child operates as a political fantasy "of form as such, of an order, an organization, assuring the stability of our identities as subjects" (1996, p. 19), even as I attend to young people who exist, here, now, who may not wish to sacrifice the notion of the future altogether.

My argument through the dissertation is not that efforts to prevent bad outcomes do not have a place in a more just and youth focused version of gender affirming care. Rather, it is to consider in what ways justifications for the provision of care to youth that return to a logic of prevention can only re-inscribe certain modes of approaching youth, and re-center irresolvable problems with knowing gender and knowing the future. Drawing on both potential and prevention enables a more careful articulation of the complex relations I witnessed between the interventions individuals undergo in the clinic and the lives they are trying to build outside of it, which understands the important role that medical care can have on individuals' capacities to imagine and actualize forms of gendered life. More importantly, by highlighting moments of engagement that challenge those modes or reorient to these problems, I demonstrate more ways for those who care for trans youth to honor their agency and to collaborate in the effort to craft more livable worlds.

Knowledge Problems

The trademark "uncertainty" (shuster 2021) of trans medicine is shaped not only by the perpetual uncertainty of the future I have been so invested in articulating, but also by the conceptual slipperiness of gender itself, which eludes capture by any concrete epistemic apparatus. To briefly return to the "Big Science" days of trans care, Meyerowitz articulates the foundational conflicts over control and authority between patients and providers, writing, "Who could decide whether a person was or should be a man or a woman? Who could decide whether to change the bodily characteristics of sex?" (2009, p. 153) To answer this question, historians have shown how trans medicine has long been dominated by cisgender providers and researchers. This, despite the fact that providers' understandings of gendered distress and the possible use of medical intervention was derived from the experiences shared with them by trans patients. In other words, the knowledge developed by clinical professionals came from no other sources than the subjective experiences of their patients, yet was transformed into the authoritative expertise when coming from the perspective of a cisgender physician (and later, as shuster (2021) shows, a psychologist, therapist, or psychiatrist). This legitimation of expertise reflects both the underlying logic of objectivity, which takes a perceived distance between an object and those who intend to know it as crucial to the legitimacy of knowledge, and a sociopolitical culture that keeps trans people from opportunities to take on those roles.

These problems in the development and legitimation of knowledge persist in trans medicine to this day. They were especially tangible in my own research when it came to the design and implementation of the HOPE Study, a multi-sited, longitudinal study of the impacts and outcomes of treatment with gender affirming hormones and puberty blockers (which I describe at length in Chapter Three). However, outside of the more explicit research context, there is also an increasingly vocal call for centering what trans people already know (about themselves, and their care) in the clinical treatment of gender, and demand for experts who also hold trans identities. Now, for example, both the president-elect and the secretary of the World Professional Association of Transgender Health (Marci Bowers and Asa Radix, respectively), the most well-known organization of experts working in trans health, are trans identified people in addition to being well-known scholars and medical providers. This suggests an increased recognition of the impact of social location in crafting epistemological claims.

Yet, relying on social location to remedy the effects of historical erasure is an imperfect solution, as philosopher Olúfémi Táíwò (2020) describes in his rendering of the cultural impact of standpoint epistemology as a practice of deference to those who are already "in the room" with them. Táíwò shows how only some, often more privileged members of marginalized groups, are usually able to "be in the room," and are thus recruited holding epistemic authority on behalf of a collective they often differ from in important ways; whose very difference often enables their ability to even be in that room. This usually manifested in my fieldwork as an attention to the missing authorship of not just trans people but specifically trans people of color, and Black trans women most significantly, as they were often discussed yet rarely engaged in the capacity of being experts. In this way, the community was often already sharply aware of the critique that Táíwò makes about how standpoint epistemology, when manifested as deference, is primarily embedded within attentional, rather than material, economies. For example, during one community forum at a conference, speakers highlighted the structural barriers to participation (conference fees, for example) that would enable the participation of those whom everyone claimed needed to be *listened to.* The question was not just, *why aren't you listening to them,* but *why aren't they here?*

Nonetheless, though on a systemic level the clinic was concerned with the recruitment of racially diverse young people into their research projects and in addressing the overall Whiteness of their patient population, when it came to practical decisions about "Who could decide whether a person was or should be a man or a woman?" (Meyerowitz 2009, p. 153), practices at the clinic mostly insisted on the epistemic authority of subjects to represent their desires. What most challenged this insistence was not young people's gender, but rather, their age. The cultural presumption of youth as unable to be stable or knowing subjects, paired with the availability of interventions that shape the distant future through fertility impacts and gendered embodiment has sharpened the need for forms of evidence that can show not only the identity outcomes of early intervention but the physiological health and wellbeing of youth who undergo such treatments. Thus, the particular relationship of new forms of bodily intervention and the subjectivity of youth, their specific forms of marginalization, magnify challenges that have always been present in trans medicine, offering an opportunity to investigate claims to knowledge within contexts of historical harm and pervasive uncertainty.

In 2021, a slate of legislative efforts to ban puberty suppression treatment hinged upon claims of a lack of evidence for its efficacy and safety in treating gender (see interlude 2: LEGISLATION). In a response largely defending the availability of these interventions, anthropologist Sahar Sadjadi nonetheless wrote, "Researchers who are not professionally and financially invested in medical treatment of gender-variant children need to conduct robust studies on the long-term health effects of puberty suppression, particularly for younger children who might not yet have the cognitive tools, life experience, and knowledge to evaluate the risks and benefits of these treatments." Yet, to so express the need for researchers who are "not invested" in the medical treatment of gender-variant children is to uphold a form of objectivity that weds truth to distance, reinstating the fantasy of what Haraway (1988) famously named the "god trick" as well as to further subsume young people's knowledge of their own wellbeing to health data derived from other sources. While studies that answer Sadjadi's call are in process, though perhaps not conducted by those who are professionally disinvested in the medical care of trans youth, this study is not that.[20] Instead, I attend to the calls for evidence, from providers, parents, legislators, researchers, and more, as part of the cultural conditions that surround the processes of delivering and receiving intervention for gender, investigating these calls as well as the attempts to answer them.

Dr M often said about cisgender parents relation to their transgender children, and sometimes about researchers (including her and I) and providers too, that there may be things about gender that non-trans people will simply not understand: because they (we) engage the world through their (our) cisgender experience. Given this reality, I approach the problem of knowledge not only empirical, observable phenomenon but methodologically and representationally as well; that is, through my positioning as an ethnographer both in the field and on the page. I am attentive to the way that I am implicated within a social scientific

---

[20] Given the current ways that medical and scholarly research is funded and conducted, it seems unlikely that such a study would come to fruition. Further more, such an ask seems to conflict with the call to repair historic injustices about the way research has been conducted through engaging trans communities in setting research agendas and leading research efforts. See, for example, (Everhart et al. 2022).

research "apparatus" (Barad 2007) which materializes its objects as much as the research I occasionally observe does. And, perhaps more importantly, given the current position of trans youth in the world, and the relation of providers to those who would see their work stopped, it was clear from the beginning that attempting a value-neutral stance towards the process of gender affirmation would neither be ethically or pragmatically possible.

Entry Points

In 2013 I was a social work intern, lucky enough to begin an internship working alongside a cadre of youth advocates and peer sex educators who were diverse in regards to gender identity, sexuality, race, and socioeconomic background. In supporting queer and trans young people develop and implement trainings, not only for their peers but for educational and medical institutions hoping to increasing the inclusivity of their practices, I came to know two important things. The first was the that unlike other forms of medical care that I was familiar with, care attempting to treat gender often relied on young people as the experts, who were tasked not only with developing a extremely nuanced vocabulary for expressing their own identity, but who were then often positioned as the ones who had to teach the other in their lives (including their parents and their health care providers) what relation that identity had to a variety of interventions they desired, medical and otherwise. The second was that it was clearly challenging to access forms of care that affirmed gender, but that treating youth as people with an inherent right to gendered embodiment and autonomy over their gender expression (rather than as a form of "property" as Gill-Peterson (2018) argues), entails committing to their right to access interventions, including interventions with impacts that touch the unseen surface of the future.

In other words, I did not come into my work with transgender and gender diverse young people curious to see if the interventions available to them were justifiable; not because I see such a question is "politically impossible" (Chu and Harsin Drager 2019; Sadjadi 2020)[21], but

---

[21] Given the centrality of such a question to so much conversation about trans youth, it seems rather

because it seemed to have be adequately answered, if one takes seriously what young trans people say, and have been saying, about their lives and needs. Instead, this dissertation turns away from the simplified dichotomy of whether or not gender affirmation through medical intervention is the correct way to approach gender care in order to describe how affirmative practices manage both young people and their futures.

As a scholar rooted in a tradition of reproductive and youth justice, I have chosen to be more, rather than less, explicit about these commitments with my interlocutors along the way, particularly one entering a field where cisgender professionals have continued to *build their careers on the backs of trans people*, as one research coordinator clearly described it. I may well be called to account for similarly reproducing dynamics of knowledge production which stake my future success on my ability to craft, out of the lives and experiences of trans youth, a compelling narrative with theoretical rigor and empirical interest. It is not unlikely that there will be moments in the future where I seem horribly out of touch, out of date. There is the risk that this, like any writing, will age badly, or that it could damage the tenuous grip on gender affirming care youth momentarily have, in unforeseen ways. Yet the ethical problem of "speaking for others" (Alcoff 1991) is not always solved by simply staying silent.

As an ethnographer, rather than attempting to obtain a form of "objectivity" that feminist studies of science have long critiqued (Barad 2007; Haraway 1988; Harding 1992; Harding 1986), I sought out sites and informants that I could "stand with" (TallBear 2014); that is, where my inquiry could remain open ended, uncertain in relation to findings, but where I produce work that amplifies the rights of trans youth to simply "be alive", (Espinoza 2016).

---

lively to be an impossibility. I am sympathetic to fact that the political eagerness to restrict and eliminate interventions for youth may limit critique for some, given how eagerly they are taken up by detractors of care—but this doesn't seem to have stopped scholars from lodging arguments that have been used to ill effect (Ashley 2019b; Sadjadi 2013, 2019). It seems to me that the bigger issue is not the lack of space to critique medical intervention from academics who support gender diverse expressions, but the failure to account for the act of scholarship as part of setting the terms and conditions of what is both imaginable and possible in the world. I am invested in extending those bounds—that of the imaginable, and the possible—and hope that my work finds its own way towards doing so which does not rely on the erosion of the few material opportunities youth have to exert control over how they embody their gender.

My way into the vulnerable spaces where I conducted most of my fieldwork—medical exam rooms, homes, quiet conversations, personal histories—was often only enabled through my direct support of young people's right to access affirmative care. If I had, instead, decided to spend much of my time with anti-trans activists and opponents of care, as interesting as it may have been for people to know what THE OTHER SIDE was doing or thinking, I would have put myself in what felt like the untenable position of claiming neutrality in an conflict where such a claim is tantamount to outing yourself as untrustworthy.[22] In other words, it is unlikely that I would have been welcomed into a space designed with the well-being of trans youth at the center if I was set on representing myself as ambivalent towards their rights to access medical intervention for gender.

Interviews

In this work, I center youth as experts on their lives and experiences, but I am ultimately not trying to consolidate narratives that are primarily about the meaning of their identities as such. Instead, my methodological choices reflect my interest in articulating how an entire apparatus of knowing and treating gender is being crafted and mobilized; how a diverse collective of individuals, with different stakes and approaches, may be co-constituting the conditions of possibility for gendered futures. In practice, this looked like studying in multiple directions: "up" towards providers with much more institutional power than I, who looked sympathetically towards my position as a mere graduate student and had no real issue telling me *no*; "across" towards those with similar social histories and economic standing to my own (most often White queer professionals in their early thirties); and "down" towards more systemically vulnerable young gender expansive people, or the precariously employed.

I was deeply troubled by the potential of replicating in my methods what Dr Y, one of the other clinicians I often shadowed, described as "basically like sitting on a witness stand

---

[22] I mean those exceedingly vocal detractors of affirming care for youth that Jules Gill-Peterson calls "bad faith artists" (2021), not any provider who simply chooses not to provide trans care, or who has concerns about it, a much larger and more ambiguous group that I also did not spend much time engaging.

and, like, testifying to your gender." This was a part of what he named as "the historical trauma of the gatekeeper model", which refers to mechanisms for accessing medical care that have required a specific form of self-narrative, which need to be appropriately delivered and signposted in order to be diagnosed and treated.[23] My worry about contributing to *gender interrogation fatigue*, as Dr M called it, or research fatigue in general (Ashley 2020b), paired with the desire to minimize elicitations of rout gender history, meant that I leaned on youth to guide me in our interviews, outlining for them my major interests and then letting them pick up what they felt like telling me about. But sometimes my effort to avoid reproducing an othering gaze was met with generous course correction, if it seemed like I was overlooking topics that my informants knew to be critical to their experience.[24]This was most explicitly reflected during an early interview with River, the first of three we would have over a span of about two years.

At the end of our first interview I ask River if there is anything else they want to share with me. River, who is thirteen at the time, tells me, "For the most part, I feel like you did a very good job and.. um.. I felt very comfortable during this conversation."

I'm immediately pleased. *What a good anthropologist.*

"It was really great—it was good to actually hear myself talk about these things and actually get it out.

Um... Hmm."

---

[23] See also Prosser (1998), especially Chapter 3, for more on autobiographical narrative as diagnostic tool and the making of a "transsexual" history.

[24] Fear of which Tey Meadow describes in her own discussion of why she choose not to interview youth but instead parents (2018, Appendix B "Why I Stopped Interviewing Kids"). Meadow details her awareness of the potential harms that might come through a youth participation in a project that takes their gendered expression or experience as something deserving of special attention. Given that my recruitment took places primarily at a clinic, where youth were already in care for gender, I was not so concerned with reflecting to youth something they were already aware of—that their gender identity was subject to care in a way that differed from their peers. I was more concerned with giving those youth space to articulate their own views in a space that was free from parents, clinicians, social workers, and where my distance from their daily lives sometimes seemed to free them from needing to ensure that they told the *right* story of their gender. I did not, however, interview youth that were too young to be actively receiving medical interventions like blockers or hormones, though I observed them sometimes during clinical consultations, a space where they were already subject to a certain clinical engagement, regardless of my presence. Outside of the clinic, however, with those youth I stuck with interviewing parents, much as Meadow did.

River takes a beat, slowly saying "I don't know. . . "

Throughout our interview, I have caught onto their habit of marking a place with an emphasized "hm", followed by a pause as they gather their thoughts, and then, usually, deliver a very carefully articulated response. This is no different, though characterized with more uncertainty, seemingly, as I listen back on it months later, questioning more of my own interest in perhaps challenging how I had chosen to go about this particular conversation.

"I keep on thinking of the topic of gender dysphoria.[25] Yeah. Um, for some reason, um, especially within the trans community, people have different, um, views on it as—"

"You mean like as a diagnosis or as an experience of, of your body, or both?" I rush in to say, interrupting them in the process.

River halfheartedly attempts to articulate what isn't being captured here, something that is "still popping up" but isn't readily available to them, until they tell me, "I don't know. I feel like, yeah, forget that."

In a circular and awkward way, we hover together, until they are able to tell me something that feels like it matters; that dysphoria specifically matters to talk about, "especially as a non-binary person. Um, because even in the trans community people—letting people have different opinions on gender dysphoria such as like some people feeling that you must have gender dysphoria to be trans or—"

"I see," I interject, softly.

"—that sort of stuff but also about like how it affects your decision making and all that fun stuff."

River calls me in, gently, for avoiding asking about what they think I shouldn't have avoided asking about. They show me that in my effort to work outside of the constraints of assuming that all trans people experience dysphoria, or that gender dysphoria itself is an object that exists to be asked about, I might be missing opportunities to tune into how young

---

[25] The current clinical diagnosis under which most transgender people are classified, which refers to "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." (APA 2013, "Gender Dysphoria").

people are making sense of their own experience, which sometimes does reflect diagnostic language or categories. River helps me to re-complicate what it means to be the person on the other side of the table, asking questions that might replicate harmful dynamics of interrogation but which cannot necessarily avoid that risk by staying silent.[26]

Observations

Back in the clinic, I had little sway over what could or would be said in any given setting, given that I was far more of an observer than a participant, with no real responsibilities than to be as little in the way as I could.[27] I was somewhere in between an intern and an auditor, around often, and noticed primarily for my conspicuous note-taking. My black notebook was not uncommonly referenced: *can I read it today*? *I'm just so curious what you are writing*, or even a quick hand on the arm in the middle of a meeting gone a little too far astray, but *don't write* THAT *down!* followed by a quick laugh, *I'm kidding*; *kidding* about what, exactly, I was rarely sure of.

During days where I shadowed clinicians into their appointments, I first obtained the written consent and assent of youth and parents, as well as a signed HIPPA[28] waiver which gave me permission to overhear conversations about what is legally classified as private health information. I conducted approximately 60 observations of clinical appointments that ranged from between ten minutes to nearly an hour, with young people aged four to 25. Providers

---

[26] This is not the only concern with interviews which not only by choice of question presupposes and limits responses, but, like all methods, have particular uses and limitations. See, for example, (Carr 2011) for a discussion of qualitative interviewing in the context of service provision (which I am somewhat adjacent to as a clinical ethnographer) using insights from linguistic anthropology.

[27] Gusterson (1997) has described how studying those who have many institutional protections, who read what we write, who can respond to and challenge it, often entails rethinking what anthropological "participant observation" means. My own understanding of limits of participation in a hospital context reflects not only such concerns but also the problematic history of anthropology's assumption of a right to access as built on a neglect of the many valences of harm we may expose our informants to (Bosk and De Vries 2004; Martin 2020). See also (Raikhel 2009) for more on the particular risk of being misrecognized in clinical settings.

[28] The Health Insurance Portability and Accountability Act, passed in 1966, is a piece of federal legislation which includes a Privacy Rule that is intended to prevent patient health information from being shared without a patient's knowledge or consent (*Health Insurance Portability and Accountability Act of 1996*).

and patients would ask me to leave, occasionally only a few minutes after we began, for privacy or to do any physical exam[29], or permit me to stay through the duration. Then, at the end of the appointment, I would make arrangements for follow-up, if they were willing, to have an interview of some sort, or simply pass off their own copies of our consent documents with a reminder that they could be in touch with me, if they felt later that they no longer wanted my observations of their care to be a part of this project. And for most people, this was it—the end of our engagement.

My approach to data collection was to anonymize as I wrote, meaning, there was no link between the clinical observation and a later interview or discussion of a patient, given the significant privacy risk of permitting an observer into a clinical exam, and the constraints of institutional access. In my observations I came to know the different habits of style providers conducted themselves with, as learned to notice when something was, by circumstance or by delivery, out of the ordinary.[30] In my note-taking, I focused on collecting bits of direct speech, and attending in particular to what seemed "resonant" (Lepselter 2016; Stewart 2007) across observations, and to "states of intensification" (Stewart 1996), attempting a form of description that draws insights from both "thick" (Geertz 1973) and "thin" (Jackson 2013; Love 2013) traditions, where the latter pushes back against the fantasy of the anthropologist who embodies "an experience that simulates (and maybe even surpasses) any of the ways in which the people being studied might know themselves" (Jackson 2013, p. 14). This is also about what it is to engage in descriptive practice that wants to communicate some of the many things that are unknown, without rendering the unknown as an absence of meaning or trafficking in my own "speculation about interiority" (Love 2013, p. 404).

---

[29] With the notable exception that I was rarely asked to leave if someone was taking off their shirt to show off results from top surgery.

[30] "The ordinary is a circuit that's always tuned in to some little something somewhere. /A mode of attending to the possible and the threatening, it amasses the resonance in things./It flows through clichés of the self, agency, home, a life./It pops up as a dream. Or it shows up in the middle of a derailing. Or in a simple pause./It can take off in flights of fancy or go limp, tired, done for now. /It can pool up in little worlds of identity and desire./It can draw danger./Or it can dissipate, leaving you standing."(Tuned In Stewart 2007, p. 12)

In other words, to allow others a stance of ethnographic refusal (which Savannah Shange notes is also an epistemic refusal (2019, p. 121) and to retain a level of "opacity" (Cox 2015; Glissant 1997) in how they are represented.

As the postcolonial poet and scholar Édouard Glissant writes, "The opaque is not the obscure, though it is possible for it to be so and be accepted as such. It is that which cannot be reduced, which is the most perennial guarantee of participation and confluence." (191) Like the "life of the name" that anthropologist Lisa Stevenson (2013) describes in her work on the youth suicide epidemic in the Canadian Arctic, in my representation of young people, in particular, I am attempting to provide, within the confines of anonymous representation, irreducible singularity, that takes no person's meaning as mere empirical grist for my theoretical mill.[31] As Angela Garcia puts it, "so much theory forecloses the possibility of letting things be vulnerable and uncertain — state of being that I want to engage and evoke" (2010, p. 35). Thus, in my rendering of clinical encounters as ethnographic writing, I have made representational choices that attempt to hold together opacity, to leave room for meaning that may be unknown to me, and which turn away from the question of *why are you the way that you are* towards whatever it is that is being presenced, including that which is present through its absence (Althusser 1971).

There are few origin stories here, few narrative explanations of how, and why, someone experiences their gender the way they do. This is not exclusively true, as I did hear or ask youth or parents about their early recollections and experiences of gender, their processes of knowing, and the trajectories of intervening based upon that knowledge, which many described in attentive, generous detail. Yet, most of my clinical data, the heart of the project, is based upon these brief observations, ones which have no history, and no future. These descriptions are not meant to play into "the fantasy of tying things down" (Berlant 2019), but to stage a conversation, as both a descriptive technique and an analytic anchor,

---

[31] As so often has been the case, in particular, with the relation of trans people to the study of gender Namaste 2008.

reflecting, as Jack Halberstam does in reference to the work of Saba Mahmood, "one very concrete way of being in relation to another form of being and knowing" which does not seek "to measure that life modality by the standards that are external to it" (2011, p. 12).

Throughout the chapters, I take advantage of the visual distinctions of italics, small capitals, font sizes, and block quoting to suggest moods and attend to the nuances of re-voicing speech (Davis 2012; Lepselter 2016) as well as to emphasize how certain concepts and frames becomes oversaturated with meaning and authority. For example, the frequent invocation of gender as a SOCIAL CONSTRUCT relies upon the assumption of a shared understanding. What happens to our reading of the use of the concept when we attempt to hold off, even temporarily, on joining the assumption? Small capitals also express an authoritative voice, and are used in moments where others were clearly imbuing their phrasing with specific sets of indirect meaning. Rather than assuming I catch it all, I have chosen in some places to attempt to recreate my own reception in that moment; that this is something which means something, even if I'm not sure what.

In the case examples, italicized text is used for framing and exposition, but in the body text, italic font indicated an indirect citation recorded in note or member, whereas quotations from audio-recorded interviews as well as texts or other documented sources are cited outright. My stylistic choices in representing clinical scenes reflect my own effort to showcase the constructed nature of writing recreated from written notes and memory, that occasionally composites patients from multiple observations into a singular scene, and to elicit in the reader something of a "structure of feeling"(Williams 1977), or the "ordinary affects" (Stewart 2007) that characterize clinical care. It uses something akin to poetics, as one tool that can invite the reader into a sense of presence, which might also let the theorizing and the world-making of those I observed in such scenes remain the focus.

Chapter Outlines

Chapter Two: “A Hard Question: Gendered Distress in a Social World”, orients readers to the perennial question of etiology in trans care through an example of care of the very youngest people, those who are so often given as the kinds of evidence needed for understanding gender as an interior state. Even as theories of SOCIAL CONSTRUCTION have come to stand in for a popularized notion that gender is unreal, understanding gender as a complex phenomenon which lives both in and out of the body enables a theorization of gender that makes space for both the validity of medical intervention and the possibilities of worlds that could configure the meaning of the body differently. Prevention logics are visible during this early age in how experiences of DISTRESS are seen to be both preventable yet diagnostically necessary, whereas potential emerges as a counter logic to articulate the value of offering gendered intervention, even, or especially, when young people might *take you up on it.*

Chapter Three: “Justifying Gendered Intervention” turns towards the ethical and epistemic relationships drawn between providers, patients, and researchers involved in transgender health care. I ask after the possibility of good relations between young transgender people and their doctors given the context of historical harm done in the name of “good medicine”. More specifically, this chapter contextualizes how the call, *how do you know someone’s gender* and its response *you ask.* To do this, I draw on the example of a iconic research questionnaire and its most contentious item, following debates about its use from the conference hall to the research lab, and attend to the relationship between the evidence cultivated in those spaces and the contemporary political attack on the provision of gender affirming care. Arguing for the inherent instability in the division between “research” and “practice”, this chapter draws distinction between clinical and research assessments and the practice of THE ASK. I suggest that the more popular metrics to justify affirmative care have focused on the ability of such care to prevent bad outcomes, like suicide and depression, due to their easy of significance. Yet, I also ask how such a focus might further tie together the very relationships that research projects are attempting to break apart, and overdetermine the conditions under which gender affirming care can be said to "work". Furthermore, this chapter explores the knowledge problems at the heart of gender affirming care, attending to how different providers, parents, and youth negotiate claims to know gender.

Chapter Four: "Just in Time" illustrates the specific temporal logics that ground the use of puberty suppressing hormones. Treatment with gonadatropin-releasing hormone analogues are often glossed as "fully reversible" by affirmative providers and most conventional medical experts, but described as having lifelong detrimental impacts by anti-trans opposition. In this chapter, I argue that the biological or chemical impermanence of these interventions enables a temporal logic of proliferating potentials, emphasizing how such an intervention responds to the pressing experience of puberty rather than the determination of a permanent gender identity. At the same time, I show how puberty suppression must respond to concerns about the prevention of future social and biological reproduction. Forgoing endogenous puberty for an exogenous one shapes youth's future fertility outcomes, as well as many embodied traits, providing the potential for youth to live with less of what Dr M calls CONSTANT NON-CONSENSUAL DISCLOSURE. But puberty also holds meaning as a time that, for some youth (and for some providers), provides a critical embodied experience of gender that can give young people more knowledge about their own desires for intervention. By drawing on my conversations with youth around their experience of puberty and puberty suppression, I complicate the dichotomy that takes puberty suppression as an intervention which does *nothing* or *everything*, attending instead to what blockers do as they are prescribed and utilized.

The last chapter, Chapter Five: "FOR THE REST OF YOUR LIFE," attends to the use of estrogen and testosterone for youth during and after puberty. Drawing out the multiple valences of the notion of THE REST OF YOUR LIFE, I highlight how care is oriented towards the prevention of REGRET and suicide, and note when practices might cultivate the potential of gendered embodiment. Throughout the chapter, I stress the dynamic relations of dependence that structure how youth itself is conceptualized, tracing the role that certainty and age have in delivering to youth the power to make decisions about their bodies and their futures, while also attempting to understand why the threat of suicide is so dominant within the discourse of justifying care. For while the threat and reality of suicide deeply shapes trans care, the representation of affirmative intervention as primarily a good tactic for suicide prevention has the consequence of transforming the persistence of suicide and suicidality as a failure of affirmative care, which fails to recognize the ongoing and intersectional challenges many youth live with that are not addressed by gender affirming interventions on their own. However, experiences from youth demonstrate how gender affirming care can be valued, and valuable, even if it is not always life-prolonging care, and even as it acknowledges the possibility that their future self might not make the same decisions they do today. Furthermore, I show how youth navigate the complicated relational commitments to those who might be attempting to prevent their access to transition by articulating the difference between their needs and others, often deciding to take on the risks of intervention by insisting, as Cam does, that "it's my happiness I live with."

Interspersed with these chapters are four interludes, which present selections of empirical material uninterrupted by my own interpretive voicing. These selections are intended to draw attentions towards the permeability of the clinic itself, as its own self-containment is breached though changing policy norms across the US and with every entry and exit of an employee. They are also moments that highlight the unstable boundaries of academic work, that highlight the theoretical understandings of my participants around gender, and the ways in which my own research protocols must operationalize concepts just as the providers and researchers I follow do. I hope those brief moments might briefly jostle or disorient readers, productively inviting in a sense of navigating an always changing terrain that so deeply shapes how gender affirming care is provided and experienced.

INTERLUDE: DEFINITION

In many of my interviews with clinical and research experts, and even with young people, I would ask them,

What is your *quick and dirty* definition of gender?

For those less inclined to think about definition as a practice they were interested in, I simply ask,

What does gender mean to you?

***

IT'S THE HARDEST DEFINITION! [laughing] It, every time it comes up, it's the hardest definition. We can all talk about gender identity. We can all talk about gender expression. We can talk about that. I think that, um, I think, ugh, I *hate* defining gender.

(Yeah, it's bad, right.) [also laughing]

Well, because I think that like - just to step back, I think defining gender is, is actually a very individual definition. Um, I think I, I feel like my definition of gender is not *the* definition of gender, um, because, because I think that gender comprises for different people, um, components of gender identity, gender expression, and how society, you know, society defines that in a particular area, which is very culturally based, um, interplay of how we're read and how we want to be read, um, based on our bodies and based on how we think, and based on various personality traits and attributes that we are ingrained to think are associated with a particular way of being. So that's my complex definition of gender that is not, uh, it's a *non*-definition definition.

***

I guess for me, its just, I feel like for me it's just, it's such a SOCIAL CONSTRUCT.

***

.... it's like wherever you happen to live at that place in time, sort of the norm or consensus of what people think about it, but it's not a real thing. So for me, its sort of like, how you choose to express yourself within that structure that's put, that you're, you're placed into. That's for me, I always like imagine what if there was nothing. Like if there was just a far away planet and, or like a desert island, I just think I would be so different.

***

I don't know. Gender is a lot of things. It's just how a person feels about, um, man, I dunno, gender is this thing that comes from within, right. We can't say what it is for another person. And, um, it could be, um, uh, one thing or many things.

***

The issue is people want to define gender as something simple. And it's not simple. They want to say it's male or it's female or they want to, you know, because that's what our brains can wrap around. Um, or they want to say, Oh, *it's the clothing that you wea*r or it's *what you want to do* or you know, and it's like, you know, people focus sometimes more on gender expression, then actual identity because they don't know what else to talk about. The DSM does that, right? For little kids, especially if the childhood diagnosis is all based in expression and like barely any of it, it's very, very minimal that's actually about identity. There's only one or two lines, right. Um, and so I think that makes it so much more confusing is that everyone has these definitions of gender that don't actually get at what gender is.

***

Oh, I don't know. Um, I never thought about that before. Um, I don't know, like probably kind of like, um, like, like how you kind of like, feel like you are inside? kind of?

Like[. . . .] like, it's not like what, like the, like what you like, like how you want to dress or how you wanna like act, but like, yeah.

Yeah.

I don't know. I feel like it's kind of like an instinct.

***

Its experienced different for different people, that's the premise, right. But I think beyond that... I think even our own gender can be experienced differently. It can be a chameleon of sorts.

***

I guess *quick* and *dirty* is probably just like someone's internal sense of themselves. And, you know, I think we traditionally think of it as male or female, but I think we know that that's, you know, male or female are so many other things. Um, but someone's kind of internal sense of who they are.

***

Um, how do you want to express yourself? Nothing to do with how you were born or like what you look like or anything. Just how you want to express yourself. How you feel?

***

Quick and *dirty* definition of gender is hard. Um. You know, a lot of times we'll say like, *how you feel*, on the inside, and that's really I think kind of a misnomer, because no one actually feels gender I think as far as a feeling within, or as an emotion. I think we bounce of off society, we bounce off of other people, as far as how they conceptualize us, as so a lot of times gender ends up being knowing who we're not.

***

I would say... like any other aspect of identity, gender is, um, a sense about .. how one... I guess how one perceives, um, their... no, I guess I'm, you know, it's so cha-what's challenging to me is like that it's such a dynamic, there's a dynamism to gender that I think I always feel at a loss when I'm, when I'm reading definitions or defining it because there's a tendency to just get essentialist, just because by nature it's an essentialist term. Um, and so, you know, it's, it's created to categorize.

And so that's really like where I try to transgress that and it's just very challenging ... for me. And, um, so I guess I would say it's an identity experience like many others that are tied to how we understand our place in the world, and relative to, um, our bodies, relative to other people's bodies, and relative to, um, kind of the cultural forces that are at play at any particular time.

***

Uh, and it is not solely biological and it's not solely social.. Um... and it's also not static across development. And so there are, um, internal kind of inter-psychic identity aspects to it, and there are behavioral aspects to it. Um, and they each inform the other. And I think when I, and that's sort of how I think about it, what I share with people, what I share with parents of clients who are struggling with their child's identity- I sometimes don't give them that whole definition. Because then it becomes sort of, uh, you know, um, almost like a deliberation or some sort of a like cross examination of, so y*ou're saying that as long as my child believes this* and that, and that's really not what I'm saying.

[....] So where I usually try to go is actually not in a lot of education right away because it's so intellectualizing that it really just creates a space where you then get into this like CONTENT and intellectualizing dynamic and it leaves, takes the parent or the caregiver away from like what actually in most cases is the blockage for them [...] we need to also have a space to like actually disarm some of all this logical, intellectual and values based rhetoric that actually contradicts what you've told me about who you are as a parent and what you want for your child.

***

Like, how do you explain to somebody your gender without, like, using genitals. It's really hard. [...] it just, it's like some... it's like trying to grab clouds.

***

It sounds simple, but people know their gender. And I think so many people get caught up in.. That it seems that gender is confusing. But the only confusing thing is when you're told you're a certain gender, and you're experiencing life as a different gender, and no one gets that. *That* is confusing.

***

CHAPTER 2

A HARD QUESTION: GENDERED DISTRESS IN A SOCIAL WORLD

On any given day in the Trans Youth Clinic, patients arrive with their parents, with their friends, with their lovers, their social workers, or, more rarely, by themselves, seeking gender related care. At the beginning of an appointment, a patient first sees a medical assistant or nurse, to get their basic vital signs taken. After vitals, they are shown into a different exam room to await their provider. This is when I would appear—hovering in the halls, clutching a clipboard piled with blank consent forms, eyes on the whiteboard which tracked what patients were at what stage of their appointment so I might optimally time my requests. Then, after a conversation which most times ended with consent for observation and sometimes for follow-up, I would take up a position left of the door, lean against the sharp edge of the counter, try to look natural, and take notes on everything that happened next.

> *Rita is 15 years old, and quiet. She and her mom seem close; they look at each other often, sit near one another, and crack inside jokes that Dr M and I can only smile blankly at. Dr M and Mom are talking about how Mom sees her own gender differently, now that she has a trans daughter. And Dr M comments that in her childhood, raised in a house with two scientist parents, they talked a lot about gender; one gets the sense this is deeply rooted in Dr M's familial understanding of gender as characteristic that disenfranchises women, in other words, gender as an unequal power relation.*[1]
>
> *Mom says to Dr M,*
>
> Gender is a SOCIAL CONSTRUCT.
>
> *Dr M muses back,* Is it, though?
>
> It's a core part of the self
> but it can't express in a vacuum.

---

[1] An understanding that some, such as philosopher Sally Haslanger (2000), put at the center of theories of gender, arguing that the meaning of gender is ultimately derived from social relations, specifically social subordination.

It's irrelevant - but it's totally relevant.

Rita teases them both, as she says, without any apparent malice,

You're both TOO OLD.

***

The question of the SOCIAL CONSTRUCTION of gender is inescapable in the world of gender care. As an adolescent medicine doctor and medical head of a gender identity clinic for young people in the United States, Dr M is an old hand at negotiating the sometimes contradictory views about what gender is, where it comes from, and how it can come to be a valid source from which to make clinical decisions about the body. I start with this particular invocation of the social construction of gender within the exam room itself as it also happens to demonstrate some of the prevalent dynamics in work with trans youth—where two adults have a theoretical conversation about the meaning of an identity held by a young person. In this case, Rita interrupts, playfully, but nonetheless draws attention to the question of whether or not their theorizing is good for anything, anyways.

The potential Rita highlights—that considerations of the possible SOCIAL CONSTRUCTION of gender is a question that is simply TOO OLD to be meaningful, at least as it related to her own understanding of, and desires for, medical intervention into gender—is a potential that subtly challenges the desire to see, in the lives of trans people, opportunities to work out philosophical claims about the meaning of gender, work that rarely provides any benefit to those same people (Namaste 2008). Nevertheless, the narrative of SOCIAL CONSTRUCTION was present ethnographically as well as theoretically, as a conceptual backdrop again which current bodily interventions were held up, and evaluated against. Occasionally, such narratives were perceived as a threat to the very basis upon which the logic of gender affirming medical intervention was challenged—after all, if something is a SOCIAL CONSTRUCT, shouldn't it be treated through social means?

This chapter describes how clinicians, providers, and young people manage the "hard questions" about the etiology of gender identity and gender dysphoria, the name given experiences of DISTRESS that stem from the perception of a disjunction between one gender identity and the gender they were assigned at birth, in an undeniably social world. I argue that theories about the social nature of gender (often glossed by my informants as "feminist" theories) have inevitably shaped how the gender affirming care has come to try and understand the relationship between gender as a "core part of the self" that nonetheless cannot be expressed "in a vacuum". As Dr Y put it to me once, the problem was not necessarily that gender could be understood as a SOCIAL CONSTRUCT but instead that such a rhetoric was often used to undercut the importance of gender itself, when "no, actually, it's a social construct that means everything, everyday, in every setting, to everyone."

The popularized version of SOCIAL CONSTRUCTION circulating in clinical and public discourse that I focus on in this chapter does not neatly track onto a specific theoretical scholarship, and my argument is not based on correcting or re-deploying such a theory.[2] Instead, I am interested in tracking how this understanding impacts current possibilities for care both in terms of potential and prevention. Specifically, I show how the need to respond to the charge (often only implied) that gender is merely a SOCIAL CONSTRUCT sometimes promotes a turn towards an understanding of gender as a biological potentiality, rooted in the interiority of the self, unaffected by social experiences. Yet, the response from the field as it is codified in diagnostic manuals and standards of care has also been to pivot towards the role of affirmative care as the prevention of gender related DISTRESS, as evidenced by the change in American Psychiatric Association diagnosis from Gender Identity Disorder to

---

[2] I draw upon small capitals in order to distinguish, in part, this version of SOCIAL CONSTRUCTION from the many particular theories, and theorists, of "social construction". Rather than assuming a coherency or stability to SOCIAL CONSTRUCTION, in my writing here I allow the concept to remain "black-boxed" (Latour 1999), in a sense, as it often was in the field, attending to the ways in which SOCIAL CONSTRUCTION operates as a "matter of fact" (Latour 2004), and often indexes an assumed social position, one that takes a liberal, feminist view towards gender as non-biological. However, the power of the concept undoubtedly maintains itself through the association with formal academic scholarship that aims to erase the given naturalness of gender categories; see, for example, Butler (2006), Kessler and McKenna (1985), and West and Zimmerman (1987) for several particularly foundational accounts.

Gender Dysphoria in 2013. The questions care providers then find themselves facing is how to determine DISTRESS due to conflicts around gender and DISTRESS due to other sources, as well as whether or not DISTRESS is, itself, a diagnostic necessity, or a preventable harm.

In this chapter, I describe how providers, young people, and parents approach the differentiation between forms of DISTRESS and reconcile their views, feminist or otherwise, of the SOCIAL CONSTRUCTION with evidence that seems to so often challenge what such a view would entail when it comes to the role of medical intervention. I argue that though clinical care has moved away from a model that largely attempted to prevent gender diversity itself, the move towards the diagnosis and treatment of gender dysphoria shares ties with that lineage; ties which are visible in a preventative clinical emphasis on the critical role of DISTRESS in distinguishing between youth who should and should not access affirmative gender care. Furthermore, the fear of treating the wrong patients, those whose DISTRESS stems from sources other than gender, is heightened in a world where the meaning and experience of gender identity itself is thought to be derived from social experience. To assuage this fear, the existence of the very youngest gender expansive people, the pre-pubertal youth fondly called "the Littles", then circulates in the field as a way of evidencing gender that is innate and unassailable as evidence.[3] Despite the fact that there exists no medical intervention before puberty, I argue that it is the experience of the youngest patients that is central to the management of anxieties linked to the theorization of gender as a SOCIAL CONSTRUCT and a learned, rather than innate, quality of self.

I do not argue that this is an explicitly intentional move, or one that is particularly deterministic. Rather I show how explanations of gender as biological or innate might become more significant, and in some circumstances necessary, when gender itself is rendered unstable because of its ties to SOCIAL CONSTRUCTION; a non-causal, yet significant relationship [4] that

---

[3] As Davis, Dewey, and Murphy write, "Looking at childhood to construct a giving gender narrative serves as a necessary, yet problematic, proxy for proving that gender is biologically determined." (Davis, Dewey, and Murphy 2016, p. 499).

[4] One that resonates with how Eric Plemons (2017) has described the relationship between theories of gender performativity and the rising significance of procedures, like facial feminization surgery, that

also reveals the ongoing impacts and reformulations of theoretical projects often assumed to hold little impact over the realities of peoples lives. In other words, I approach this "essentializing" discourse (Schilt 2015; Spivak 1988) ethnographically and with attention towards the strategies it reflects and effects that it has.

But another thread is co-present with these many valences of prevention, which challenges the role and necessity of DISTRESS itself, and forwards an ethic of potential, where youth who just might *take you up* on the offer of affirmative care deserve access to it, regardless of the source of that desire or its permanency. In this case, the Littles are not reduced either to pure plasticity, or to evidence of true essential gender identity, but understood as holding a rare experience of gender no more or less valid than any other. In this way, I also suggest that rather than creating yet another false binary, this time between treating gender socially and medically, that it is through the access to and use of affirmative gender interventions that gendered social expectations and norms can also be changed. In other words, treating gender medically is also, already, treating gender socially, and might be essential in creating the conditions of possibility for enactments of gender that extend how gender categories are signified in relation to the body.

This Didn't "Develop": Gender Identity Among Pre-Pubertal Youth

"I'm probably like more essentialist than like your average feminist," said Ingrid, an academic research psychologist with decades of experience analyzing, constructing, and implementing gender related measures. Ingrid was not the only practitioner to explicitly invoke a feminist history when describing her own understanding of what gender is, and how it shows up for young gender expansive people. Sarah, a clinical psychologist several states away, works in a University setting (one of three in the city she lives in) as well as in her own private practice. She, too, told me about how she "had always identified as a feminist," telling me, "really probably for a while, I really thought of gender identity as being totally socially

---

understand gender as a process of social recognition.

constructed."

For Sarah, as for Ingrid, what has reshaped this initial feeling of the "total" social construction of gender is their work with very young gender expansive people, the rare but profound cases of 4-year-olds who come into spaces as fixed and determined about their gender as any cisgender kid. These are often the young people we see highlighted in the media and in popular narratives of trans kids. Young people such as Jazz Jennings, first made famous at six years old by her interview with Barbara Walters on a 2007 episode of 2020, or Jenny, whose mother and I talked on the phone after we had met one day in clinic. Jenny's mother told me how Jenny used her parents old camcorder to tape herself asking to be called girl, not boy.

> She brought it to me in the morning and said *I want you to watch something really important.* And then she ran off and hid. So I watched the video and she came back and said, *do you see why it's important?* and I said, *I do honey.* I said, *I do.* I said, *do you, are you feeling like you want to be a girl?* And she said, *no, I am a girl, I am a girl.* And I said, *Oh.* I said, *well, you know boys can wear whatever they want to, and like girly things,* and then she said, *but I'm* NOT A BOY. And I said, *okay, okay.* So at that point I was like, [she laughs a little] I had never heard of, you know, like a child that young expressing any sort of – anything like that.

The Sony camcorder that Jenny used to record her message, a toy that she liked to use to leave little videos for her parents, became the last in a string of events that started before Jenny was four which, taken together, indicated to her parents that *something* was going on. But even though they weren't surprised at her wanting to be "called girl", based on her interest in growing her hair long, the kinds of things she liked, they still weren't sure what to do with this admission. So they went to the place they hoped would have answers—the doctor's office.

The "Littles", as children like Jenny were affectionately called at the Trans Youth Clinic, were a minority of the patients I would see while shadowing providers. They were only slightly more present at conferences and during the other fieldwork activities I conducted between 2015 and 2019. Yet, their presence is unmistakably important in expert narratives (the ones that are circulated as authoritative texts through venues like journals and public presentations) about gender expression, experience, and in answer to the oft felt, sometimes stated, question of the relationship between gender transition and messy social forces.

The presence of young gender expansive people in these expert narratives serve as evidence which can reshape views about the innate or biological components of gender. Many of the providers and experts I worked with would reference a generic thought experiment about the social world of gender and how it might impact the desires of the youth they saw, in particular how it might be pushing youth to express their gender in predetermined ways. It was the "desert island" experiment, or, for one doctor, the "in space" way of thinking of gender; if we lived in a vacuum, alone, isolated, would there be any reason to want to change your body? Would we have a concept of gender? If we went there, to that place, it is difficult to imagine having any kind of response at all; stranger still to try and understand what someone like Riley would do, without parents to leave a note for, or grocery store clerks to avoid, or dresses to lust after.

> *On the floor of Dr. M's office, Riley and I have a small heap of little toys and objects. It was ten or twenty minutes into her appointment, and Riley had become increasingly impatient with her parents' recital of her gender history. I gave up writing field notes from my chair by the wall, and unobtrusively sat down on the floor with her. It felt a shame for a family that had crossed three state lines to be here, after months of waiting, to split their attention between entertaining a bright and busy four year old and talking through a vast world of anxieties about their kid and her future with an authoritative source. From my current position, I could help with only one of those things.*
>
> *Riley had already unwrapped a handful of new toys, selected from a substantial box that Dr M kept for this purpose. Still, it isn't much fun to play with yourself. Boxed in by the knees of her parents on the one side and those of Dr M on the other, I quietly took one long piece of green waxed string, curling it up into a spiral with a little tail. Underneath the cloud of* PUBERTY SUPPRESSION *and* HER BATHROOM ISSUES *and* WHEN WE TOLD MY PARENTS *that hovered above us, I say to her, in a low voice,*
>
> look.
>
> it's a snail.

Riley likes this, so I make her glasses, a bicycle, a tightrope to hang things from, all out of the flexible, waxed string in muted yellow, purple, blue, red.

can you make me another one?

sure.

I fold one end of the string in tightly and begin to roll.

do you want to try it?

I whisper to Riley, who is less concerned with disrupting the conversation happening above our heads. Carpet lint gathers on my pants and my loose shirt, the one that masks some of my own gendered signals, and likely contributed to Riley's earlier confusion. After Dr M had disappointed her by saying that she doesn't actually make vaginas, *Riley had switched her attention to me, asking,*

> how does HE do it?
>
> *as I wrote furiously and missed the question entirely.*
>
> *Dr M laughed, told Riley*
>
> HE is not a surgeon either! *and,*
>
> IT'S NOT A VAGINA THAT MAKES YOU A GIRL..

now you have no eyes!

and you have to answer
a hard question!

oh!

I close my eyes. One of the ropes has caught the bicycle. To free it, and regain my sight, I have to answer Riley's trick question. She makes them up on the fly, seemingly pulling from what is around her to recreate something that sounds familiar.

what has .... is round and has three legs and is a door?

a lunch box?

ye-es! Alakazam...

She waves her wand, also made of waxed string

now you have eyes again!

* * *

This game Riley and I play on the floor is an ordinary kind of "worlding" (Haraway 2013), a term I use to connect these "string figures" to the many other forms of SF—science fiction, speculative fabulation—that offer ways to see relations and truth[5]. While being altogether unique, this moment still manages to encapsulate so much of what troubles the clinical treatment of gender. Riley takes my eyes, and gives them back, if only I can provide the correct answer. Lucky for me, she wields her power benevolently, but the game mimics to me the ways that our "hard questions" about gender are impacting her capacity to envision the future with the body she wants. Where the reminder that IT'S NOT A VAGINA THAT MAKES YOU A GIRL sits as a representation of the SOCIAL CONSTRUCTION of gender, but the desire to *have a vagina* nonetheless remains

Many of the physicians, nurse practitioners, social workers, and psychologists I talked with waved away the question of social construction as fundamentally irrelevant to practice. People do not live in isolation, on islands or moons without the context of a social world to shape their selves. In my interviews I occasionally prompted reflection about the relationships between interventions which target phenotypic traits and understanding of how the social world shaped the experience of the body as gendered. Other times, the concept emerged organically, if less likely to be named as SOCIAL CONSTRUCTION. Take, for example, a research team meeting, where members discussing how one might measure a socially

---

[5] I am thinking about the work that Riley and I did, there, on the hard carpet, as an ordinary kind of worlding that all people might participate in. In a speech to the Science Fiction Research Association, Donna Haraway (2013) remarked upon Joanna Russ's novel *The Female Man,* (1986) drawing attention to the use of cat's cradle as the sign of peacemaking, and the pattern-making recognition which allows such signification. Making string figures, Haraway suggests, is another form of SF (in all of its multiplicity) that can be taken as scholarship, and as world-making. I highlight this game I play with Riley to amplify the creative potential of this moment, where we are not playing string games precisely, but we are playing games with string; where we exploring the potential of the world and her power to shape it.

influenced level of DISTRESS, that is, unhappiness which might be best attributed not to a de-contextualized set of physical attributes, but rather to the prevalence of transphobic environments.

In one such meeting a handful of team members were gathered to discuss what they colloquially called THE BAD SCALE. A primary object of the next chapter, THE BAD SCALE is intended to measure gender dysphoria, or the feelings of discomfort and unease related to a disjunction between the gender one was assigned at birth and the gender one feels themself to be.[6] Many on the team thought it only reinforced gendered stereotypes about feminine and masculine behavior and the *right* way to be trans. Beau, a research coordinator, was reporting back to us on how the small focus group he ran of trans-identified staff members discussed the role of the social in their brainstorming session on how gender health (in contrast to gender dysphoria) might be measured. He brought up the ways in which people craved an explicit admission of how social expectations, structural cisgenderism, and its intersections with other identities like race, negatively impacted their ability to see a way towards living a good gendered life; that it was those things which spanned far beyond the walls of the clinic which really produced the poor health outcomes gender affirming care tried to improve. But Max, a medical doctor and the principal investigator, was concerned with overemphasizing the impacts of the social, despite her consistent recognition of its importance.

> *Max sat at the head of the table, as usual. She was railing at the general* ASSHATTERY *of the world (also as usual). In particular, the kind of sentiments which prevent people living healthy and satisfying lives. Max also wanted to warn against all this emphasis on* what if the world were different, *because she is interested in collecting data about what happens with phenotypic gender changes, not just social ones.*
>
> Parents say to me

---

[6] A label that is often, but not always, synonymous with the diagnosis of “Gender Dysphoria” adopted by the American Psychiatric Association (2013).

well if there's more acceptance,
everyone would be fine.

The flip side of POOR COPING is YOU'RE SPECTACULAR!

I don't want us to get to this place of

if we get to GENDER UTOPIA...

***

Max grumbled as she spoke, clearly unsatisfied with the notion that all concerns of trans people would be met through enough shifts in social expectations. No amount of *acceptance* can transform an un-bearded face into a bearded one, and as she well knows, sometimes that's exactly what a person wants. She left unsaid the implication of returning, again, to the imagined space free from gendered social expectations and outside of current gendered reality, but I imagine that it is a worry about relegating the use of medical intervention to merely that of a stopgap measure. A quick fix, until the world started to be less gendered.

While Max, too, wants to imagine the world where gender diversity might be celebrated, she believed in the world where it could be celebrated through the use of gendered medical interventions like hormones and surgery. As much as she would be happy to see folks who didn't want to use those interventions living their best lives without them, there is a subtle disavowal of the notion that the need for gender affirming medical care itself could be prevented through increasing the potential to signify gender differently. Instead, she sees medical care as always having a role, GENDER UTOPIA or not.

Sarah also named this sentiment, in the third installment of our interview, telling me

> you know, that just that whole argument of *if society was more accepting of, you know, men doing more feminine things and women doing more masculine things*, like would people feel that need to be transgender, you know, people still, bring that up. Definitely like in the early, early days, [I had to] grapple with that a little bit just because I'd come from such a feminist perspective, like sort of like gender being socially constructed and *blah, blah, blah, whatever.*

By tying in her own early views, ones she comfortably understands as “a feminist perspective”, Sarah illustrates how highly educated professionals, in particular, must sometimes overcome their own biases against what it means to understand gender as a social category. She, and others like her, must reconcile such understanding with the knowledge of the importance of affirming a person’s experience of gender, including if and when they might choose to bring their bodily traits into further alignment with social expectations of what men and women should look or be like.

Ingrid told me that “even though I’m like incredibly feminist in my thinking… I think because of my work with trans stuff I feel like a lot of gender is like, people bring it with them, when they’re born, I just hear that so much, that I can’t, I can’t think that it’s not true… that there’s not some truth to it. That some people are just physiologically, they just act, in a more masculine and feminine ways.” She laughs, and tells me, “I guess I’ve just seen too many two year olds, like [laughing] you know, there’s just no way that there not some element of that that comes from the body, right?” Her comment leverages the figure of the two-year old gender expansive child, a figure which has undoubtedly changed how trans medicine is practiced, both in how it is conceptualized and who it is imagined to be for.

Knowing a “2-year-old” who expresses a gender that is incongruent with their sex assigned at birth is a unique experience for experts as well as parents, one that challenges understanding of bodies as purely “plastic” as Gill-Peterson (2018) puts, able to embody any gender with the right conditioning and circumstances. While trans gender youth are not new, as Gill-Peterson argues, they have become increasingly central in the field of affirmative care, and their rising visibility has forced a reckoning—both in public and in professional spaces—about the kind of characteristic gender is envisioned to be. For example, Ingrid, who trained in adolescent developmental psychology, had to adjust how she understood when gender became a core part of identity in order to account for the existence of pre-pubertal gender expansive youth. She told me about how she always thought that, “like sexuality”, young people's knowledge of their gender—if it was different than the gender they were assigned at birth—would be formed in the teenage years, by way of experimentation and experience (neither of which are associated with prepubertal youth).

At the same time, Ingrid admitted that she didn't really think too hard about these young people until they appeared at one of her first focus groups. She went on to tell me a story about two boys, with similar narratives; how they started carrying "boy's" clothes to school and changing on the way, how their teachers' were the ones to call home asking after "your son" only to be corrected to "my daughter", and how these young people were affirmed and happy when she met them. They played sports, had friends, and overall, had different experiences of parental support than some of the other trans young people who frequented the spaces she had been conducting research at across the United States. She said, "...meeting those two kids was just eye opening for me. Ok, these two kids had gender, this didn't DEVELOP as an identity, this is something that was just THERE. And then it was expressed. It was well before anyone was really talking about publicly, in the United States, really talking about identity that way."

Identifying Distress

The impossibility of knowing precisely how gender identities come to be felt and expressed structures how providers guide parents towards recognizing the inevitable uncertainty of a life course, and the inevitable uncertainty of the process of diagnosing and treating "gender dysphoria" (the current clinical diagnosis applied to most gender expansive people seeking medical intervention). Though there are no medical interventions for young people before puberty, the clinic is a central location for families to work out their concerns about what constitutes affirming treatment along with who should access it. Families often put providers into the awkward position of becoming an arbiter of "true" gender, an expectation that some providers attempt to fill with long intake interviews and questionnaires, and others find impossible. As Harley, a social worker with the clinic, put it to me in a casual interview one day, “Parents come in here wanting, a lot of times, wanting an assessment, right? They want to know- *is my kid trans?. . . .* So this is a really big question. *Harley, is my kid trans? By the end of this visit, are you going to be able to tell us, if in fact, my kid is trans?* To which I will have to break it to them. . . . *There is no assessment for your kid being trans or not.*” In our conversation, Harley stresses the significance of the person, no matter how young, as the ultimate authority on their own identity.[7]

The very notion of the authentic, interior self that can be revealed and thus treated is contested among both providers and scholars. Sahar Sadjadi (2019) who writes about contemporary trans medicine for youth, argues that the field is oriented towards finding an interior truth, linked to the sanctity of individual selves. Sadjadi describes practices such as when doctors discuss the underwear a young person wears as indicative of a “truth” of gender.[8] Yet, what Harley and the other providers understand their role in the gender clinic to be, is not to determine the gender identity itself, but rather, to ascertain the level of clinically relevant DISTRESS experienced by the young person, and to reflect with them if gendered intervention is going to reduce that distress. Relying on DISTRESS as a metric is challenging, and not all young people are as forthcoming as Jenny and her video recorder. Many parents simply think of their five-year-old as someone who last week, *wanted to be a dog.* If they do decide to shape their child’s experience, proving a framework for them to understand their DISTRESS through the lens of gender, other adults and community members often use this as an opportunity to undercut the legitimacy of a child’s identity.

Leah scrolls through photos on Mom’s phone, bored with the conversation. She

---

[7] The following Chapter expands upon the epistemic difficulties of claiming to know gender as it related to the importance of crafting evidence from which to justify medical practice and standards of care.

[8] The practice of looking towards underwear as a significant marker of the “true” gender identity of an individual was never used in the clinical spaces I frequented. I believe it has fallen quite out of favor as it was usually only mockingly referenced. The relative skepticism of almost every provider I met towards this practice and other like it lead to me to question how applicable Sadjadi’s findings are towards the most current iteration of gender affirming care, and at the very least, I find that the political implications of her arguments, which have been used to emphasize restricting interventions like puberty suppression, to be built out of a misunderstanding about what expanding the potential of the gendered futures could requires in terms of access to material, bodily interventions.

occasionally interrupts the conversation happening primarily between Dr Y, Mom, and Dad to show off something to Mom, her purple suede boots dangling off of the end of the paper-covered exam table. She wasn't sure that kindergarten was a grade, when we were talking earlier, but either way, she was just about to start in the fall. Leah's leggings have small black hearts on them, and she occasionally smiles or giggles to herself as she sees a photo that brings up a fond memory, or maybe just looks silly.

Dad talks about the anger Leah used to have. He calls it PRIMAL RAGE. *Now, she just gets mad. Like a regular 5-year-old.*

You know, she's sassy.

her mom says. Both parents talk about how they are

so lucky

that she is

so verbal

as Dr. Y explains how it's rare to be of trans experience, and even rarer to know so young. Even if they have a thought, it's usually crushed *he says.*

Dad describes their community as THE LAND OF MEGA-CHURCHES.

Where people think we went wrong, is that we gave her the language.

We told her

> we think you have a girl brain, in a boy body.
> That's called transgender. And she was like
>
> > oh,
> > well, that's it.

We didn't confuse her.

We relieved her.

* * *

They had been accused of "confusing" Leah by their community. If only they had focused on preventing a trans future, rather than attended to the potential of it, perhaps she would have continued on as an angry boy, made do a little longer. Leah's parents rolled their eyes at this, despite feeling torn at past moments. They still opened up to the possibility that things might be different, sharing with us their daughter's recent observations that *it was easier to be a boy.* Dr Y asked the parents, *what if she does wake up one day, and says, it's just easier to be a boy?* Mom replied that she would say*, I love you, okay, have a nice day* and pulled a face at Dr Y, and then me. Her expression says, well, what else can you do?

Operating from a space of potential here also means grappling with and accepting a level of uncertainty, accepting the limited control one has; seeing, as Leah's parents do, their role as fostering Leah's ability to exercise choice in how she presents as a gendered person, even if she might choose differently in the future. While Leah's parents saw her PRIMAL RAGE as an expression of DISTRESS, it wasn't until they gave her the opportunity to show them that she wanted to be gendered differently that they linked that DISTRESS to gender specifically. The pivotal moment came when Mom took Leah to Target, to pick out two things, *from anywhere.* Leah went directly towards the items that cried out GIRL in the biggest, pinkest, fluffiest GIRL way. For them, this was enough information to see that Leah had the potential to be happier living more as a GIRL. Yet their community, sure of the power that parents and other social influences have over a child's identity, suggested that Leah's parents provided a possible solution that could have been prevented. Beyond the way this shows how anti-trans sentiment permeates an environment, such a view also complicates seeing young children as the examples of untainted gender identity. Rather, here, Leah's youth is also her vulnerability—her potential openness to confusion, to being mislead—as well as being a rationale for minimizing her gendered desires.

In her parents description, Leah was undoubtedly happier now, making them feel more confident in the steps to socially transition their son to their daughter. What parents and providers often agree upon is that affirming gender care counts as effective when young people are happier and healthier—less depressed, anxious, doing better in school, or simply able to enjoy life in a way they didn't before. Sometimes, especially for very young people, this involves a level of experimentation, allowing young people to embrace a different gender expression and then checking in on how they feel or act once permitted to do so. This thread within the affirmative care model that picks up on the potential benefits for young people who desire to be affirmed in a gender other than the one they wee assigned as birth, even temporarily, stands in opposition to the once dominant clinical view that gender identities in youth could be shaped with consistent behavioral enforcement of gendered expectations and norms (Zucker 2018), and sees trans identities as ones which should first attempt to be prevented. As such views have fallen out of favor,[9] a subsequent effect has been the entrenchment of DISTRESS as the object of treatment, rather than gender identity or expression itself. Yet centering DISTRESS comes with its own set of challenges and complications.

Depathologization and the DSM 5: Centering Distress

Insurance denials are common conversation during weekly staff meetings. The team, including the financial advisors who deal with insurance companies the most, always try and help families realize that they should expect at least one round of denials when submitting for coverage of procedures like puberty blockers and some surgeries. The warning rarely softens the sting.

> *Today Dr M has brought in an insurance denial. She wears the iconic black Danskos of people who work on their feet, popular especially among nurses and chefs. Her glasses are off of her face, resting on the table as she reads aloud.*
>
> . . . Our reviewer has determined your features are within the normal range for females
>
> *Someone else mentions how there is a counterargument about* mental health need.

---

[9] Although as I will argue in the following chapters, these logics nonetheless persist, most frequently through the focus on the future to be prevented. Though treatments that explicitly attempt to reconcile youth with their gender assigned at birth are no longer explicitly endorsed by major medical groups, such desires are palpably present in current waves of legislation that I describe in the following interlude and chapters.

> *Under her breath, Rachel, a therapist and social worker says,* DISTRESS. *Whether he heard her or not, a doctor repeats*
>
> WPATH says its really about DISTRESS.

***

WPATH, or the World Professional Association for Transgender Health, is the current iteration of the organization founded in 1979 as the International Harry Benjamin Gender Dysphoria Association. The group formally came together after the the 6th International Gender Dysphoria Symposium (*History - WPATH World Professional Association for Transgender Health*). Endocrinologist Harry Benjamin, author of *The Transsexual Phenomenon* (1966), was well known in the United States for his openness to treating gender medically, standing apart from the psychiatric and psychoanalytic work of many of his contemporaries (Meyerowitz 2009). Since its inception, WPATH members from a number of disciplines have collectively authored the Standards of Care (2012), one of the documents often referred to when justifying medical intervention to insurance agencies attempting to deny coverage.

Though the language of gender dysphoria dates back to these original formal associations, within the world of diagnosis and treatment, gender dysphoria has only recently resurfaced as the primary framing used by biomedical and mental health providers. Within the United States, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), remains the primary diagnostic tool used to identify the need for, and legitimate, gender-focused medical care. In 2013, the DSM published edition 5, which dropped the diagnosis of "gender identity disorder" (GID) and introduced "gender dysphoria". GID and its companion diagnosis of "transsexualism" had been in the DSM since the DSM III, which was published in 1980 (Zucker 2010). Though the DSM is not the only relevant diagnostic framework, for patients in the United States the DSM remains the primary diagnostic tool used to legitimize intervention and obtain necessary insurance coverage.[10]. Yet while the DSM provides the diagnosis, as a manual for all mental disorders it is not designed to

---

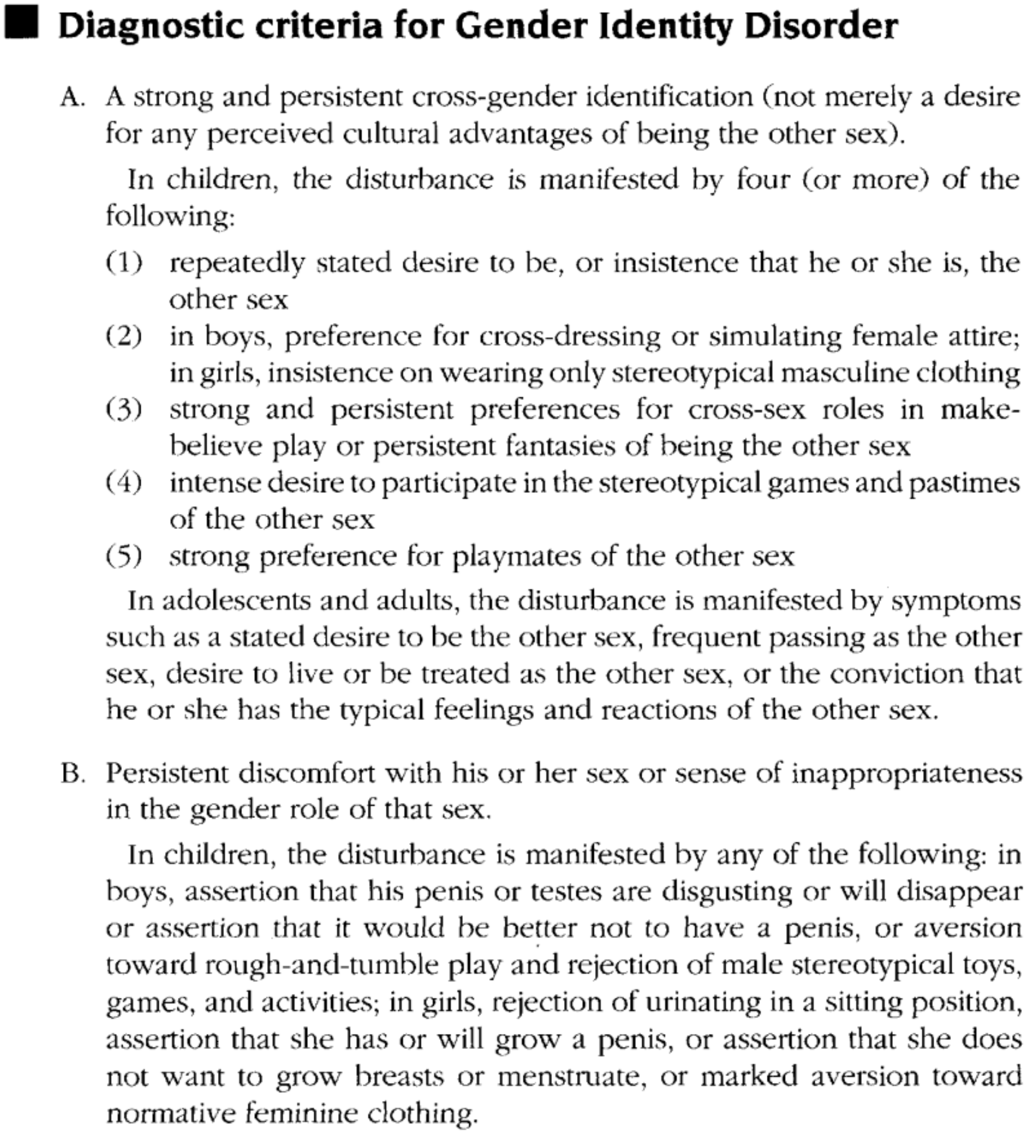
[10] The most notable alternate being the ICD—see the World Health Organization (n.d)

provide an in-depth look at any single condition. So both the SOC and the DSM co-exist, with all of the inherent coordinating complications of two documents with different origins and stakes.

In the first published Standards of Care, gender dysphoria is described as "that psychological state whereby a person demonstrates dissatisfaction with their sex of birth and the sex role, as socially defined, which applied to that sex, and who requests hormonal and surgical sex reassignment" (WPATH 1985, p 81-82). As Sandy Stone (1992) describes it, for a brief moment before the advent of academic gender clinics, surgery was available to those who could make the case for it. Yet beginning in the 1960's, academic gender clinics emerged. In such spaces, a more comprehensive methodology for accepting patients was required. Before diagnostic criteria, Stone writes, the act of asking for surgery was taken as one of the defining moves of a "transsexual". But unsurprisingly, the need for a "objective, clinically appropriate, and repeatable" (Stone 1992, p 9) test for gender dysphoria quickly took hold within the field. The subjective feeling of being "in the wrong body" (p 9) was too capricious for legitimate medical science to lean on as a grounding for interventions as substantial as hormone replacement therapy and surgery.

If "transsexuals" were once understood by medical providers as those who came to request intervention into the body on the basis of gendered identification, paired with a level of clinically perceptible DISTRESS ("dissatisfaction") then looking at the contemporary criteria shows, in some ways, remarkable continuity. But despite such continuity, looking towards the moments where change was possible, or happening, reveals some important tensions within expert communities about the role of diagnosis and how DISTRESS is operationalized. Unpacking moments of revision, in particular the work which led the DSM to adopt the language of "gender dysphoria" in the fifth edition, reveals some of those tensions—including complex ways of navigating the notion of DISTRESS in a social world.

In 2009, WPATH put together a set of working subgroups in order to provide their rec-



Diagnostic criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

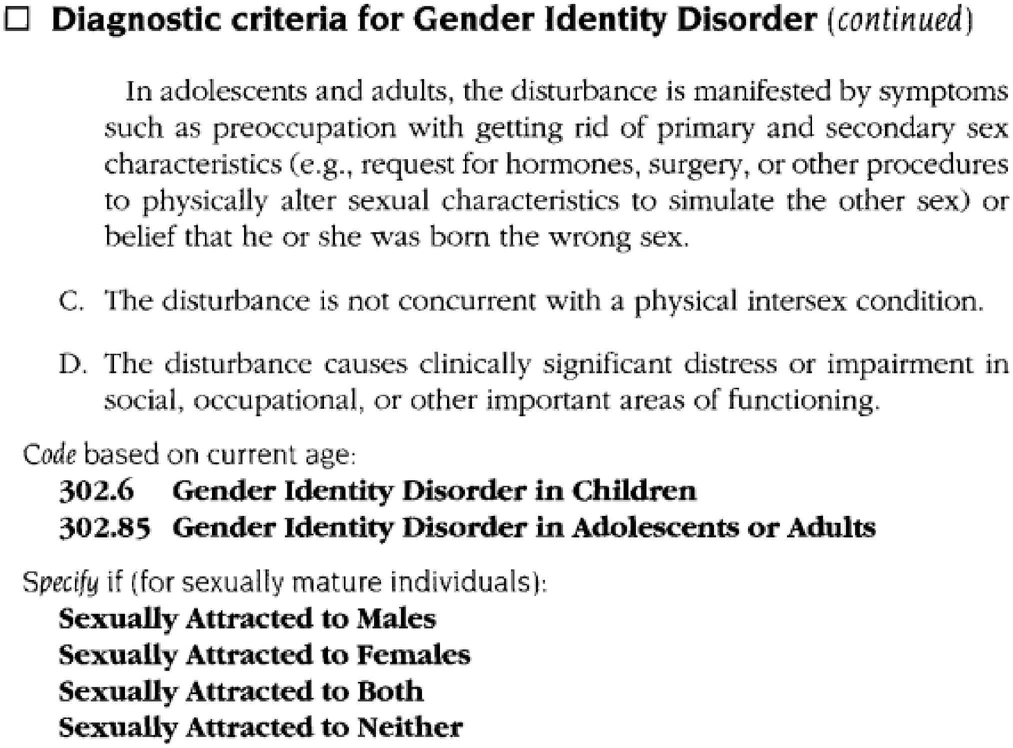
(1) repeatedly stated desire to be, or insistence that he or she is, the other sex
(2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
(3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
(4) intense desire to participate in the stereotypical games and pastimes of the other sex
(5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

Figure 1: DSM IV Criteria for Gender Identity Disorder in Children



☐ **Diagnostic criteria for Gender Identity Disorder** *(continued)*

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

302.6 Gender Identity Disorder in Children
302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Sexually Attracted to Neither

Figure 1, continued: DSM IV Criteria for Gender Identity Disorder in Children

ommendations for the diagnostic revision to the APA's then-diagnosis of GID.[11] To balance the pragmatic utility of a clinical diagnosis with the widely accepted professional understanding that being transgender is not, in fact, a mental health condition, WPATH stressed the important of renaming and relocating the diagnosis. In the executive summary, WPATH argues for the language of "gender dysphoria" over "gender identity disorder", writing that "the diagnostic criteria should focus on distress, not identity" (Knudson, Cuypere, and Bockting 2010, p. 116). Though there was no consensus as to whether any diagnosis should be included in the DSM at all, may argue that current realities of health care in the US demand the continued listing of a diagnosis which can be used to bill insurance.

As "dysphoria" specifically describes distress or discomfort, the eventual acceptance of this nomenclature within the DSM reflects an increased effort to de-pathologize gendered

---

[11] There were nine working groups comprised of 37 WPATH members, and many groups published their consensus statements in a 2010 volume of the WPATH flagship journal, the *International Journal of Transgenderism* (itself retitled in 2020 to the *International Journal of Gender Health*).

Diagnostic Criteria

Gender Dysphoria in Children **(F64.2)**

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder/difference of sex development (e.g., a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome).

Coding note: Code the disorder/difference of sex development as well as gender dysphoria.

Figure 2: DSM V Criteria for Gender Dysphoria in Children

behavior and appearance (F. Beek, Cohen-Kettenis, and Kreukels 2016). In other words, it attempts to accept that people may experience conflict between their gender identity and the gender they were assigned at birth, and to clarify that the DISTRESS due to that conflict, rather than the conflict itself, is the object of treatment. So while DISTRESS has always played a role in the clinical understanding of what constitutes transgender experience and identity, recent attempts to rectify older views which took all transgender identities as inherently problematic (and as legitimately categorized as psychiatric disorders) have effectively further entrenched DISTRESS as the logic necessary to de-pathologize gender identity.

The WPATH consensus group tasked with examining the specific role of DISTRESS, previously criterion D, describes the significance of the "bidirectional" sources of distress (Bouman et al. 2010). They foreground how experiences of minority stress, stigma, prejudice, and other socially-derived sources of DISTRESS must surely complicate any clinical ability to differentiate between DISTRESS due solely to internal gender conflict, and DISTRESS shaped by factors deemed external. Pointing out how many DSM diagnoses include DISTRESS as a core definitional symptom, they question the diagnostic utility of such a measure, asking if it is even possible to determine, clinically, the location or source of DISTRESS.

Yet, at the same time, authors claim that requiring DISTRESS to be both "severe" and "persistent" will prevent those who are more likely to REGRET intervention from being able to access treatment (Bouman et al. 2010, p. 104). Thus, despite the significant critique of DISTRESS as a concept, the WPATH consensus process eventually favors a diagnosis fully-wedded to the notion, as well as provides a set of expectations about the need for providers to identify the right kind of DISTRESS before they offer any intervention. This, I argue, is deeply wedded to a vision of trans care that is ultimately preventative care, and which reinforces a view of affirmative intervention that is always that last possible solution, offered only when all other potential causes of DISTRESS, social or otherwise, are eliminated. In other words, it is a version of care that seems to focus more on the anxious possibility of treating the wrong patients rather than the benefit of serving the right ones.

DISTRESS is a very real, and very present aspect of the experience of many trans youth. Rates of suicide, depression, and self-harm are one way to understand that (Johns et al. 2019; Kosciw and Gay 2014; Olson et al. 2015; Thoma et al. 2019); another is simply to be present in the lives of the people who are or who care for trans youth. So none of this is to say that DISTRESS isn't meaningful, but rather, a clinical logic, DISTRESS brings with a new set of problems and stakes in the attempt to de-pathologize gender identity while making space for individuals to access bodily intervention. Considering diagnosis as a practice which binds individual to social institutions and systems (Rosenberg 2007), one can also imagine how increased emphasis on DISTRESS in the diagnostic process could bind a certain form of suffering to the experience of gender diversity. Furthermore, the attempt to garner specificity around the form that DISTRESS takes will never be enough to stop questions about the social relationship between the body and DISTRESS; the persistent fantasy that clinical experts will be able to clarify a true source of bodily dissatisfaction, untainted by messy social worlds. And sometimes, it creates an environment where the iconized versions of trans youth are those who can turn towards their body as *something to hate.*

Something to Hate

It is a common conception that more trans feminine young people come to the clinic at a very young age, particularly when compared to the surge of trans masculine folks who would appear at or shortly after puberty. Shared explanations for this included physiologic and anatomical difference, in particular, that there's *nothing to hate,* for a boy until he starts to grow breasts, unlike for a trans feminine person who might experience intense distress at her genitals from a very early age. Additionally, there are the myriad ways in which embedded social expectations for correctly gendered comportment are differently distributed among children. As Dr M was fond of saying, NO ONE IS RUNNING TO THE DOCTOR BECAUSE THE PERSON THEY THINK IS THEIR DAUGHTER WANTS TO WEAR PANTS!

The feeling about the early patients only partially held up in practice, as in 2019, the 42 new patients between ages 5-11 were evenly split between trans boys and trans girls, with four young people identifying as nonbinary or otherwise gender diverse. Yet, compared to the largely trans-masculine population later on (70% of the new patients 12-17, and 53% of the new patients 18-25 were trans-masculine,[12]) it perhaps felt that one was much more likely to see a trans feminine young person at an earlier age. This number doesn't account for the differences within the 5-11 group, and so may include trans masculine folks starting puberty at age 9, 10, or 11, which would support the clinical logical about the changing body and the changing distress levels.

Many of the most extreme examples of young people taking their gender into their own hands involves unsanctioned attempts to remove the body parts that cause them the most distress; the *something to hate.* One provider told me of a patient who showed up at an emergency room with a genital injury in hopes that it would be enough to warrant surgical removal, as a way of evidencing the severity of unwanted genital presence. This narrative also has surfaced as a part of media portrayals of what it means to be young, trans, and un-affirmed. For example, a recent miniseries produced by the BBC called "Butterfly", illustrated the iconic scene of potential genital destruction when the main character, Maxine, is shown in the bath, with a sharp piece of glass, considering her options. *I don't want it!* She says through the locked bathroom door to her anxious parents. *I want to get rid of it!* (Episode 2, 10:02). The scene recalls an earlier moment where where she had wished to her father, a reluctant party to the conversation on gender and the possibility that his son could really be his daughter, that it would *just fall off* (Episode 1, 21:14). Even this, in the series, isn't quite enough to prove that Maxine really might be happier if she didn't have to constantly confront the realities of a testosterone dominant puberty.

The strength of concern over the existence of a penis, its sanctity and importance, means that even when young people are many years away from needing to making a decision about surgical intervention they are still thinking about it—like Riley, asking her question,

---

[12] See Table 1 for more complete 2019 new patient data

how do you make a vagina,

first.

Unsurprisingly, the penis operates as an organizing structure not only in narratives around gender and gender transition, but of course, has a long history of being centered philosophically and theoretically. The emphasis on genitals often reflects a fundamental abhorrence towards the idea of genital removal or adaptation, though psychoanalytic traditions have their own histories of emphasizing the phallic. David Valentine writes about "a sense of horror at the thought of cutting into the non-transexual body at the key somatic locations that secure its non-transexuality, a visceral shudder at the thought of losing (rather than gaining) literal flesh that has, for all our theory, come to tell us something real and essential about ourselves" (2012, p. 203). He articulates a relation between the visceral and the abstracted "political" such that those allied non-transsexual individuals who might support individual rights to genital surgeries still manage to question "the politics of that", arguing this discourse persistently naturalizes the non-transsexual body. What I find important to account for here is how, even far before surgery is ever on the table, the genitals are a site of gendered truth and distinction.

One parent I met in Dr M's office, without her child present, said, "he loves his penis!" At the same time, she struggled with her child's interest in menstruation, pregnancy, and his desire to have a uterus. In another instance where we sat together with parents and without children, Dr M and I learned about the history of a young trans boy, a football playing, Nutella-loving, child of divorced parents with a step-sister who was just starting to go through her own puberty. It was unclear if her puberty was distressing Jason, or if it was primarily distressing the parents, who then came to the clinic with the explicit goals of understanding more the next steps for Jason when puberty inevitably arrived. He was only in the 3rd grade, but Mom remembered her own puberty, and her sisters—*we were* EARLY.

First he wanted to be named Bob, after SpongeBob.

Mom sighs. She's got her phone in her hand, waiting for her ex-husband to Facetime us from the city he lived in several hours away, while her current husband sits to her right, saying little.

Now it's Jason, after the Red Power Ranger.

While we wait for the call, Dr M collects more of a gender history. She wants to save the explanation of gonadotropin-releasing hormone analogues, the medication commonly called "blockers", for when everyone is present. Without Jason here, I have to imagine what he might think about this conversation, about his comfort with his body, about his way of moving through the world. Dr M asks about CHEST DEVELOPMENT.

He still rolls around the house with no shirt on.

I know he's been working on his six-pack—he's always lifting weights in front of the TV.

Mom laughs a little as she describes her son, voicing him imitating the men in his life, both the one on the couch, and the one soon to be brought into the room via iPhone. Dr. M understands Jason's experience of relating to his body as a young trans person supported in his gender expression as characteristic of THE HONEYMOON PERIOD; *this time before puberty, before chest tissue grows, before the body displays the signs which register, again and again, as male, or female, in the eyes of others.*

Your kid, IF HE IS GOING TO KEEP IDENTIFYING AS A BOY is going to have to navigate life as A BOY WITHOUT A PENIS

He says that he has a penis all the time.

aw! my tenders

Mom mock grabs at the phantom presence that is her son's phantom presence.
We all smile.

* * *

The HONEYMOON PERIOD, as providers in conferences and in clinics often called this time of Jason's life, is the period of growth before puberty, the time when young people's bodies had yet to enter into fully gendered meaning. For those without "something to hate", like Jason, the acceptance of "tomboys" could mean that they went through life content with their body until something else—or some*one* else—came along to shift their interpretation of it. Such potentials, rare as they might be in practice, are highlighted among providers who wish to move away from a model of care that requires DISTRESS to be centered, and where the purpose of gender affirming care is strictly to prevent DISTRESS. Without ignoring that real aspect of care, they also want to imagine what a form of affirmative care would look like that actively responded to the potential for youth to desire gendered embodiment without requiring a specific form of suffering.

Decentering DISTRESS

Young people like Jason, who are affirmed in their identities, may be able to experience their bodies, not as SOMETHING TO HATE, but as simply a part of their being. Yet, in the clinic, the possibility of living without DISTRESS was not exactly synonymous with the concept of GENDER UTOPIA sometimes used to undercut the necessity of medical intervention. Rather, providers finely balanced representations of the possibility of the world without DISTRESS with the importance of ensuring access to individual interventions that shape the body.

Conferences were one place where I learned about larger trends in practice outside of the clinic I directly followed. As they were spaces that put providers in the position of articulating their views to a larger audience, usually comprised of a combination of colleagues, parents, and communities members, and more infrequently, young people themselves, it was an opportunity for me to pick up on what individuals and practice models found important in their own work—a distilled, sometimes formulaic version of what their work was like in practice, that inevitability left out some complexity but was often exceptionally helpful.[13]

There are a number of professionals well-known for their approaches to care, and whose

---

[13] Between 2015 and 2020 I attended seven such conferences. Any quotations or citations I make from conferences uses the real name of presenters when possible, and with their consent, usually obtained after the sessions. I anonymize any comments from participants that were directed towards the presentation and available to the entire group.

frequent conference attendance gave them ample opportunity to teach others and refine their own perspectives. Many presenters I have seen multiple times, in different settings, and across the years, sometimes delivering the same basic talks, updated with new stories or for new settings. Consistently, I noticed how experts relatively new to the field used these key opportunities to sort out some of their own confusions and concerns about working in the field, while more established professionals further clarified the way they presented their views. Thus, conferences were a good place to learn how the field coheres around certain ways of making sense of complicated notions, like DISTRESS and SOCIAL CONSTRUCTION.

In 2019 I attended a conference session called "How Much Distress is Enough?" led by two therapists, Darlene Tando (based in San Diego), and Aydin Olson-Kennedy (based in Los Angeles).

> *The room is packed; one of the fullest sessions I've been at, with people filling in the floor and a slight spillover into the hallway. One of these years, someone jokes, they'll learn to put you in the big ballroom. I imagine that there's something more satisfying to speaking to a crammed room rather than the echo chamber the ballroom always becomes; no matter how many people are there, it never fills up. Darlene begins by explaining how* DISTRESS *is often leveraged as the distinguishing factor between kids who are gender expansive and those who are transgender. But, as she goes on to ask,*
>
> Why would we want DISTRESS from anyone?
>
> *A few minutes later, she asks, in reference to timing intervention if not waiting for a prescribed level or type of* DISTRESS,
>
> How do we know when the right time is?
>
> *And someone from the crowd calls out*
>
> when they ask for it!
>
> *The presenters laugh.*
>
> We keep planting you in our audiences!

***

As Aydin has said elsewhere about the DISTRESS requirement, “It is not okay that we are asking young people to feel unsafe in their bodies. That is unacceptable” (Helen Webberly 2020). He and Darlene highlight the problems with using DISTRESS as a proxy for gendered certainty, and pushback against the use of DISTRESS as the singular factor which could support a decision to provide young people the resources to socially or medically transition. They emphasize the possibility of moving away from being *reactive and responsive,* permitting access to affirmative care only after crisis and clear, adamant demands. *Many of you have kids where that's not their temperament,* they say. Some kids are *not insistent on anything.*

It's true, Darlene says, *that if you offer options, your kid might take you up on it. Maybe because it's right for them.* What Darlene points to in this moment, without explicitly naming it, is that many parents are afraid of giving options that their kids *might* take them *up on.* That their kids might be like Leah, who when given the option to choose her outfit *from anywhere*, and runs to the girl's section. The sense that one should never offer care based in this potential, in case it is used, conflates offering with shaping—it builds off of an anxiety that gender in young people can be changed simply by opening up their social world. In other words, it harkens back to some misconstrued ideas about SOCIAL CONSTRUCTION, where SOCIAL CONSTRUCTION indexes a view of gender identity as voluntary, ephemeral, and fickle. The refusal of this glossing, through the explicit movement towards gender as something that “doesn't develop”, amplifies an idea of an internal gender identity that can be validated by expression of DISTRESS even as gender itself eludes full conceptual capture by any diagnostic apparatus.

This is also a conflation of DISTRESS with certainty, where significant levels of DISTRESS demonstrates that a young person's stated gender is permanent and solid. This, too, is a false promise, and one that Darlene and Aydin argue we shouldn't look for anyways. As Aydin says, *we do everything all the time, without certainty.* Why should this be any different? This pushes back against the concept that WPATH forwards, that requiring a certain level and amount of DISTRESS is a critical component of preventing regret. Rather, these providers allow for the possibility that not only is DISTRESS a poor simulacrum of what adults in young people's lives really want (which is certainty), but that we could, instead, *be courageous* in the provision of care. To BE COURAGEOUS, as I read it, requires a new way of approaching how young people are expected to communicate their identity and their desires for care, as well as recalibrating our sensibilities towards evidence and the possibility of knowing the future before it arrives.

Katarina: The Rebel

"How cute was I?!" Katarina, a Serbian-American woman just on the cusp of aging out of pediatric care, is leaning over our table to show me pictures of her young self on her iPhone. We're at an upscale vegan Mexican restaurant, so the table is full of nachos with cashew cheese, fried cauliflower, and California style chopped salad. The pictures on her phone are snaps of physical photos elsewhere, maybe in frames or a photo album, where her past self pops a hip, posing for the camera with eyes behind round sunglasses and covered in flamboyant accessories. She's contradicting a narrative about of trans identity and growth, that one says you could never, would never, want to see yourself *before*, when you live in the *after*. The cover of music and an evening dinner crowd provided a sound cover for our conversation, but nonetheless, Katarina noticeably quieted her voice when naming body parts, or the "transgender thing". Throughout our interview she often shares her own reflections about the ways her experiences as a social being influenced her desires for gendered embodiment.

"You know what's weird?" Katarina asks me, rhetorically. "I've thought about this a lot, 'cause I'm like a very analytical person. But for me, I feel like if societal norms weren't a thing, I always questioned if I would have actually gotten the surgery."

Across the table from her I have already formed my own assumptions about what such a conventionally attractive, non-disclosed, woman would feel about the social or theoretical aspects of gender. I try my best to relay noncommittal listening despite feeling surprised.

“Ah. . . .. Yeah?”

“But that also is not full truth because at the same time, like, you know, before everything. . . before everything I really... it’s like, I don’t know how to explain it without saying like, I craved like the feeling of having a vagina.”

Her voice drops dramatically, as she near-whispers the word vagina.

“Like it’s weird to explain, but like, it’s like I kind of like knew where like the hole would—like, you know, like I knew everything where it would be and like I literally sat to pee like my whole life, like my whole life.”

Katarina, a pseudonym she jokingly mentioned as glamorous, didn’t have a lot of people in her life that knew her as trans, especially after her vaginoplasty at age 18 and her move away from the city she grew up in. Her description of a particularly feminine boyhood, however, set her apart from some of the other early transitioners I met, like Riley and Jason. She told me that she felt different from many of the clinics’ other patients in other ways too, recognizing her privilege and relative wealth as indicating a different set of options and opportunities. In Serbia, when she was quite young, she “danced to Britney Spears all day”, there was “nothing masculine” about her, and she said, people, her family, just thought, *that’s what she liked.* She was in the first grade when she wanted (and asked for) her first pair of heels.

“So you tell your parents you want a pair of heels, you have that kind of relationship with them?” I ask, assuming that such a request indicated a parental trust, or closeness.

“I never—no. It’s not that I have that relationship, it’s just that like I literally was just shameless. Like I had, I just was like, I had no sense of, *it was wrong*, you know?”

“And even if even if they did make it feel that way. . . Even once they started putting like a shame to it or like a notion or emotion or a feeling behind it, I still kind of was *well, this is what I liked.* So like *I don’t really care.* Yeah. And honestly, I don’t think I’d be where I am if I wasn’t such, like, born with a rebel spirit.”

Katarina corrects my assumption that her ability to communicate with her parents a desires for feminine objects was due to a close or secure relationship, and instead, emphasized her own agency and attitude. And even though her early childhood was marked by a level of acceptance, it wasn't long before she began to be warned about the social repercussions of her non-conforming behavior; before her family and her peers started to be clear about the *wrongness* of her way of being. By first or second grade, she started to be bullied, and her parents and family warned her there was more of this to come. Then, by ninth grade, her family started doing "really fucked up shit", the kind of things that makes her upset to think about now that she's older and recognizes how troubling it was.

She told me about how her parents printed out some kind of article about certain boys who "looked like women", which stressed the bad things that happened to them. Katarina remembered how the article showed their photos, and how her parents would make sure to tell her how that boy got killed. This affected her later, when she started partying more and felt that concern, "am I going to get, like, the shit beat out of me?" While her responses to the situation included bullying the bullies back, becoming the "Regina George", of her high school, as she described it, there is an undeniably traumatic aspect to teaching a young person that their identity should be ultimately considered as a risk for violence, especially as a means towards dissuading their self-expression.

Katarina didn't start hormone treatment until 15, and she told me about the tension between anticipating (or being told to anticipate) the changes of puberty and her own refusal.

"I never got facial hair, I never got an Adam's apple, like nothing ever. Like, it's fucking crazy… they [her brother and others] would just like bully me so much, and I was like, *it's not going to happen,*" she said, once again invoking her power of will. As she put it, despite the constant external reminder that she was going to grow a beard, that her body would inevitably change, Katarina refused such reminders. Her ability to "manifest" an absence of bodily change before she was able to access medical intervention was a lucky biological break, in many ways. For so many, it is those bodily signs that can put so many young people at greater risk of violence and the outcomes reported on in the paper that Katarina's parents showed her. Her ability to choose when, how, and if to disclose is one of the major impacts of early intervention for gender, and for many people, their access to tools which allow them to be in Katarina's position deeply shapes their future.[14]

Though Katarina considers the idea that "social norms" have impacted her desire, she also sees herself as an individual; as someone who experiences herself a particular way and expresses that identity along gendered lines. She spends far more time discussing how she celebrated herself, even as a very young person, than telling me about her troubles, but hardship lurks around the edges, even when such hardship is coped with by occasionally wild partying and social climbing. Her ability to do what she wanted, even when others tried to "shame" her, or scare her away from expression, reflects a certain style of personality which might be necessary given current constraints on who is allowed to access care. Opening up that access would draw upon an ethic of potential, to attend also to those who many not be as "insistent" as Darlene would say, and also, those who may not be as comfortable in the normative, binary version of gender that suits someone like Katarina.

Conclusion: Abstract and Concrete

> *Dr Y is telling me about a* surprising *patient he saw last week. Surprising, because he told me, you don't often see very young trans masculine people in the clinic.*
>
> *In the appointment, Mom talked told Dr Y how her* INNER FEMINIST *was, in some ways, troubled, by all that is associated with gender. She is anxious about the possibility that her child thinks they can only like or do certain things if they identify as that gender.*
>
> *Dr. Y assures me, that he assured Mom,*
>
> They aren't always going to be like that.
>
> *Because 4-year-olds are*

---

[14] As I will continue to discuss, particularly in Chapters Four and Five.

Really CONCRETE right now.

Then he tells me,

she was kind of joking.

kind of not.

* * *

Gender care among the Littles is plagued by the attempt to put definite answers to "hard questions" that are, in essence, unanswerable. While there remains an uncertainty around the social locations and the potential etiologies of both DISTRESS and gender itself, providers must nonetheless move forward with their work and their care for the people who come to them seeking answers. Thus, undergirding the everyday practices of gender affirmative medicine lurks the persistent tension between understanding a "feminist" understanding of gender as a SOCIAL CONSTRUCT and legitimizing individual experiences of deep, meaningful gender. Overriding it all is the desire to reduce experiences of DISTRESS, whether or not that DISTRESS is thought to stem from individual or social sources.

The expectation around the necessity of DISTRESS, prevention of which serves as a justifying force for gendered intervention, seems to mirror what Judith Butler has written about the very way that gender may operate. In her 1999 preface to *Gender Trouble*, Butler writes, "The anticipation of an authoritative disclosure of meaning is the means by which that authority is attributed and installed: the anticipation conjures its object. I wondered whether we do not labor under a similar expectation concerning gender, that it operates as an interior essence that might be disclosed, an expectation that ends up producing the very phenomenon that it anticipates" (2006, p. xv). While Butler is naming at the way that gender might become a experienced as interior due to our expectation that it should, I am also interested in how the expectation of a discourse of DISTRESS may subsequently delivers such DISTRESS, as providers like Aydin suggest.

Authoritative discourse works upon gender and the idea of DISTRESS simultaneously; DISTRESS functions as part of what gives an individual young person the authority to name and identify their own gender, rather than accept the one they have been given. While one can conceptually criticize the very notion of gender as an individually held and determined attribute, or the very concept of a self able to know and disclose its own truth, what remains true is that taking the needs of young people seriously requires attention towards the way that these logics never completely determine how individuals make meaning of their own lives.[15]

Frameworks that assume the necessity of distress and the sanctity of interior identity work because they draw upon a logic of prevention; preventing both DISTRESS and preventing the wrong youth from accessing care. Yet attending to the prospect of the potential to change social structures alongside the potential for medical care to enable youth to live in the gendered bodies they desire gives a value to medical intervention that doesn't assume reliance on such tools negates the possibilities for changing structures of meaning around gender. Though some providers might still say, as one presenter I watched joke around with their audience, *if we could have society come into the office . . .*, others roll their eyes at the imagination of GENDER UTOPIA, expressing the tensions between how different people imagine what changing the social world would do for them. Like Katarina, who weighs on one hand the possibility that without social pressure perhaps she would have made other choices, and on the other, a deep certainty that she is just being herself—and if the pressures of this world weren't enough to dissuade her from living as she wanted to live, then she couldn't imagine that any world would have changed her course, either.

In the following three chapters, I will continue describing how these questions about the relationship of the gendered self to a social world of gender continually reappear, in the practices of assessment and clinical research, and during the provision of puberty suppressing

---

[15] Furthermore the critique of the self-knowing subject might be often misplaced; see, for example, Henry Rubin's (1998) compelling argument about the importance of phenomenology to trans studies and the ways that an analysis of discourse can coexist with such method.

hormones and affirmative hormonal treatments. Without attempting to resolve this integral tension at the center of what it means to treat gender medically, I ethnographically approach the practices of knowing and treating gender, and by doing so, illuminate how this tension is often managed through the appeal to futures to be prevented, and potentials to be cultivated, as ways of living with gender even as it is never fully known.

INTERLUDE: LEGISLATION

In 2021, over 100 anti-trans pieces of legislation were introduced in the United States, many specifically targeting young people and their health care. 2022 is on track to surpass this record-breaking year .

***

Alabama

House Bill No. 1 / Senate Bill No. 10

“The Alabama Vulnerable Child Compassion and Protection Act”

Sponsored by: Representatives Wes Allen (R), Mike Holmes (R), Phillip Pettus (R), Arnold Mooney (R), and Chip Brown (R)

Sponsored by: Senator Shay Shelnutt (R)

First read: Feb 02, 2021

SYNOPSIS:

This bill would prohibit the performance of a medical procedure or the prescription or issuance of medication, upon or to a minor child, that is intended to alter the appearance of the minor child’s gender or delay puberty, with certain exceptions.

This bill would provide for the disclosure of certain information concerning students to 16 parents by schools.

This bill would also establish criminal penalties for violations.

[. . .]

Section 2.

The Legislature finds as follows:

(1) The long-term effects and safety of the administration of puberty blocking medications and cross-sex hormones to gender incongruent children have not been rigorously studied. Absent rigorous studies showing their long-term safety and positive benefits, their continued administration to children constitutes dangerous and uncontrolled human medical experimentation that may result in grave and irreversible consequences to their physical and mental health.

***

Texas

House Bill No. 68

A BILL TO BE ENTITLED: AN ACT Relating to the definition of abuse of a child

Sponsored by: Representative Steve Toth (R)

Introduced: Feb 25, 2021

(B) subject to Paragraph (C), includes the following acts by a medical professional or mental health professional for the purpose of attempting to change or affirm a child 's perception of the child 's sex, if that perception is inconsistent with the child 's biological sex as determined by the child 's sex organs, chromosomes, and endogenous hormone profiles:

> (i) performing a surgery that sterilizes the child, including castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty;
>
> (ii) performing a mastectomy;
>
> (iii) administering or supplying any of the following medications that induce transient or permanent infertility:
>
> > (a) puberty-blocking medication to stop or delay normal puberty;
> > (b) supraphysiologic doses of testosterone to females; or
> > (c) supraphysiologic doses of estrogen to males; or
> > (iv) removing any otherwise healthy or non-diseased body part or tissue; and

(C) does not include an act described by Paragraph (B) performed on a child born with a medically verifiable genetic disorder of sex development

[. . .]

***

Missouri

House Bill No. 33 AN ACT : to amend chapter 191, RSMo

Sponsored by: Representative Suzie Pollack (R)

First Read: January 6, 2021

191.1180. 1. Any physician or surgeon licensed under chapter 334, any person licensed to practice professional or practical nursing under chapter 335, or any other health personnel licensed by a state licensing board in this state shall be prohibited from administering puberty blockers, prescribing hormone therapy, performing a vaginoplasty, orchiectomy, metoidioplasty, phalloplasty, or hysterectomy, or performing other genital or hormonal interventions for the purpose of gender reassignment for a child. As used in this section, "child" means a person under eighteen years of age.

***

Mississippi

Senate Bill No. 2171

“The Transgender 21 Act”

Sponsored by: Senator Angela Burks Hill (R)

Died in Committee: February 2, 2021

TO PROHIBIT THE STATE, ITS AGENTS, AND POLITICAL SUBDIVISION FROM INFRINGING ON A PARENT’S RIGHT TO WITHHOLD CONSENT FOR ANY TREATMENT, ACTIVITY OR MENTAL HEALTHCARE SERVICES THAT ARE DESIGNED AND INTENDED TO FORM THEIR CHILD’S CONCEPTIONS OF SEX AND GENDER OR TO TREAT GENDER DYSPHORIA OR GENDER NONCONFORMITY;

TO PROHIBIT CERTAIN MEDICAL PROCEDURES FROM BEING PERFORMED UPON A MINOR; TO PROVIDE A PENALTY FOR ANY MEDICAL PROFESSION WHO PERFORMS CERTAIN MEDICAL PROCEDURES UPON A MINOR;

TO PROVIDE A GOOD-FAITH EXCEPTION FOR A MINOR BORN WITH A MEDICALLY VERIFIABLE GENETIC DISORDER OF SEXUAL DEVELOPMENT;

[. . .]

SECTION 3. Definitions.

(d) ”Minor” means any child below the age of twenty-one (21).

[. . .]

(f) ”Sex” means the biological state of being female or male, based on sex organs, chromosomes, and endogenous hormone profiles

***

Utah

House Bill No. 92

Medical Practice Amendments

Sponsored by: Representative Rex P. Shipp (R) Sponsored by: Curtis S. Bramble (R)

Adjourned Sine Die: March 5, 2021

General Description: This bill prohibits a physician or surgeon from performing a transgender procedure on a minor.

[. . .]

58-67-102. Definitions

[. . .]

(a) "Medically unnecessary puberty inhibition procedure" means administering or supplying to an individual younger than 18 years old, alone or in combination with aromatase inhibitors:

- (i) gonadotropin-releasing hormone agonists;
- (ii) progestins; or
- (iii) androgen receptor inhibitors.

(b) "Medically unnecessary puberty inhibition procedure" does not include administering or supplying a treatment described in Subsection (17)(a) to an individual younger than 18 years old if the treatment is medically necessary as a treatment for:

- (i) precocious puberty;
- (ii) idiopathic short stature;
- (iii) endometriosis; or
- (iv) a sex hormone-stimulated cancer.

[. . .]

***

North Dakota

House Bill No. 1476

Sponsored by: Representative Terry Jones (R)

Introduced: January 28, 2021

A BILL for an Act to create and enact a new chapter to title 14 of the North Dakota Century Code, relating to nonsecular self-asserted sex-based identity narratives, to prohibit the state from creating or enforcing policies that directly or symbolically respect nonsecular self-asserted sex-based identity narratives or sexual orientation orthodoxy pursuant to the establishment clause of the First

Amendment to the United States Constitution and section 3 of article I of the Constitution of North Dakota; to provide for the continued enforcement of secular marriage policies; to prohibit discrimination for nonsecular beliefs pursuant to the free exercise clause of the First Amendment to the United States Constitution and section 3 of article I of the Constitution of North Dakota.

[...]

Pursuant to the First Amendment establishment clause of the United States Constitution and section 3 of article I of the Constitution of North Dakota, and the state's compelling interest to discourage licentiousness, an agent of the state may not directly or symbolically create or enforce policies that respect or recognize nonsecular self - asserted sex - based identity narratives or sexual orientation orthodoxy, by:

a. Issuing or recognizing a marriage license that does not involve a secular marriage;

b. Appropriating, distributing, or awarding public funds in a manner that directly or indirectly respects, promotes, or endorses the plausibility of nonsecular self - asserted sex - based identity narratives, sexual orientation orthodoxy, or nonsecular marriage ideology;

c. Appropriating, distributing, or awarding a grant of public funds to cover the cost of sex reassignment surgery;

d. Prohibiting or unduly restricting conversion therapy;

e. Displaying a flag that promotes nonsecular self - asserted sex - based identity narratives or sexual orientation orthodoxy in a manner that would be unconstitutional for the same state actor to display a flag that respects or promotes the edicts of an institutionalized religion;

f. Promoting the use of puberty blockers, especially to minors;

g. Permitting a person who was born as a biological male to change the person's gender to female on the person's birth certificate, driver's license, or any other official government form;

h. Permitting a person who was born as a biological female to change the person's gender to male on the person's birth certificate, driver's license, or any other official government form;

i. Assigning or housing an inmate who was born as a biological male in a ward or cell designated for inmates who were born as biological females;

j. Assigning or housing an inmate who was born as a biological female in a ward or cell designated for inmates who were born as biological males; or

k. Mandating pronoun changes.

3. Pursuant to the First Amendment establishment clause of the United States

Constitution and section 3 of article I of the Constitution of North Dakota, and the state's compelling interest to discourage licentiousness, a public school or a public school's agent may not create or enforce policies that respect or recognize nonsecular self - asserted sex - based identity narratives or sexual orientation orthodoxy, by:

> a. Exposing students to a curriculum concerning nonsecular self - asserted sex - based identity ideology or sexual orientation orthodoxy unless the programming is part of a sex education program and only after a student's parents have:
>
> > (1) Intentionally opted their child into participating in the programming in writing;
> > (2) Received a warning from the school or department of public instruction that the messaging could expose their child to licentiousness and one particular religious worldview.
>
> [. . .]
>
> f. Mandating pronoun changes; or
>
> g. Hosting or sponsoring drag queen story time for children or similar programming.

***

Indiana

House Bill No. 1505

Sponsored by: Representative John Jacob (R)

First Reading: January 14, 2021

Synopsis: Minors transitioning to the opposite sex. Prohibits specified health care professionals from: (1) performing certain medical procedures on a minor; or (2) subjecting a minor to certain activities; with the intent of assisting the minor to physically transition to a gender that is inconsistent with the minor's biological sex.

[. . .]

Sec. 4.

(a) Except as provided in section 5 of this chapter, a health care professional may not, with the intent of assisting the minor in physically transitioning to a gender that is inconsistent with the minor's biological sex, engage in any of the following activities:

(1) Prescribe, administer, or furnish to the minor a drug to stop or delay puberty.

(2) Prescribe, administer, or furnish to a female minor testosterone or estrogen-suppressing drugs.

(3) Prescribe, administer, or furnish to a male minor estrogen or testosterone-suppressing drugs.

(b) Any individual who has reasonable cause to know or suspect, based on facts, that a minor has been subjected to an activity specified in subsection (a) shall report that knowledge or reasonable cause to either: (1) the department of child services as child abuse or neglect; or (2) the local law enforcement agency.

[...]

***

Oklahoma

Senate Bill 676

Sponsored by: Senators Warren Hamilton (R), David Bullard (R), Shane Jett (R)

Introduced: February 1, 2021

A. It shall be unlawful for a person under the age of twenty one (21) years to undergo gender reassignment medical treatment in this state.

B. It shall be unlawful for a parent, guardian or other person in this state having charge, control or custody of a child under the age of eighteen (18) years to obtain gender reassignment medical treatment for the child.

C. It shall be unlawful for a health care professional to intentionally perform gender reassignment medical treatment on a person who is under the age of twenty-one (21) years.

[...]

D. “Gender reassignment medical treatment” means any health care to facilitate the transitioning of a patient’s assigned gender identity on the patient’s birth certificate, to the gender identity experienced and defined by the patient. The term shall include, but not be limited to: 1. Medical procedures to suppress the development of endogenous secondary sex characteristics; 2. Medical procedures to align the patient’s appearance or physical body with the patient’s gender identity. This does not include clothing, hairstyles, the use of makeup or other nonpermanent actions of the patient; and 3. Medical procedures to alleviate the symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th

Edition. The term does not include behavioral health care services, such as mental health counseling. E. Any person guilty of the provisions of subsection A, B or C shall be guilty of a felony punishable by imprisonment in the custody of the Department of Corrections for a term of not less than three (3) years nor more than life and a fine of not more than Twenty Thousand Dollars ($20,000.00).

[. . .]

***

Iowa

House File 193

Sponsored by: Representative Sandy Salamon (R)

Introduced: January 22, 2021

An Act relating to actions relative to treatment or intervention regarding the discordance between a minor's sex and gender identity, and providing civil penalties.

Section 1. FINDINGS. The general assembly finds all of the following:

> 1. "Sex" is the biological state of being female or male, 4 based on sex organs, chromosomes, and endogenous hormone profiles. An individual's sex is genetically encoded into an individual at the moment of conception, and it cannot be changed.
>
> 2. Some individuals, including minors, may experience discordance between their sex and their internal sense of gender identity. Individuals who experience severe psychological distress as a result of this discordance may be diagnosed with gender dysphoria.
>
> 3. The cause of the individual's impression of discordance between sex and gender identity is unknown. Diagnosis is based exclusively on the individual's self-report of feelings and beliefs.
>
> [. . .]
>
> 11. This unproven, poorly studied series of interventions results in numerous harmful effects for children, as well as risks of effects simply unknown due to the new and experimental nature of these interventions.

[. . .]

Sec. 3. NEW SECTION. Prohibited practices.

1. Notwithstanding any other provision of law to the contrary, it shall be unlawful for a medical professional to engage in any of the following practices upon a minor,

or to cause such practice to be performed to facilitate a minor's desire to present or appear in a manner that is inconsistent with the minor's sex:

[. . .]

Sec. 5. NEW SECTION. Protection of parental rights.

Notwithstanding any provision to the contrary, if a government agency or political subdivision has knowledge that a minor under the care or supervision of a government agency or political subdivision has exhibited symptoms of gender dysphoria, gender nonconformity, or has otherwise demonstrated a desire to be treated in a manner incongruent with the minor's sex, the government agency or political subdivision shall immediately notify, in writing, any parent of the minor. The notice shall describe all of the relevant circumstances with reasonable specificity.

[. . .]

***

New Hampshire

House Bill 68

AN ACT relative to the definition of child abuse

Sponsored by: Representative Dave Testerman (R)

Introduced: January 4, 2021

Found *Inexpedient to Legislate:* February 23, 2021

ANALYSIS

This bill adds sexual reassignment to the definition of an abused child in RSA 169-C, the child protection act.

***

Arkansas

~~House Bill 1570~~

Act 626

"SAVE ADOLESCENTS FROM EXPERIMENTATION (SAFE) ACT"

Sponsored by: Representative Robin Lundstrum (R) and Senator Alan Clark (R)

Cosponsored by: Representatives Barker, Bentley, Brown, Bryant, Cavenaugh, Cloud, Coleman, C. 5 Cooper, Cozart, Crawford, Dalby, Dotson, C. Fite, Furman, Gazaway, Gonzales, M. Gray, Haak, 6 Hollowell, Ladyman, Lowery, Lynch, J. Mayberry, McGrew, McNair, S. Meeks, Miller, Payton, Penzo, 7 Pilkington, Ray, Richmond, Slape, B. Smith, Speaks, Tollett, Tosh, Underwood, Vaught, Warren, 8 Watson, Wing, *Bragg, Hillman, Wooten*

Cosponsored by: Senators A. Clark, B. Ballinger, Beckham, Bledsoe, B. Davis, J. English, Gilmore, K. Hammer, Hill, 10 Irvin, B. Johnson, M. Johnson, Rapert, Rice, G. Stubblefield, D. Wallace, *D. Sullivan, Hester, T. Garner*

Passed from House to Senate: March 10, 2021

Vetoed by Governor: April 5, 2021

Overruled by House and Senate: April 6, 2021

Current status: Under Judicial Stay, until the outcome of current lawsuits are settled.

(3) For the small percentage of children who are gender nonconforming or experience distress at identifying with their biological sex, studies consistently demonstrate that the majority come to identify with their biological sex in adolescence or adulthood, thereby rendering most physiological interventions unnecessary;

(4) Furthermore, scientific studies show that individuals struggling with distress at identifying with their biological sex often have already experienced psychopathology, which indicates these individuals should be encouraged to seek mental health services to address co-morbidities and underlying causes of their distress before undertaking any hormonal or surgical intervention;

(5) Even among people who have undergone inpatient gender reassignment procedures, suicide rates, psychiatric morbidities, and mortality rates remain markedly elevated above the background population;

[. . .]

> (A) Some healthcare providers are prescribing puberty- blocking drugs, such as gonadotropin-releasing hormone analogues, in order to delay the onset or progression of puberty in children who experience distress at identifying with their biological sex.
>
> (B) The prescribing of puberty-blocking drugs is being done despite the lack of any long-term longitudinal studies evaluating the risks and benefits of using these drugs for the treatment of such distress or gender transition;

(7) Healthcare providers are also prescribing cross-sex hormones for children who experience distress at identifying with their biological sex, despite the fact that no randomized clinical trials have been conducted on the efficacy or safety of the

use of cross-sex hormones in adults or children for the purpose of treating such distress or gender transition;

(8) The use of cross-sex hormones comes with serious known risks, such as:

[. . .]

(14) It is of grave concern to the General Assembly that the medical community is allowing individuals who experience distress at identifying with their biological sex to be subjects of irreversible and drastic nongenital gender reassignment surgery and irreversible, permanently sterilizing genital gender reassignment surgery, despite the lack of studies showing that the benefits of such extreme interventions outweigh the risks; and

(15) The risks of gender transition procedures far outweigh any benefit at this stage of clinical study on these procedures.

[. . .]

20-9-1501. Definitions.

[. . .]

(6)(A) "Gender transition procedures" means any medical or surgical service, including without limitation physician's services, inpatient and outpatient hospital services, or prescribed drugs related to gender transition that seeks to:

> (i) Alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex; or
>
> (ii) Instill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex, including without limitation medical services that provide puberty-blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite biological sex, or genital or nongenital gender reassignment surgery performed for the purpose of assisting an individual with a gender transition.

[. . .]

20-9-1502. Prohibition of gender transition procedures for minors.

> (a) A physician or other healthcare professional shall not provide gender transition procedures to any individual under eighteen (18) years of age.

[. . .]

SECTION 4. Arkansas Code Title 23, Chapter 79, Subchapter 1, is amended to add an additional section to read as follows: 23-79-164. Insurance coverage of gender transition procedures for minors prohibited.

***

Arizona

Senate Bill 1511

AN ACT AMENDING SECTIONS 13-705 AND 13-3623, ARIZONA REVISED STATUTES; RELATING TO FAMILY OFFENSES.

Sponsored by: Senator Wendy Rodgers (R)

Introduced: February 1, 2021

[. . .]

Sec. 2. Section 13-3623, Arizona Revised Statutes, is amended to read:

13-3623. Child or vulnerable adult abuse; emotional abuse; unlawful medical practices; classification; exceptions; definitions

[. . .]

E. A HEALTH CARE PROFESSIONAL WHO ENGAGES IN ANY OF THE FOLLOWING PRACTICES OR CAUSES ANY OF THESE PRACTICES TO BE PERFORMED ON A CHILD OR VULNERABLE ADULT TO ATTEMPT TO CHANGE THE CHILD'S OR VULNERABLE ADULT'S SEX OR TO AFFIRM THE CHILD'S OR VULNERABLE ADULT'S PERCEPTION OFTHE CHILD'S OR VULNERABLE ADULT'S SEX IF THAT PERCEPTION IS INCONSISTENT WITH THE CHILD'S OR VULNERABLE ADULT'S SEX IS GUILTY OF AN OFFENSE AS PROVIDED IN SUBSECTION F OF THIS SECTION:

1. PERFORMING SURGERIES THAT STERILIZE, INCLUDING CASTRATION,VASECTOMY, HYSTERECTOMY, OOPHORECTOMY, METOIDIOPLASTY, ORCHIECTOMY, PENECTOMY, PHALLOPLASTY AND VAGINOPLASTY.
2. PERFORMING A MASTECTOMY.
3. ADMINISTERING, PRESCRIBING OR SUPPLYING ANY OF THE FOLLOWINGMEDICATIONS THAT INDUCE TRANSIENT OR PERMANENT INFERTILITY:

    (a) PUBERTY-BLOCKING MEDICATION THAT STOPS OR DELAYS NORMAL PUBERTY.

    (b) SUPRAPHYSIOLOGIC DOSES OF TESTOSTERONE TO FEMALES.
    (c) SUPRAPHYSIOLOGIC DOSES OF ESTROGEN TO MALES.

  4. REMOVING ANY OTHERWISE HEALTHY OR NONDISEASED BODY PART OR TISSUE.

F. A PERSON WHO VIOLATES SUBSECTION E OF THIS SECTION IS GUILTY OF:

  1. IF DONE INTENTIONALLY OR KNOWINGLY, THE OFFENSE IS A CLASS 2 FELONY AND IF THE VICTIM IS UNDER FIFTEEN YEARS OF AGE IT IS PUNISHABLE PURSUANT TO SECTION 13-705.

[. . .]

***

Tennessee

House Bill No. 0578 / Senate Bill 0657

AN ACT to amend Tennessee Code Annotated, Title 8; Title 36; Title 37; Title 39; Title 49; Title 53; Title 56; Title 63; Title 68 and Title 71, relative to courses of treatment for children.

Sponsored by: Representative John Ragan (R) and Senator Janice Bowling (R)

Cosponsored by: Representatives Terri Lynn Weaver (R), Bruce Griffey (R), Rusty Grills (R), Jerry Sexton (R)

Assigned to Criminal Justice Subcommittee: February 10, 2021

Passed to Senate Judiciary Committee: February 11, 2021

SECTION 1. Tennessee Code Annotated, Title 39, Chapter 15, Part 4, is amended by adding the following as a new section:

[. . .]

(1) A person shall not provide or facilitate the provision of sexual identity change therapy to a minor who has not yet entered puberty.

(2) A person shall not provide or facilitate the provision of sexual identity change therapy to a minor who has entered puberty unless both parents or the legal guardian of the minor provides a signed, written statement recommending physical sexual identity change therapy for the minor from:

> (A) Two (2) or more physicians licensed under title 63, chapter 6 or 9; and (B) At least one (1) physician licensed under title 63, chapter 6 or 9, who is board-certified in child and adolescent psychiatry, and who is not the same person as any physician whose written recommendation is used to satisfy subdivision (b)(2)(A).

[...]

***

Georgia

House Bill 401

"Vulnerable Child Protection Act"

Sponsored by: Representatives Ginny Ehrhart (R) , Mark Newton (R), Rick Jasperse (R), Micah Gravley (R), John Carson (R), and Karen Mathiak (R)

Introduced: February 10, 2021

[...]

31-20A-3.

Except as provided in Code Section 31-20A-4, no healthcare professional shall engage in any of the following practices upon a minor or cause such practices to be performed for the purpose of attempting to affirm the minor's perception of such minor's sex, if that perception is inconsistent with such minor's sex:

> (1) Performing any surgery that sterilizes, including, but not limited to, castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, or vaginoplasty;
>
> (2) Performing a mastectomy;
>
> (3) Removing any otherwise healthy or nondiseased body part or tissue; or
>
> (4) Administering or supplying medications that induce transient or permanent infertility, including, but not limited to:
>
> > (A) Puberty-blocking medication to stop or delay normal puberty;
> > (B) Supraphysiologic doses of testosterone to females; or
> > (C) Supraphysiologic doses of estrogen to males.

[...]

***

Montana

House Bill No. 427

“AN ACT PROVIDING FOR YOUTH HEALTH PROTECTION LAWS; PROHIBITING SURGICAL PROCEDURES FOR THE TREATMENT OF GENDER DYSPHORIA IN MINORS; PROVIDING ENFORCEMENT; AND PROVIDING DEFINITIONS.”

Sponsored by: Representative John Fuller (R)

Referred to Judiciary Committee: February 26, 2021

[. . .]

NEW SECTION. Section 2. Purpose. The purpose of [sections 1 through 5] is to enhance the protection of minors, pursuant to Article II, section 15, of the Montana constitution, who experience distress at identifying with their biological sex from being subjects of irreversible and drastic non-genital gender reassignment surgery and irreversible, permanently sterilizing genital gender reassignment surgery.

[. . .]

NEW SECTION. Section 4. Surgical procedures prohibited.

A health care provider may not:

> (1) perform gender transition procedures on a minor to treat gender dysphoria;
>
> (2) remove any otherwise healthy or nondiseased body part or tissue of a minor to treat gender dysphoria; or
>
> (3) refer a minor to a health care provider for gender transition procedures.

[. . .]

***

Kansas

House Bill 2210 / Senate Bill 214

Sponsored by: Senator Mike Thompson (R) and Representatives Brett Fairchild (R), Randy Garber (R), Cheryl Helmer (R), and Bill Rhiley (R)

Introduced: February 10, 2021

AN ACT concerning crimes, punishment and criminal procedure; creating the crime of unlawful gender reassignment service;

[. . .]

New Section 1.

> (a) Unlawful gender reassignment service is knowingly performing, or causing to be performed, any of the following upon a child under 18 years of age for the purpose of attempting to change or affirm the child's perception of the child's sex, if that perception is inconsistent with the child's sex:
>
> > (1) Performing a surgery that sterilizes, including, but not limited to, castration, vasectomy, hysterectomy, oophorectomy, orchiectomy and penectomy;
> > (2) performing a surgery that artificially constructs tissue with the appearance of genitalia, including, but not limited to, metoidioplasty, phalloplasty and vaginoplasty;
> > (3) performing a mastectomy;
> > (4) prescribing, dispensing, administering or otherwise supplying the following medications:
> >
> > > (A) Puberty-blocking medication to stop normal puberty;
> > > (B) supraphysiologic doses of testosterone to females; or
> > > (C) supraphysiologic doses of estrogen to males.
> >
> > (5) removing any otherwise healthy or nondiseased body part or tissue.
>
> (b) Unlawful gender reassignment service is a severity level 8, person felony.
>
> (c) The provisions of this section shall not apply if a child was born with a medically verifiable disorder of sex development.

[. . .]

***

Kentucky

House Bill 477

Sponsored by: Representatives Melinda Prunty (R), David Hale (R), Richard Heath (R), Kim King (R)

Introduced: February 10, 2021

AN ACT relating to parental consent for transgender healthcare services

[. . .]

(4) (a) Medical, dental, and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

(b) Notwithstanding paragraph (a) of this subsection, medical and other health-care services shall not be rendered upon a minor in order to facilitate the minor's desire to identify with, present, appear, or live as a gender that does not correspond to his or her sex at birth without the written consent of the parent or guardian of the minor patient or to any other person having custody of the minor.

[. . .]

***

Iowa

House File 327

Sponsored by: Representative Jeff Shipley (R)

Introduced: February 2, 2021

[. . .]

2.a. A physician shall not perform any treatment or intervention on the sex characteristics of a minor diagnosed with gender dysphoria unless all of the following conditions are met:

[. . .]

3.*a.*A practitioner who engages in discussions or counseling regarding gender dysphoria treatment or intervention options with a minor shall fully and accurately disclose all known and documented adverse events relating to such treatment options.

[. . .]

***

Kentucky

House Bill 336

Sponsored by: Representative Savannah Maddox (R) Co-sponosored by: Representatives Melinda Prunty (R), Lynn Belcher (R), and Jennifer Hensen Decker (R)

Introduced: February 2, 2021

AN ACT relating to public protection.

[. . .]

(2) Notwithstanding any other provision of law, it shall be unlawful for any medical professional to engage in or cause to be performed any of the following practices upon a minor in order to facilitate the minor's desire to present or appear in a manner that is inconsistent with the minor's sex:

> (a) Performing surgery [. . .]
> (b) Administering, prescribing, or supplying the following medications [. . .]
> (c) Removing any otherwise healthy or non-diseased body part or tissue.

(3) This section does not apply to the treatment of a minor born with a medically verifiable genetic disorder of sexual development

[. . .]

***

Indiana

Senate Bill 224

Sponsored by: Senator Dennis Kruse (R)

[. . .]

Sec. 3. (a) Except as provided in section 5 of this chapter, a health care professional may not purposely attempt to change, reinforce, or affirm a minor's perception of the minor's own sexual attraction or sexual behavior, or attempt to change, reinforce, or affirm a minor's gender identity when the identity is inconsistent with the minor's biological sex, by performing or causing to be performed any of the following procedures on the minor

[. . .]

***

Missouri

Senate Bill 442

Sponsored by: Senator Mike Moon (R)

Hearing Conducted: March 10, 2021

[. . .]

191.1180. 1. Any physician or surgeon licensed under chapter 334, any person licensed to practice professional or practical nursing under chapter 335, or any other health personnel licensed by a state licensing board in this state shall be prohibited from administering any hormonal treatment or performing any surgical treatment for the purpose of gender reassignment for a child. As used in this section, “child” means a person under eighteen years of age.

[. . .]

4. A person commits the offense of abuse or neglect of a child if such person coerces a child who is under eighteen years of age to undergo any surgical or hormonal treatment for the purpose of gender reassignment.

[. . .]

CHAPTER 3

JUSTIFYING GENDERED INTERVENTION

THE BEST ONE

The good thing about Science is it's true whether or not you believe in it.
—Neil DeGrasse Tyson, @neiltyson, June 14, 2013

The office where the research coordinators work is on a small branch off of the main looping hallway that forms the backbone of the Trans Youth Clinic. When I first got to the clinic, someone told me in a lighthearted way, almost joking, that if *you're looking for the trans guys* you had to go that way, *by the break room!* but the *trans women* were all *over there*. Even here, this is how it goes: the *girls* and the *guys*.

There are four doors on this small offshoot of the main hallway. One leads to the break room and the attached patio, another to the interior office of the newest physician. Open the third door and you'll see one of the social workers, Harley, and the last, a research coordinators office shared between Beau, Brian, and sometimes, a medical student-slash-research intern.

The research coordinators, Beau and Brian, have both spent much of the last year working on one of the largest longitudinal studies of transgender and gender expansive young people in the United States. As coordinators, they are the ones primarily responsible for recruiting new participants, enrolling and consenting them into the study, as well as shepherding them through the "audio computer-assisted self interviewing" survey questions.

> *I've been sitting in their office for a while now, clicking through item after item on the 24 month follow-up survey. It's quiet and dark, with only a little natural light filtering in from the single window. I didn't think much about how I would answer things ahead of time—how to think about my own sex assigned at birth, my own gender identity, if I was taking this survey as myself or as a hypothetical participant, one who is having a lot, a little, or not too much depression, anxiety, or suicidal thoughts. I just wanted to know what it was like to be taking the survey.*

> How old were you when you realized that your affirmed gender was different than your sex assigned at birth?
>
> *I would never know what it was like to be taking the survey.*
>
> I feel like my gender identity or expression is embarrassing. Have you considered a change, or would you want to change your breasts if it was possible through medical or surgical treatment? Because I don't want others to know my gender identity, I pay special attention to the way I dress or groom myself. In the past 7 days I felt energetic. How often do you attend church, temple, synagogue, or other religious meetings? If I express my gender identity, most people would think less of me. On average, how much yogurt did you eat each time you had yogurt during the past week? If I express my gender identity, I could be arrested or harassed by the police. I can solve most problems if I try hard enough. If I express my gender identity, I could be a victim of crime or violence. In the past 7 days I liked myself. If I express my gender identity, I could be denied good medical care. In the past 7 days, how many times have you played street hockey? I like to behave sexually as a girl.
>
> *I pause.*
>
> I LIKE TO BEHAVE SEXUALLY AS A GIRL *remains up on the screen, as behind me, Beau walks in, a plastic bag with his lunch hanging from one arm.*
>
> You're on THE BEST ONE!

***

The Science of the ASK

This is not the first time I have encountered the question I LIKE TO BEHAVE SEXUALLY LIKE A GIRL. In fact, the question itself operates as a shibboleth in all kinds of conversations about what it means to create evidence to justify the use of gendered interventions like puberty suppression and hormonal treatments, and about what tools like surveys and questionnaires offer to both researchers and clinicians. It's often the first thing that someone says when referring to the Utrecht Gender Dysphoria Scale (UGDS), which is just one of the many measures that make up the survey I am clicking my way through. Yet, throughout the course of my fieldwork, most people faced with such a question would comment that *it doesn't mean anything*—at least, not anything relevant to any individual's gender identity, or to their entitlement to access medical intervention.

Instead, those at the TYC (and many elsewhere) would response to inquiries like THE BEST ONE with a rhetorically posed question and its perennial answer:

> *How do you know someone's gender?*
> YOU ASK.

One of the reasons that this mantra of sorts was so frequently invoked connects to the legacy of treating everything except self-disclosed identification as the truest indicator of gender. Historians and social scientists have tracked the way that information about sexual histories, underwear choice, employment, or ability to "pass" as a specific gender have undercut or superseded individuals stated gender, and subsequently, their ability to access interventions like hormones and surgery through institutional channels (Gill-Peterson 2018; Meyerowitz 2009; Sadjadi 2019; shuster 2021; Velocci 2021). At the TYC, they laughed about clinicians who *looked to underwear* to learn something about gender. Nonetheless, amassing the data needed to prove to skeptics that gender affirming interventions were not harmful but necessary, often meant that certain historical precedents maintained their presence. In other words, while some kinds of questions have fallen out of use as a part of clinical practice, at least the practice I attended to, those questions might still appear as a part of knowledge production. Things like the best question, which no one seemed to think meant anything and yet, here it was, smack in the middle of the survey, its inclusion nothing if not a form of validation.

This chapter tracks many different ASKS that are a part of gender care, demonstrating how such ASKS form an ethical and epistemic "apparatus" (Barad 2007) oriented towards the production of evidence that can justify, to a skeptical public, the benefit of gendered intervention, on a scale beyond that of an individual patient. After all, this is a time where the types of interventions provided at this clinic and others like are currently under deep public scrutiny, often due to a purported lack of "evidence"—in this case, the absence of randomized control trials.[1] Thus, the need to deliver widely palatable evidence, quickly, is signifiant for those hoping to push back against further restriction or elimination of care, and to justify the existence of the particular medical subspecialty of pediatric gender affirming care.

Without disregarding the severity of the need to produce evidence, and its centrality to many of the practices I discuss here, this chapter examines the production of knowledge about youths' gender experiences, in order to illustrate the evidentiary regimes[2] that hold sway over how youth are seen as capable (or more often, not) of justifying their requests for gendered intervention. I ask after the possibility of good relations between young trans people and the institution of medicine, given the historical pathologization of trans people by medicine. Furthermore, by describing how present desires for a SCIENCE of gender appear across settings, as parents ask after the possibilities of brain imaging and blood tests, and clinicians refine their assessment practices, I demonstrate how the interwoven worlds of research and practice are shaping visions of the gender care of the future. I ask after the possibility of good relations between young trans people and the institution of medicine, given the historical pathologization of trans people by medicine. Furthermore, by describing how present desires for a SCIENCE of gender appear across settings, as parents ask after the possibilities of brain imaging and blood tests, and clinicians refine their assessment practices, I demonstrate how the interwoven expectations about good research, and good practice, are shaping visions of the gender care of the future.

For while professionals are increasingly concerned with evidence based practice (shuster 2016, 2021), which requires the ongoing use of tools that have validated histories to demonstrate the efficacy of intervention, there is also an assumption that as much as the worlds

---

[1] See the Interlude: LEGISTLATION, last year's current efforts to ban care, which have only been increasing in 2022.

[2] I am indebted to my friend Alejandra Azuero-Quijano for offering this particular phrase to me when reading an early draft of this chapter.

of research and practice inform each other, they are nonetheless distinguishable. Yet as I focus on tensions that emerge in the attempt to fill the needs of a field whose authority is shored up by its proximity to scientific research, I show how deeply implicated each form of knowing gender, and justifying gender care, is within the other. In other words, I focus on how the need to justify an entire field brings up additional ethical and practical implications for how gender affirming care is done, while also attending to how participating in clinical research is, itself, often a form of receiving clinical care.

I argue that providers, when they framing ASKING youth as the most clinically relevant process for youth to obtain gender care, center the potential of young people to be trans and receive care based on their claim to it. As Nina, the nurse practitioner at the TYC puts it, "there's no way for us to prove anybody's gender—we have to really listen to what the person is saying. And that feels scary, a little bit." It is "scary", in part, because concern with gender affirming care has often fixated on the prevention of bad outcomes, including bad outcomes that are attributed to providing, as well as withholding, access to affirmative interventions. The development of a formal process of assessment from clinical experts, like social workers and psychologists in particular, is rooted in the need to filter out young people whose futures might not be trans, and whose DISTRESS could be mediated through other types of intervention. However, this preventative thrust is also reflected in how care is justified among youth who do have trans futures—one which takes the best justification of gender care to be the way that it works to reduce and prevent experiences of depression, anxiety, suicidality, and especially, gender dysphoria, which the UGDS attempts to name and quantify.

However, as I will argue, the constant return to tools like the UGDS trouble so many because such tools do not simply pick up on objects, like gender or DISTRESS that exist outside of the quest to know them. Instead, it simultaneously performs ethical, ontological, and epistemic work; that is, such ASKS draw relations between subjects and objects, structured by power, which also create objects as much as they create opportunities to know them.[3] Therefore, I attend to the way that practices are determined to be sufficiently scientific, and how those determinations also reveal assumptions about what it means to say that gender affirmative care works, and for whom. I look for moments where the negotiation of authority, expertise, and knowledge run into trouble, whether over the utility of a specific measurement or the disagreement about who precisely should be listened to in the process of expert consensus that determines current standards of care.

In those moments I also witness efforts to confer upon youth an epistemic status that recognizes their capacity to know their own gendered experience, and to critique institutional norms that have historically disenfranchised and harmed trans people. This attentiveness to the purpose of the scientific and clinical ASKS that attempt to know gender is what might enable more ethical relations between youth and those who are trying to care for them; relations that could move beyond the sloganized imperative to PROTECT TRANS KIDS to the more radical request to TRUST YOUTH, but only after an acknowledgement of the limitations of science in the face of the inscrutable object of gender.

Defining Success

Dr M was often traveling for work, spending time away presenting at conferences, giving expert testimony, or offering trainings and consultations to other sites. After one such trip,

---

[3] This way of understanding what it means to create tools and contexts for producing scientific knowledge is much beholden to the feminist science studies scholar and physicist Karen Barad, who writes that "there is something fundamental about the nature of measurement interactions such that, given a particular measuring apparatus, certain properties become determinate while others are specifically excluded." (Barad 2007, p. 19). Though Barad was more interested in experimental designs, it seems the case that what would be true in the physical sciences would also be true here—that diagnostic and assessment measures aimed at making something like gender determinate inevitably exclude properties of gender that might contradict itself. In addition, such measures can never account for the impact of the "measurement interaction" itself, or the experience of undergoing processes like research surveys and assessments. If those experiences are to be themselves measured, they have lost their purpose as scientific tools. Furthermore, Barad argues that "observations to not refer to properties of observation-independent objects (since they don't exist as such)" (Barad 2007, p. 114). Thus, to follow Barad, like following Mol, the only meaningful way at engaging the world in a scientific way is to get increasingly specific—to account for the material practices that, in Barad's terms, "effects an *agential cut* between 'subject' and 'object"' (emphasis in the original) (p. 40), which is precisely what this chapter tries to do.

which had included both witnessing at a trial several states away and presenting at an international conference, we sat in her office catching up, and talking about some interesting talks she had seen, and some persistent frustrations. She showed me a simple equation that she uses sometimes in talks or just more generally in her work to justify the logic of affirmative intervention:

$$\text{Distress} + [\text{Intervention}] = \text{Success}$$

Yet, *we're not in agreement about any piece*, she comments.

The disagreement Dr M points to is not only contestation over what counts as DISTRESS or intervention, but how any of these *pieces* might be understood to impact the other; that is, about the measurement of impact, and the evidence of change. In contemporary research, this formulations focus on DISTRESS reflects a focus on showing how affirmative interventions reduce experiences of depression, suicidality, and other undesirable outcomes (Kann et al. 2018; Olson et al. 2016). Yet, this focus on success as predicated by the reduction of DISTRESS is related to the fairly recent shift towards de-pathologizing gender diverse identities and eliminating corrective, or reparative, approaches to intervention; in other words, to change the marker of success from simply being a cisgender experience to a less-distressed experience.

This is still a relatively new change, in that many existing providers were initially taught to see gender diversity (which was, at the time, fully entangled with sexual orientation) as critical problems that were themselves objects to be treated.[4] For example, Amy, a child and adolescent psychologist, told me, "I really did get trained with, *this is all pathology*, including I got trained that being gay was a pathology. I didn't believe it at the time, by the way. And I didn't believe what I learned in graduate school that it was OVERBEARING MOTHERS, WEAK FATHERS making boys who didn't want to be masculine. I thought" and she starts to laugh, lightly, "*no, there's something really wrong with this theory.*"

---

[4] See Sedgwick (1991) for early queer theoretical investigation into the depathologization of sexual orientation in the DSM and its relation to gender diversity, and Lavery (2020) for an important critique of Sedgwick.

Amy received her PhD in 1974, so when she describes her training, I assume she is alluding to works like Richard Green's (1987) *The Sissy Boy Syndrome: The Development of Homosexuality* and other similar scholarship that was adamantly reparative. In a more contemporary sense, the focus on success as a cisgender future is often connected to contentious figure Kenneth Zucker, who for many years was one of the more preeminent researchers and clinicians known across the globe for overseeing the Canadian Centre for Addiction and Mental Health's gender clinic. However, in 2015, CAMH was closed after an investigation into whether or not the clinic was practicing reparative therapy. Though the investigation ultimately did not support such a claim, it held up enough criticism of the clinic to shutter it.[5] Clinicians held this up as further evidence of the problems with reparative or close-to-reparative practices (Schreier and Ehrensaft 2016), and former patients, many of whom had been advocating for years to stop Zucker's practice, celebrated the elimination of a site that had caused them harm (Schwartzapfel 2013).

Yet despite the closure of Zucker's clinical practice, which he has continued to fight against, the lingering effects of his work as a researcher, and his inclusion in spaces that formulate the standards of care for trans youth and adults has remained an affront to many community experts, advocates, and clinicians. Zucker's historical impact on the field is not only felt through the pervasive use of statistics about the "persistence" and "desistance" of childhood gender nonconformity which are being leveraged in many pieces of legislation attempting to halt puberty suppression, but in the ongoing use of standards developed out of a organization that long recognized and legitimized his practice as a form of expertise.[6]

Given the lack of controlled trials in this field which can be used to ground practice recommendation, the World Professional Organization of Transgender Health (WPATH)

---

[5] Much of the writing about Zucker at this time, including the report itself, has been difficult to track down. Much comes from the activist websites run by Lynn Conway (Trans News Update) and Andrea James (Transgender Map), which were hubs for much of the collective work to de-platform Zucker. Also see reporting by NPR (Spiegel 2008) and a letter to the editor of the Journal of Child and Adolescent Psychiatry reflecting on Zucker's practice model (Pickstone-Taylor 2003).

[6] I discuss Zucker's substantial contribution to debates on persistence and desistence in more detail in the following chapter.

uses available existing research as well as a process built on the recognition of experts in the field to set their widely used Standards of Care for the treatment of trans people. As I learned during my attendance at the 2019 US Professional Association of Transgender Health (a biennial meeting that alternates with the global WPATH conference), WPATH uses the DELPHI method as a key part of their standards creation. A process developed by the RAND corporation in the 1950's, the DELPHI method uses a process of surveying identified experts and reporting to those experts a statistical portrait, with the goal of reducing the range of responses and arriving "at something closer to expert consensus" (*Delphi Method*). It is reasonable to expect, then, careful reflection on the process of including people as experts, and unsurprising when criticism about who has been excluded from those processes emerges.

For WPATH is not uniformly recognized as a beneficial good to the trans community, despite the ways that having a global organization dedicated to trans health has likely been a critical component of the widening availability of care. Instead, at USPATH and in other spaces, participants were often critical of the ways that the continual process of defining what counted as success, or DISTRESS, or intervention, was a process limited to those counted in professional settings as experts, which so often in the this field as in others, limits the participation of those who draw on their lived experience to validate their claims and knowledges. The category of the expert also isn't always a category one aspires to belong to.

For example, in a very different conference setting, I had watched as Hannah, a trans woman who worked in the TYC providing support for legal name changes, co-presented material with another trans colleague. She told us that *people might call me an expert*, but shied away from claiming that descriptor herself. Despite her years of lived experience, her knowledge from the inside about trans medicine, or as I would come to find out in our later interviews, her time spent as a personal care attendant for women receiving gender affirming medicine overseas, Hannah found the framing of the expert to be irrelevant to her own way of demonstrating her knowledge and sharing it with others. In her understanding, we were *all learning*, and she was simply here to share what she knew, with others, who might themselves have something to offer.

In this sense, Hannah, like many, is conveying a pragmatic skepticism about the limits of institutional knowledge, or standards, or even expertise, in providing the security that so often audiences were looking for. Rather, she highlights the process of *learning* over the confidence of knowledge, which includes providing information to those who need and ask for it but doesn't preclude anyone from being able to provide insight that might be relevant, particularly when that insight stems from lived experience. And it's this insight which is so often critical in this form of care, even what it is downplayed as a form of scientific evidence or found less helpful in determining, among a coalition of professionals, what counts as success. After all, as some of the researchers most involved with studies that wanted to determine the eventual outcomes of youth with gender dysphoria found, "explicitly asking children with GD (gender dysphoria) with which sex they identify seems to be of great value in predicting a future outcome for both boys and girls with GD," (Steensma et al. 2013, p. 588).

In this sense, the "outcome" of concern is the continued claim of a trans identity. In other words, if you understand success as the provision of intervention only to those who will continue to identify as trans[7], then a key indicator stems not from any expert analysis but from the process of asking young people about the gender they identify with. On the one hand, the simplest approach—but on the other, the most contested.

Asking About Gender

Early on in my fieldwork, someone had explained a bit of the organizational logic of this place, chuckling a little once they got to the top levels. As they described it since Dr. N is the Director of the Adolescent Medicine Division, he's ABOVE Dr. M, but Dr. M is the Medical Director for the Trans Youth Clinic, so in other ways, she's ABOVE him. A circuit

---

[7] A definition which is not shared by all affirmative providers, as I have and will continue to show.

of authority, which nonetheless never seemed to cause any conflict that I observed.

I only shadow Dr N two days during my fieldwork, both times which I set up through an office assistant who manages his schedule. He's often with medical trainees, and works off-site as well as having a busy administrative schedule, though my own reluctance to ask for his time is undoubtedly more connected to the ease I felt working with Dr M, Nina, and Dr Y (the other three providers) than any actual logistical difficulty.

> *The patient is 17-years-old, and sits next to me at a small round table in Dr N's large office. The patient's mother and older sister settle in only after Dr. N rustles up another chair from the waiting area. This is the first time they've come to the clinic, which means they've already met with a social worker to go through a basic intake, connect with family resources, and have some of their questions answered.*
>
> So.
> Why are you here today?
>
> I just really want to start testosterone.
>
> *They first contacted the clinic almost a year ago. Dr N asks about the delay; there was an issue, maybe with insurance.* I'm sorry that it took so long, *he says, before introducing himself. Dr N talks about how he has been in adolescent medicine for 30 years, doing trans health care for 28, describes how a large part of this appointment will be to get* your gender story, *though he is also clear that,* because you're 17, the ultimate decision will be Mom's.
>
> *7th grade. He remembers seeing something. A video, of someone who was trans.*
>
> It just broke, at some point. I didn't WANT TO BE TRANS.
>
> *Dr N asks about what he was looking for, probing for a bit more detail.*
>
> I typed in
>
> > what it means to be uncomfortable with your chest |
>
> *Dr N asks the patient's sister if she or Mom remembers the patient as a child. Mom is monolingual Spanish speaking, and they had already declined the offer of an official clinic translator, so the sister translates Mom saying,*

she always ACTS LIKE A GIRL
but also,
mama realized,
he was always taking out his hair, *didn't want to wear dresses,*

only pants.

Dr N asks Mom what she thinks now and she starts to cry. The patient's sister starts to tear up too. Dr N puts a box of tissues in the center of the table.

It's normal to feel sad.

The patient's sister resumes speaking.

Now she just wants to support him. Like he said, I'm the last one to approve.

Sister clarifies that she, too, is here in support. In enabling him to
DO WHAT HE NEEDS TO DO.

How SURE ARE YOU, that this is WHO YOU ARE? *Dr N asks.*

For me

if I woke up
if I grew up
as a boy
I would have been happy.

***

The interview that Dr N conducts during this first appointment is a critical component of how professionals come to say that they are able to provide gender affirming care to the right young people. Answers to questions like *why are you here today*, which are prevalent across medical fields.[8]. Methods of asking about gender, however, are contentious in the field. As

---

[8] This might be considered a permutation of the question "What is your problem," which Annmarie Mol poses as the "medical question par excellence" (2002, p. 128)

Dr Y might tell a patient, coming in for the first time, *I do, obviously, ask questions about gender.* Yet, he would contrast that with *determining your gender*, telling young people (and sometimes subtly, their parents), *that's something only you can do. I'm not* KEEPING SCORE.

The notion that providers might be KEEPING SCORE has multiple meanings and impacts. From the perspective of parents and providers looking to understand the experience of a young person, questions like the one asked by clinicians provide information that some times seem to corroborate (*always taking out his hair*), and others times feel to complicate (ACTS LIKE A GIRL) a youth's claim to a gender identity, often based on stereotypical understandings of binary gender. This was valued because youth themselves are often treated as unable to be trusted to name and know their own identities, as parents coming into the clinic express their concern to providers, saying, *I wanna ask you, how do you* KNOW, even as they then realize, sometimes before their breath ran out, that it's only *talking to your kid.* Yet, this simple work of *talking to your kid* can still feel insufficiently scientific, or objective. There was a palpable fear about the lack of evidence, as Harley, one of the TYC social workers, told me, "families come in all the time thinking there's no data, no science." Perhaps its no surprise, then, that a parent once turned to me, sitting quietly in the back, shifting the direction of her commentary away from Dr Y to say, *so when you're asking, can I sit in and do research—yes. There's not a lot out there.*

In much of trans medicine, discerning between those who should receive intervention and those who shouldn't often comes down to the determination of clinical professionals who looked for key attributes of gendered behavior and desirability to determine who would receive access to care (Meyerowitz 2009; shuster 2021; Stone 1992). This model of access which has so long dominated the field is often described in shorthand as GATEKEEPING. Generally used in a pejorative sense, GATEKEEPING is criticized for putting unfair standards on trans patients and failing to trust their own report of their mental state (Ashley 2019a). In this sense, GATEKEEPING is particularly descriptive of a kind of care that minimizes the truth value of what young people say about themselves, subsuming those narratives beneath the importance of other authoritative practices.

While this has largely referred to the kind of formal psychological assessments used in mental health care, as Dr Y told one father, *we do have parents saying*, PUT MY KID THROUGH AN MRI, alluding to the potential desire for an increasingly technological solution to the uncertainty of gender. Yet, as he explains, such an effort would reveal little about the gender identity, or the gendered desires, of a young person. People have a lot of *feelings* about gender, Dr Y says, because there is no way to *measure* it.

Of course, this doesn't mean that every parent, patient, or provider is content with the epistemic authority of a young trans or gender expansive person. More often, youth were under intense scrutiny to provide adequate evidence of their gender, and sometimes those around them relayed their wishes for medical tests, brain maps, or genetic markers, which might confirm or deny what a youth said about their own identity. Something that could feel like SCIENCE, which would assure parents and justify to an increasingly concerned public that care is given only based on an untainted interior experience, safe from other potential explanations of gendered distress, and protected from the possibility that others could be influencing young people towards certain outcomes.

Thus, despite the pushback against GATEKEEPING more broadly, social backlash from increased access to intervention has maintained the pressure on providers to be SCOREKEEPERS; those who could be the true arbiters of gender identity, or of gendered distress which is deserving of medical intervention. Given the availability of programs which did operate on a model that relied more on expert forms of assessment than the TYC, this partially meant that the parents who most desired that form of care often went to alternative programs.[9] But this didn't meant that providers at the TYC weren't engaged in these field-wide conversations, or caught up in difficult negotiations with specific families. It did mean that much of

---

[9] This could sometimes veer all the way into reparative therapy, as if some patient, who had failed to come in for a follow-up appointment, was found to have been sent to a *residential* program out of state, a place like *Utah,* as staff would speculate during a weekly meeting.

what I learned about the purpose of *talking to your kid*, and the many ways it was reframed by professionals working in affirmative care, took place outside of the walls of the clinic, in my work at conferences and in interviews with those who worked at programs across the United States. Especially because it was, as Dr M puts it during one weekly staff meeting, discussing the emergence of several new youth gender programs on the scene, *a good example of an ideological rift in the provider community.*

Getting the Answers

Back at USPATH 2019, which I attended for nearly a week, a presenter acknowledges that assessment is a *controversial* topic. She describes the measures as DATA and the interview as INFORMATION. While she suggests that naturally, the interview provides all the INFORMATION you need, the measures back it up, with DATA.

Assessments, or formalized measures, are often one of the first things highlighted in discussions about whether or not a given practice is a part of a GATEKEEPING model of care. Ingrid, a research psychologist, told me, "I think it's hard to know when to turn to what kind of evidence, and that's a question that people don't, I mean, you don't know—because the problem with measures is people get really concerned that, oh, well, the use of them is for GATEKEEPING." She goes on to say that "one of the people that we collaborate with, she gets accused all the time of GATEKEEPING, because she does assessments with children, and, the thing is the families that she works with—the parents—love getting the answers."

Most practices do some form of assessment for new patients, especially if they are young. At the TYC, this intake portion of their first meeting is handled by one of the two social workers, Alex or Harley. While I never observed any of these initial meetings, Alex shared with me that they worked through what is commonly called the HEEADSSS assessment, a screening tool prevalent in across adolescent care built on the understanding that for most young people, their greatest health risks come from risky behaviors rather than any particularly physical condition (Goldenring and Rosen 2004; Katzenellenbogen 2005). This is more of a structured interview guide, that providers use to ask young people questions about various life domains (Home, Education, Employment, Eating, Activities, Drugs, Sexuality, Suicide, and Self-Image), which in our case, puts gender related questions in the category of self-image. There is no scoring in the open-ended model, though they do use two other scored tools, the PHQ-2 (Kroenke, Spitzer, and Williams 2003), a two question screening tool for depression that, if young people score high enough, leads to a handful of additional questions, and a short screening for generalized anxiety called the GAD-7 (Spitzer et al. 2006). This process happens in one meeting, and no results on these screening are used to determine whether or not a young person meets with a provider or can start on a path of hormonal intervention; the goal is, rather, to ensure that the needs of youth are identified and met.

The programmatic model at the TYC is fairly unique, and in many respects, the closest thing to an "informed consent" model for youth.[10] Amy, a psychologist who co-directs another major program, described informed consent models for youth as being similar to current trends in adult care, built off of an understanding that there is "no reason for that kind of gatekeeping." As I often heard Dr M describe it in her conference and training work, she saw the reliance on mental health care providers to grant permission to access intervention as both unnecessary, given the capacities of the medical doctors to treat youth holistically, and problematic, given she saw it as contributing to conditions that encourage youth to simply say what they thought they should, in order to access care.[11] In practice, this looked like Dr Y telling a new family, *we never ask our patients to prove gender to us*, explaining his role as helping to determine *what interventions make sense to you.*

---

[10] Chapter Five discusses more about the role of consent and the relation of professionals and adults to the risk of treatment. See also shuster (2019) for how providers in trans care vary in regard to their own understanding of informed consent as a tenet of care, especially as informed consent related to tools of assessment and lack of clinical evidence about the long terms effects of medications.

[11] Which maps onto what Sandy Stone (1992) has described about the ability of people to learn and produce the right kind of narratives in order to get the care that they wanted.

Of course, helping to determine *what interventions make sense to you* means different things in different places. Often, this determination entails a strong reliance on mental health professionals, moving away from informed consent towards a model the relies on professionals as key decision-makers. Describing the program she co-directed, Amy said to me, “we very much feel that we want, um, a mental health professional to weigh in on whether this is a good part of the gender health plan for them to have either puberty blockers or hormones, and to have them at that particular time.” What Amy and others are looking for is someone willing to “recommend, from a psychological perspective, that intervention would be in this kid’s best interest.” Yet, she also contrasts that with a third option, the “other model”, where “you need to do really an extensive protocol with standardized tests and extensive interviewing because this is such a serious matter.”

While even those most committed to assessment might agree that none of their tools provided insight into gender that a young person didn’t have, approaches towards care that are oriented towards determining who should get care and who shouldn’t are concerned about preventing the use of gender affirming care in situations where young people are actually experiencing DISTRESS for other reasons. Some of the most common alternate explanations given were things like histories of trauma, or undiagnosed mental illnesses, which have a long history of problematic association with trans people. At USPATH, during the several days of pre-conference trainings I attended aimed at introducing new providers to best practices in the field, multiple participants in different sessions raised the question of what to do with patients who had experienced sexual violence. They wanted to know, for themselves or on behalf of parents, if this might be connected to a particularly sudden or unexpected disclosure of gender dysphoria. Finally, after yet another version of this question was raised, a participant in one of the back few rows raised their hand, and loudly projected the sentiment that if sexual trauma *made people trans*, we would have *a lot more trans people.* Applause erupted in response.

Providers who rely on strong assessment procedures thus generally do so out of an interest in ruling out any other causes of DISTRESS, gender-related or otherwise. Sarah, another prominent psychologist in the field, was the person perhaps best known for her assessment procedures out of all the clinicians I interviewed. She acknowledged that "anybody who came to the clinic" was generally there because they desired medical intervention; as she says, "people weren't coming for gender assessment." Nonetheless, she worked with medical providers who would first need a recommendation from her or from others she worked with to confirm a patient's readiness for gender affirming intervention (much like the program run by Amy). I asked her, "what were you working on in terms of making that recommendation [for medical care]? What were the kinds of things you were trying to assess for?" Outside of discussing specifically what they wanted "in terms of medical intervention," her assessment covers,

> a really comprehensive history of gender identity development...
> ...when the dysphoria started...
> ....fairly typical mental health, kind of in general assessment or intake, just assessing for mental health, um, problems like a kid's life...
> ...other things like social, like social life, so like their friends and social support...
> ...information about the family dynamics... in addition to the basic stuff we do with any, in any psychological assessment, there's a lot of additional pieces related to gender and also how the, how different members of the family are supporting the kid or not supporting the kid...
> ...cultural and religious and other diversity factors that may be, um, you know, making it harder for the family or complicating things for the kid....
> ...some school... general like how they're doing in school and all of that. But also, you know, how is the school being supportive... what bathrooms are they using and how are they managing PE class..
> ....And then early developmental stuff with the parents. Um, medical, like, you know, some basic medical information, family, psychiatric history, um, history of abuse, trauma, bullying....

Sarah then clarifies that "though it is an assessment as though it's mostly, you know, gathering information and then like, there's this kind of battery of measures that, um, I use like psychosocial and gender measures." This "battery of measures" that Sarah refers to is what Amy suggests sets these two approaches apart, along with the number of sessions it usually took to obtain the necessary information.

Parents who find this type of process reassuring, who love to "get the answers" as Ingrid comments, may find a packet of researched notes complete with quantified evaluations comforting when it comes to deciding if they would consent to their child's gender affirming care. But it wasn't just the use or absence of artifacts like formal measures or in-depth assessment interviews that sometimes made the recommendation of a therapist valued or not. Sometimes it also had to do with who was trusted to be objective enough to provide that input. As Harley, one of the TYC social workers who did intakes, explained to me, he was quite careful about who he disclosed his own trans identity to. Even though he wasn't formally assessing youth for gender dysphoria, knowing his own identity could be a moment of connection for families who may have no trans adults adults in their lives upon who to project their visions of their child, or, it could be a fact leveraged against his clinical authority.

This is because many parents of gender expansive children held deep-seated anxiety about the possibility of social influence on their child's experience of gender, which was occasionally amplified when working with clinicians who are trans, or sometimes who are even thought to be too close to trans people. For example, Harley could become not just a social worker but instead someone "who is also a transgender", a phrase he showed me in a medical history note from an outside provider which doubted Harley's ability to remain impartial in the face of a young person's distress. In this case, Harley found himself spliced into a narrative about providers offering intervention too easily, bending to the capricious desires of a child, or even, as it is sometimes glossed, MAKING KIDS TRANS, a phrase not infrequently tossed around the clinic as shorthand for a variety of what were felt to be nonsensical accusations.

Even further, despite the way that much of clinical care of gender is oriented towards finding and eradicating any possible alternative explanation for gendered DISTRESS, even to the point of interrogating the capacity of providers to deliver sufficiently objective viewpoints, for those who do receive access to care, they are often found regurgitating old stories of their gender any time they enter into new medical settings. In other words, as was the experience of Ravish, a college-student I interviewed several times between 2019 and 2021, medical institutions are historically sites where any health concern might be due to their gender care.[12] Rav went to an urgent care because "I thought I had bronchitis or something" and "just wanted to get it checked out." He couldn't remember if he had his gender marker legally changed at that time, though he knew it was before his name was changed.

> The doctor came in, or it was like a PA [physicians assistant], I think. And um, she was like asking about my history and things like that, and noticed that I had testosterone listed as one of my, like medications that I'm taking. And um, she was like,
>
> > *Oh, what is this for?*
>
> And I was like, well, that's a little off topic, but I'll tell you, I guess, you know. And um, I was like,
>
> > *Oh, well I'm like, a trans man, so I take it to help transition.*
>
> And um... what did she say after that.. she was like,
>
> > *how do you know, you're like, trans*
>
> or something, just [laughing] asking, like, all these ridiculous questions. [...] I was there for like, my lungs, you know, I don't know why I'm being like interrogated on, um, my whole gender thing. She was like,
>
> > *did you have to be on hormones?*
> > *do you feel like you needed to be on it?*

---

[12] A phenomenon sometimes colloquially called "trans broken-leg syndrome", discussed in conferences and other spaces where a big concern about inequities in healthcare for trans people was not just about increasing availability of gender affirming care but of making typical health care less problematic, reducing the likelihood that upon entering an emergency room to seek care for a broken bone a physical would first recommend stopping your hormones.

> and things like that.
>
> And um, well, she found out I had bronchitis, at least, so she got that much done

What Rav experiences is unsurprising in a world where clinicians are expected to play the role of the skeptical assessor, constantly prepared to evaluate the legitimacy of a youth's gender even, at times, when they are not the ones expected to justify prescriptions or treatment paths. It demonstrates one version of the bad relations that run through medicine, which on an institutional level, has so often been the carrier of desires to prevent trans futures whenever possible. Yet even as some practices are attempting to move away from this troubling clinical heritage, the contemporary need to ground clinical practice in objective evidence, in scientific precedent, often means relying on the same histories they aspire to leave behind. After all, most of the published evidence showing that gender affirming care provides good outcomes (or at least, isn't linked to bad ones), stems from a specific era, and a place; specifically, the Netherlands in the 1990's, where youth were *heavily, heavily assessed*. As one psychiatrist suggested to a massive ballroom full of practitioners, it would be comparing *apples* and *oranges* to *not do an assessment*. Thus, despite what I argue is a desire to include ways of treating youth based in potential, not merely prevention, the current climate around gender care makes such a move increasingly difficult. Instead, ideological disagreements about what might be used to justify decisions to intervene and validate current norms in the field are, more often than not, silenced by a referral to what has historically been the most dominant force in global trans care for youth—the Dutch Model.

The Dutch Model

If it doesn't come from the Dutch, then it's not valuable. Dr M tells this to me when reflecting on the challenge of creating new scales and measures that might show the utility of interventions like puberty suppression, hormonal therapy, and early access to surgery for young trans people. She was a bit exasperated by the expectation that the best way to show that care for youth worked was to continually return to models of gender dysphoria, in particular, the Utrecht Gender Dysphoria Scale, or the UGDS (host of the infamous BEST question) which relied on gender norms and expectations that no longer fit the experiences of many of the young people she served. But before diving into the specifics of the UGDS, sometimes simply referred to as THE BAD SCALE by those on the research team, and its relation to the broader aims of the HOPE Study at the TYC, a quick detour to the Netherlands, the source of not only the UGDS but the first gender-affirming clinical protocols for youth.

The UGDS and the affiliated clinical approach originate from Dutch providers and researchers who opened a gender identity clinic at Utrecht University Medical Center in 1987 (de Vries and Cohen-Kettenis 2012). Scientists and providers affiliated with this team moved sites within the Netherlands between the late 1980's and today, but their approach to early intervention is known as the Dutch model. This model undergirds most contemporary US clinics in one way or another, whether directly, as early clinics sent psychologists and others to train with Dutch providers on their protocol, or through the publication of research papers that described their methods and showed positive outcomes (Cohen-Kettenis and Van Goozen 1997).

Though the TYC had begun to treat patients as a part of its HIV prevention program in the late 1990's, the publication of the Dutch model in an English-language journal in 2006 detailing the use of puberty blockers for youth is widely accepted to be a moment that aligns with a shift towards increasing the possibility that young people could start to access around or soon after puberty (de Vries, Cohen-Kettenis, and Delemarre-van de Waal 2006). Up until this point, there was little concrete guidance for how to treat young people seeking intervention for their gender.[13] In my conversations with professionals, primarily psychologists, who had been trained by the Dutch in the early days, they speculated about how these circumstances shaped the protocol that was eventually developed. As one psychologist told me, "I also think there's probably an element that, again, that they just had to be so

---

[13] Though Gill-Peterson (2018) in particular has shown how the long existence of trans youth has been a part of the medical treatment of gender for decades before, as I describe in more detail in Chapter One.

cautious. Like they just couldn't risk, you know, having people go forward and having it not go well because then it could just, you know, ruin the treatment plan that, you know, going forward as a, in the world. You know, as, as a treatment."

In this sense, the desire to cultivate a set of medical possibilities for youth who did not yet have them required an especially cautious approach, one which may have been less invested in reaching all potential trans people but instead the ones who were mostly likely to provide evidence that this new treatment was beneficial for those suffering from the feeling that the sex and gender traits of their body were at odds with their gendered self. "Clinical Management of Gender Dysphoria in Adolescents" (de Vries, Cohen-Kettenis, and Delemarre-van de Waal 2006) discusses three different possible approaches to intervention, which gives a good sense of the clinical environment into which this new approach was emerging.

The first approach they describe is defined by the view that youth should experience their full endogenous puberty in order to make decisions about gender, and advises no intervention until adulthood. The second suggests that youth should experience most of their puberty, until Tanner Stage 4 or 5, at which time they could be provided with puberty suppression to prevent the further development of sex characteristics (around age 15 or 16), possibly followed with gender affirming hormones soon after. The third protocol, the one that most closely resonates with the current practice at the TYC and many other current clinics, suggests that young people may benefit from the suppression of puberty at Tanner Stage 2 or 3, followed by gender affirming hormones at age 16, and also emphasizes the role of a mental health provider, who should be "involved with the adolescent (and the family, for younger adolescents) for a minimum of six months prior to making a recommendation to begin hormonal feminization/masculinization (p. 92), which also aligned with the WPATH Standards of Care at the time (de Vries, Cohen-Kettenis, and Delemarre-van de Waal 2006).

It is this last model which so radically reshaped the possibilities for care in many parts of the world, including the U.S. But what may have been a dramatic shift in potential approaches to treating gender also brought along expectations that now might feel less helpful, more restrictive, especially as the Dutch model has been centered as the ideal formulation of care. For example, Dr Y and Dr M frequently discussed the difficulty of using age as a marker of developmental readiness, particularly when parents were unsure if a young person under age 16 could have access to hormones, or wanted to start a youth who was already well-into puberty on a regime of blockers only (a move that providers likened to *putting someone into menopause*, which they did not often recommend). They would often comment that age 16 is the *age of consent in the Netherlands* (Kranendonk, Hennekam, and Ploem 2017), positing that a significant contributor to the use of age 16 in the Standard of Care was related to the specific legal context of the Netherlands.[14]

Not only was there the challenge of determining what in the Dutch model was linked more to the Dutch legal context than to medical reasoning, there was also the difficulty of seeing the development of the Dutch model as, in its original form, simultaneously being about the development of a set of practices guidelines and the development of a body of evidence that would justify those practices. Before joining the TYC, Dr X had worked at a different major youth clinic in the US alongside providers with different approaches to assessment, in particular. I had asked him about his experience there, and with other providers working to develop their centers, and he told me about one clinic that relied on a heavier model of assessment, saying, "they say [it] follows the Dutch protocol… which is a RESEARCH STUDY…" His careful pauses, highlighting the RESEARCH STUDY connote to me a distinction between the creation of knowledge, for its own sake or to cultivate evidence, and what might be integral in order to provide good care. The distinction is sharpened further as he goes on to say, "which the Dutch don't do in practice anymore anyways." Amy, too, had mentioned that the young people would receive standardized measures and assessments at the clinic she helped run if they were involved "in research". This points to

---

[14] And, in fact, age 16 is the legal age of decision making consent for some forms of medical care in places that utilize a Gillick standard of competence, such as the United Kingdom, Canada, and Australia—see Chapter Five fn2.

the difficulty in disentangling aspects of care necessary for good *research* from those needed for good *practice,* given the entangled purposes of the original model; in other words, what purposes do all of these ASKS serve? And who are they for?

As yet another conference presenter at USPATH pointed out, in the beginning of one of many conversations about the role and use of assessments and measures I attended, many measures aren't *clinically normed,* meaning, not all measures have been given to a population-representative sample in order to determine what would truly be a "high" or "low" outcome (Hunsley and Giulio 2006). This is especially difficult for psychological studies of trans people, given how many psychological measures are normed to cisgender populations with binary gender distinctions (Webb, Holmes, and Peta 2016). In such a context, one has to defend both the questions that are asked, and the implications drawn from any results. It raises, again, the question of whether measures are intended to produce a form of statistical evidence, highly valued in scientific spaces, or to guide clinical practice in the moment with individual people. As the presenter went on to describe, it was important to ask if a given measure even has *clinically meaningful dimensions.*

Some questions, like the BEST ONE seem to lack a discrete, *clinically meaningful dimension.* Yet, this is not only about the role of these ASKS in determining access to care. It is also about the fact that processes which require young people to go through certain standard questions or intensive assessment procedures might have impacts. Still at USPATH, I later observe a neuropsychologist put into words what may be grounding some of the controversy around the necessity of measures, as he rhetorically asks, *what are the iatrogenic effects of giving measures*? He medicalizes and in some ways normalizes the critical question of harm through the use of "iatrogenic", a term which specifically refers to the illness or symptoms experiences by a patient which were caused by treatment; treatment which in this case is associated with giving measures. Thus, it reminds us that there may be both anticipated and unanticipated harmful results connected to the testing or assessment procedures used by clinicians in their practice. And it was this possibility that drove much of the consideration of what could, and should, be included on the HOPE study, and if the intended good use of scientific evidence meant to improve available health care was enough to overlook the potentially harmful process of constructing patients into research subjects.

The HOPE Study and THE BAD SCALE

The Health Outcomes and Puberty Effects of Interventions for Transgender Youth, which I call the HOPE study (a pseudonym), contains a wealth of measures meant to provide evidence on the safety and value of gender affirming interventions. From the scales meant to get at the amount and type of bone-density supporting calcium-rich foods a person might be eating (*On average, how much yogurt did you eat each time you had yogurt during the past week?*), and the amount and type of bone-density increasing activities a young person takes part in (*In the past 7 days, how many times have you played street hockey?*) to the perhaps more expected measures on depression, anxiety, and body-image, the data collected appealed to the fact that there are many dimensions across which the safety of treatment with puberty blockers and hormones has yet to be evidenced in a sufficiently robust way.[15]

By shown I mean that while clinical providers can and do draw on their clinical experience to justify intervention, there remains a lack of published data to draw upon when legitimizing their clinical decisions; not so little as some legislators argue, but not as much as even proponents of such care would like. When it comes to young people, parents want to know about the impacts of treatments, both expected and imagined. In my clinical observations parents asked, *does it effect the mood? Or is it* JUST PHYSICAL? Do subcutaneous injections *create more consistent levels* compared to intramuscular injections? What counts as *a very serious side effect?* How common is it for youth to *change their mind?* If we start blocking

---

[15] I suspect that there is no level of evidence that would satisfy the insatiable call for proof from those who would see care stopped altogether, and that in many instances, such calls instead simply mask the desire to prevent the youth from receiving medical intervention based on the recognition of their gender identity. However, producing evidence in order to justify care was nonetheless a significant desire of those who saw such evidence as a powerful way to lobby for increased access and which could help new providers, reluctant parents, and even the occasional hesitant youth, to better understand the possible risks and outcomes of treatments like puberty suppression.

puberty now, will it *make him shorter? Is there a blood test*? Is this *normal*?

To try and answer these and other questions, the HOPE study collects physical data drawn from medical charts, labs, and bone density scans as well as asks about topics in mental health, social support, and feelings of gender. Though everyone who was not an endocrinologist tended to roll their eyes at the number of items that they wanted to support their inquiry into bone density (there were up to 16 individual items about calcium intake alone), no measure was as uniformly contentious as the Utrecht Gender Dysphoria Scale (UGDS), the source of what Beau calls THE BEST ONE. Its inclusion on the HOPE study was, when I arrived in the field, the subject of an ongoing conversation simply known as THE BAD SCALE Meeting. During my fieldwork, the team went from using the UGDS as a part of their measurement of gender dysphoria, to questioning its relevance, to removing the scale entirely, and planning to replace it with a new measure being developed by a colleague on the East Coast.

Coming to the decision to remove the UGDS was not a simple process. As Max said in a research team meeting about the very composition of the HOPE study, *what I struggle with is that people don't get good care. What data do we need so people get access to care?* She acknowledged, often, that this base-level data was neither the most interesting or the most relevant to community, rather, it was *really for cis providers.* Yet, this data also came with a cost; a cost extracted from the young people the project purported to serve, a cost which might be understood as an epistemic undercutting of the clinical belief that in order *to know* someone's gender, you simply need *to ask* them.

As in many research settings, the HOPE study has a number of study coordinators whose lived experiences align them with study participants, something often pointed out as a critical asset for the team as a whole. Yet none of the original investigators of the project were themselves trans. This contributed to a concern among mostly trans staff about institutional and team *blind spots*, especially when it came to evaluating the costs and benefits of some of the more contentious measures. And no measure was more contentious than the UGDS, a scale developed in the Netherlands as an attempt to measure “gender dysphoria”, the feelings of distress and unhappiness with ones assigned gender, among adolescents.

The UGDS has 12 items on each of its two scales, which are separated according to sex assigned at birth (Cohen-Kettenis and Van Goozen 1997; Schneider et al. 2016). For people assigned female at birth, along with THE BEST QUESTION the UGDS also asks “I prefer to behave as a boy,” “a boys life is more attractive for me than a girl’s life,” and “I wish I had been born as a boy,” among others. Items for those assigned male at birth included “It would be better not to live than to live as a boy,” “I feel unhappy because I have a male body,” and “Only as a girl my life would be worth living.” The items were not matched; that is, there are two different scales divided by the sex assigned at birth each paired with an assumption of the transition to a binary opposite gender identity.

Having two separate scales divided by sex assigned at birth which made it difficult to use the measure longitudinally and after youth had begun any transition procedures. This issues has been partiality addressed by the revision of the scale to be more gender-neutral, as done by the University of Minnesota’s National Center for Gender Spectrum Health. The UGDS-Gender Spectrum relies heavily on the construct of “assigned sex”, and “affirmed gender” including items like “I prefer to behave like my affirmed gender,” and “It is uncomfortable to be sexual in my assigned sex,” (McGuire et al. 2016). While ameliorating some of the ways that the original UGDS is now viewed, particularly the difficulty of using the tool longitudinally and not only among youth who had yet to begin their physical or social transition, it was either not available or considered as a part of the initial design of the HOPE study, meaning it was the original UGDS that was a part of the study from the beginning. The particular phrasings of each of the questions were often pushed back upon—what is “a boy’s life”, after all? What if youth already saw themselves as their affirmed gender? Or has already started treatment than changed how their body fit social gender expectations? And, of particular concern at the TYC, how did such ASKS contradict with a care that was concerned with expanding, rather than limited, the potential for gendered life—a care which wanted to move away from reifying both *behavior* and the *body* as gender, even the study was intended to offer evidence that supports the importance of opportunities to align bodily traits and an internal sense of gender.

The challenges with this set of questions were more than ideological. Right before she left the clinic for a new job, I interviewed Imi, a data manager on the HOPE study. She told me about how the research coordinators were the ones noticing most carefully the issues with some of the scales, but that "even that handful I had done, it had come up where it's like, that question is really troubling or weird." Rather than making an argument about the quality of the items, which were felt to be clearly understood, she told me about the complications this caused for the overall utility of the scale itself.

> so where we went from that was like, okay, well *if we're going to have to construct these scale scores, let's just start looking at it and seeing what's happening with it.* And then in just running frequencies of the scale items, we saw that a lot of people were refusing to answer. So it's like, okay, *that's a score*—like, in line with what the coordinators are saying and what the participants are saying afterwards. And then also, like, if there's so many people refusing to answer, it's not very methodologically sound to still calculate a scale score off of that.

As Max said in yet another meeting discussing how to make the HOPE Study more affirmative for young people, *there's a lot of things that I feel I know clinically, but others don't,* even as she says, the process of attempting to make that clinical knowledge into objective data makes her want to *poke her eye out.* Yet, as Beau points out, this feeling is magnified, many times, by those trans staff. *Every single one struggles*, he tells us. *It's like informing cis people on the backs of trans people, again and again. And the kids go through it and it makes* them *want to poke their eyes out.* Some are nice, he says, they *tamp it down*, but he wonders, aloud if it will all be worth it in the end, if it will deliver the changes in care that have been promised.

Because simply pointing to the theoretical issues with some of the items, like the BEST ONE, may not have been enough on its own to lead the principal investigators to remove the scale, Beau and other study coordinators had put together what they called the sub-study.

Starting with the simple frequencies that Imi described, the sub-study also asked several reflective questions about what it was like to take the survey itself. This was a moment which re-conceptualized the work of science in trans care as it relates to both the desire to produce evidence that such care can *prevent* bad future outcomes, and the difficulty of reconciling such research efforts with an practice model that wants to emphasize the *potential* of expanding possibilities for the gendered future. Put otherwise, I see here a tension that emerges in part because of the conflict in the way that preventative and potential logics might justify the decision to provide gendered intervention, a conflict that is especially tangible within the epistemic space of science; where the quantifiable, historically-defined characteristics of the future to be prevented are much easier to operationalize than the uncertain, emergent, possibilities for a good future.

Furthermore, the observations that study coordinators like Beau made were also about seeing participation in the research study as not only enabling future care to work differently, but as a lively component of the care youth were actually receiving. Study procedures actively impacted youth, creating "research fatigue" (Ashley 2020b), and could shape how youth saw themselves and their futures in un-affirming ways, through repeated asks that focusing on feelings of distress and unhappiness, and experiences social discrimination. Both understood as important to know and also deeply limited, the coordinators saw the extractive costs of the projects, and wanted to push for more consideration of how the study could account for the existence of the social pressures that caused those poor outcomes, in other words, moving away from seeing trans people as what could be changed, but able to document how transphobic, racist, and otherwise oppressive social worlds prevented the experience of what they sometimes called *gender health.* Yet, ultimately, as Beau described it to me, what became clear to him was that HOPE wasn't a study for trans people. It was for the people who are trying to get in the way of trans care. As much as it pained him that, as he saw it, once again trans people were being asked to suffer so that the needs of cis people would be met, he also acknowledged that the HOPE study would "give basic, basic, knowledge that hormones are safe and effective for youth." And maybe right now, that would be enough. Because as he said, "People need survival first, before they can get somewhere higher. This study will help people survive."

Goonies Never Say Die

In my own approach to understanding the impact of medical intervention on the lives of young people, I relied far less on the standards and assessments needed by the clinic or even the research project; one of the many benefits, in my perspective, of being an ethnographer. Yet, this didn't mean I didn't also play my own part as a part of a scientific effort to know more about young people, their experience of gender, and the impact that medical care was having on their lives. The relative willingness of most youth to freely discuss these topics aside, for some young people, it seems like I, too, might just be replicating efforts to know them rather than to let them be. Such tensions could be even more apparent when parents were also a part of the conversation, given how my own interest in hearing youth talk about their gender aligned often aligned with their interest in having their children talk, or explain, to anyone, about an aspect of their self that parents often couldn't easily understand.

I met Ady's mom first, at a bar and restaurant a short walk away from their house, which was deemed too *chaotic*, with the recent introduction of a new, three-legged dog to the family, to be a good site for recording an interview. It turned out that there was a mid-day acoustic set that interrupted us only a handful of minutes in, causing us to relocate to the back patio, despite sweltering sun and hot furniture. The interview is briefly derailed by Mom's recognition of a tattoo I have, a skull above the phrase *"never say die"*, as a reference to the 1985 film "The Goonies". It's is one of my favorites and also hers, and she is delighted by it.

After we had talked for a while, Ady called, and decided to join us, lured by the promise of lunch, followed soon after by their father. Though it was my usual preference to talk separately with young people and their parents, Ady didn't take their parents up on the offer to leave us be, and so we talked together, until they tired of the heat quickly and walked home with their mom, leaving Dad and I to talk for a while longer. Before they left, however, the four of us sat together, chatting fairly casually, about school, the new dog, and eventually, Ady's gender. I has just told Ady and Dad that I was interested in knowing about how, as a family, they had been navigating gender and in particular, what role medicine, and seeing the doctor, had in their lives; what it was like, what did they think was important.

Ady turns to their father.

"Yeah, Dad, what's it like being trans?" they ask.

Ady has the characteristic quick-wit and ready sarcasm of a thirteen year old, and applies it liberally to their parents and themselves as we chat, often answering questions in elliptical more than straightforwards terms, sometimes letting their parents clarify for my benefit. Mom interjects with some information about the timeline of medical interventions that Ady has used, which has included a puberty blocker, followed by estradiol and then progesterone. When I ask about the medications, Ady first comments about their dislike for taking pills, their wish that they could just "insert themselves into me."

"What have been the things that you've noticed," I ask, "when you got your blockers, or after you started estrogen? What changed for you?"

"Mood swings," they say.

"You got them, or they went away?"

"Ohhohohh, I got them," Ady says, as their father shows his agreement with a deep, sighed, *oooohhhh*.

Ady's parents start describing the intensity, their questioning—*is the kid going crazy?*—followed by the realization that Ady was experiencing these deep highs and lows around the time of the injections, which were the first type of puberty blockers they had tried. Dad says still, to this day, that he is "never quite sure what is normal, teenage, hormone stuff, what is possibly side effects form the medication..."

"Yeah," Mom confirms.

"... because, you know, they have anxiety attacks, and still have mood swings, and, you know, lots of things that, I just don't know one way or the other, *would this be here anyways*? Because I know what MY TEENAGE TIME was like [laughing], and it was no cake walk."

"And then there a part of me that, it just doesn't matter, I guess. Because it's like, THIS IS THEIR ADOLESCENCE, no matter what, you know," he says.

Ady's parents may be at a place now where they can live with the kind of uncertainty about the causal relationships between every intervention decision and the current way that Ady is able to be, in part because there is this underlying acceptance Ady's Dad identifies, that regardless of the *why* of certain experiences, what remains true is that they have them. As he says, THIS IS THEIR ADOLESCENCE. But it wasn't a simple process for them to arrive at the place where they could accept that this was Ady's life and journey. As both Mom and Dad tell me separately, Mom struggled when Ady first came out to them as trans, working through her own fears about what this meant for Ady's future and their prospects while Dad had an easier time. Yet, seemingly as soon as Mom found her footing, Dad had to manage his own feelings about the meaning of his child's gender identity. For both of them, one of the more difficult aspects of Ady's transition for their parents has been their identity as nonbinary, which has taken some time to understand and reconcile with.

Ady tells us at one point, "I think my favorite thing at the hospital is, uh, the checker board things sort of thing."

"The abacu—sort of thing?" Dad asks.

"Yeah" Ady says.

"It was like, male, female..." they start to recall.

"It was intense," Mom says, and Ady turns to her.

"Why was it intense?" they ask.

Mom explains that it was "the first time you were able to explain to me in a way that I can understand it. About where you were at. It was amazing."

Ady was ten at the time, and recollects Mom "crying" and dad interjects, in a emphatically deepened voice, "It's your mother, of course she cried," and the three of them laugh, though Mom doesn't seem to find it quite as funny as the other two do, given that it was "before Lexapro, honey, so, yeah."

I ask Ady how they filled out this tool, called the "gender abacus" which allows individuals to adjust a set of movable beads along a four different spectrums: anatomy, gender identity, gender expression, and sexual/romantic attraction.[16]

"Um, it was like male, female, and I put it kind of 60, 40... 70, 30?"

I'm not really sure what that means, and I remember from conferences and workshops that this tool has multiple spectrums, so I attempt to clarify with Ady which one they were working with and how they arranged them at the time, but aside from remembering that they weighed the feminine side of things heavier. Other than that, they "don't remember—it was like, almost four years ago."

"Do you think you would, do you think you would still split it like that for identity? Or would you split it kind of different now?" I ask.

"Maybe 50/50?" Ady says, tentatively at first, then with more confidence.

"Yeah. It's probably 50/50, 60/40, still."

"Can you, uh, explain to me a little bit about like what that means for you or like what that feels like?" I ask.

"I mean, it's really fatty pieces, not as tender as like, a good 80/20 blend," Ady says.

I start to snicker, both in appreciation of their particular sense of humor, and at the feeling that Ady is drawing a boundary around how much they are willing to "explain" to me.

"Even the 70/30 blend, if you liked that kind of leaner meat tenderness, but like 50/50...

---

[16] The gender abacus was a tool originally developed by Dawn Ashbrook and Johanna Olson-Kennedy in 2011.

that's just like a ball of fat," they say.

"So, you're not going to give a real answer," Dad states, while I, in an attempt to grant Ady this moment of autonomy, reply,

"So, that's your gender."

"My gender is a hamburger."

Ady's parents seem to accept "my gender is a hamburger," albeit a bit begrudgingly, and Ady decides to head home fairly soon after. In this exchange, I see a materialization of epistemic gulf that Dr M sometimes references; the inevitable divide between cisgender parents and transgender youth, about an object, gender, which they experience in widely different ways. This distance is what most of these ASKS are attempting to bridge. Yet, though Ady's parents might have reconciled through a combination of approximating closer knowledge, thanks to tools like the gender abacus, and acceptance of what they don't know, as Ady's Dad seems to invoke when he describes the feeling that, no matter what, THIS IS THEIR ADOLESCENCE, many others turn instead towards the promise of science; in particular, not just scientific authority as it is embedded into techniques of assessment and governed by professional claims to objectivity, but increasingly technological and biological claims towards the meaning of gender as it might be found in the brain.

Jonathon's Brain

Look for the big guy in Birkenstocks, Jonathon's mother texted me as I got off of the train. She was referring to Richard, her husband and Jonathon's father, who was waiting for me in front of the public library, looking very much as I expected. We said hello, and he joked with me as we made our way to the library room they had reserved for some privacy. There was, he told me, an unfortunate limit on the number of hours you could hold the room, so they had already decided that Jonathon would talk with me first. When we started our conversation, in quiet tones with our backs to the glass wall, Richard quickly checked back in with us, letting us know they could tell we were talking, but they couldn't make out any words.

Jonathon characterized his town to me as “weird. It’s like, half the people are gay and then the other half are like, violently homophobic.” This ambivalence was pretty typical; and if anyone had asked me at 13 how I felt about my town, I probably would have been similarly exhausted and annoyed by it.

When I asked Jonathon about the process of coming to know himself as trans and beginning to access care based on that knowledge, he tells me a lot about the early trouble he had with his parents, specifically his dad.

“My dad was like, he didn’t want me to start anything. He was like, *I don’t know if this is like real or not yet*,” Jonathon said.

As he tells his, his dad had been “difficult” during their first visit to the clinic. But not only did this difficultly arise from Richard’s view that (as voiced by Jonathon) *oh, I know this is*A PHASE, but due to what Jonathon glosses as his dad’s “medical background”, which turns out to be years spent as a nuclear-medicine technician. Such a background seems to be understood as critically grounding Richard’s desire to KNOW everything, which Jonathon recalled as *oh, I want to know, like, I want to know like how you do* THIS, *or* THIS, like *subcutaneous*, and in a strong reliance on the objects and processes of scientific authority.

Jonathon told me, “he only let me start T after he talked to my therapist, and it was like… he wanted, uh, like my therapist to tell him that like, *this is real.* And like, I do have, like, gender dysphoria and I actually am transgender. This isn’t, like, A PHASE, or anything.

“Umm, what was that like for you?” I ask.

Jonathan sighs.

“I didn’t like it, but I understood because he was like—he wanted to hear it from a medical professional because he was like… I mean, I understand it, honestly.”

“You’re worried about your kid. You’re—you think, you don’t want them to make, like, the wrong decision, you don’t want them to be affected later in life... Um, cause you know, they’re like—that could happen where someone like, has something like that, like A PHASE where they think they're something like they're not. But I was still a little upset that he like wouldn't believe me, but I understand."

Later, I asked Richard what this process had been like from his perspective. He struggled at first, then told me, "I don't know how to say this in 5 million words or less, because it's a very complicated reaction to all of this."

Richard contextualizes his perspective first, describing his "science background" and telling me that he thought the topic was "interesting, but one of those rare things... something interesting and fascinating that happens to other people." Later, after describing a Charlie Rose ("before he got fired") episode that talked about gender identity in terms of "brain structures", "hormonal changes", "different fluctuations", Richard compares his interest in gender diversity to that of an interest in a "supernova"; something you might read about, that was interesting, but very, very distant.

A few moments later, he tells me,

> okay, here's the thing.... [...] as far as we understand it, Jonathon's brain is different and I haven't read enough literature [...] you know, reading more about the neuroanatomy of what's going on in the transgender brain, as opposed to a gay persons brain as opposed to a heterosexual persons brain. And I know that there are these neuroanatomical differences—although that's interesting, the whole idea of, you know, what's, what's causing what, is it the brain structure that's different about Jonathon that's causing him to be this way, or is the fact that he thinks this way and wants to be this way that makes his brain different. And that's something I'd really like, I'd really like to know more about.

Richard really wants to "know more about" how differences within the brain might be identified as something that sets his child apart, though also hesitates to draw out any kind of conclusive knowledge from that. While he seems to take it somewhat for granted that there are such differences, he also suggests that what he really wants to know about are the pathways that might explain the relationship between those presumed differences to someone lived experience of gender.

This understanding of trans identity "as brain intersex" (Wang 2022) might feel like a contemporary possibility, intrinsically connected to the emergent capacities of neurobiological science, but as scholar Thelma Wang describes, such a way of thinking is deeply imbricated with the history of scientific and medical treatment of sex and gender. The turn towards the brain is just one of many such turns in the history of attempting to understand sex/gender, but it is one that has a particular impact, and is a part of both the heritage of the scientific past and the potential of the scientific future, as they are narrated in relation to the prospect of knowing gender.[17]

Gay Brains

It was common for Dr M to *kick out* a parent for part of her appointment with a young person, especially those who were in high school and want to talk privately with their doctor about sensitive topics like sexual health, drug use, anxiety, and their relationships with their parents. When young people initiated the *kick out*, they sometimes turned to me, and clarified that, *you can stay, it's just her(him) I want gone.* But Dr M, who had many patients she has seen for over a decade now, was bolder in her assertion of the importance of time alone with patients, and would straightforwardly boot me out along with any other extras to get that time. It often relieved me that she was so clear, because I worried less about overstepping my bounds, or impinging upon a young person's care.

During one such session, after we had all talked together about the schools in a particular suburb, and heard a bit from Emilia about what it had been like to be one of the few Black young people in her school (before she switched to a different school, where now her social life *was amazing*, though her *academic life was . . .*), her White father and I exited the room. We took up too much space in the hallway, chatting about the project, when he asked me if I knew much about those studies examining *the gay brain.*

I was one of them! He tells me.

---

[17] See, for example, Sarah Richardson's work Sex Itself (2013) which details how sex became located in chromosomes, and Gill-Peterson's History of the Transgender Child (2018) on the endocrinological roots of trans medicine.

The *gay brains* studies began by looking for differences in brain anatomy between cisgender men who were attracted to those of the same gender and those who were attracted to cisgender women. In 1991, neuroscientist Simon LeVay examined the anterior hypothalamus, using postmortem tissue from women, men who were "presumed to be heterosexual", and homosexual men who had died of AIDS (clearly, this was not a study my parent informant was a part of). In the study, LeVay notes differences in the size of a group of cells between heterosexual men and the brains of both homosexual men and women. While there is no real argument about the particular relevance of this brain area, given the stated challenges of working with postmortem tissue from men who have died of AIDS which may not be representative of "gay brains" writ large, LeVay stresses the finding that "sexual orientation in humans is amenable to study at the biological level" (1991, p. 1036).

LeVay's work was immediately swept up into the larger cultural debates about sexual lifestyle choices and arguments of being *born this way.* His own history and his decades of partnership with a man who died of AIDS in 1990 also became spotlighted. Though he left academic research shortly after this publication, and acknowledged the trouble of looking for biological explanations as a path towards greater social acceptance, his work nonetheless was a particularly signifiant moment in narratives about the biological basis of sexual orientation. While some academics interrogated his binarization of sexual orientation and investment in the biological (notably Ann Fausto-Sterling), other people and organizations found relief in the notion that the body could be to blame for their (or their children's) sexuality (LeVay 1994; Nimmons 1994).

Often in clinic there would be questions about genetics, *blood tests*, the brain, and the potential biological etiology of trans identity. The drive to locate gender in the body, and into more and more interior spaces, is part of a larger narrative which elevates the biological to the domain of the immutable. This argument about being *born this way* is an often useful response to other narratives which locate the source of gender diversity in the social world as a way of undercutting its significance and the potential utility of medical interventions.

Yet not only do people leverage the logic of the body as the source of gender diversity as a way of combatting arguments about parenting inadequacies, social media trends or other influences on gender, but in order to concretize and validate someone's gender identity as they have already disclosed it. They look to the body and to tests on the body to reveal something that they think a young person cannot.

> *Dad has another question, this one about the brain.*
> There's been studies of MRI.
> *Studies that he believes show the difference between the brains of people of different genders.*
>
> Do you do anything like that, or do you just go on WHAT THEY SAY?
>
> *Dr Y explains that the MRI studies are* not a diagnostic test.
> Even brains within one gender are very diverse.
>
> *Though Dr Y mentions how according to some research, yes, the brains of trans people are more like those of their same gender rather than their sex assigned at birth, he emphasizes the inadequacy of the tool for the task at hand.*
>
> Gender is hard for anyone in medicine,
> or in science,
> because
> we can't measure it.

***

While not everyone in science or medicine agrees that gender isn't measurable, what Dr Y points to here is the certain inherent level of uncertainty that must be managed in this kind of care. From a practical standpoint, this is what guides providers to answer like Dr Y, reminding parents that there aren't currently methods for ascertaining gender that are going to look to the body over what a youth might say. Sometimes the conversation gets even deeper, as was true during another instance where Dr Y and a parent discussed the current research he had been reading. Dr Y commented that it was *interesting,* suggested that data from twin studies provides some grounding for the idea of a biological connection to trans identity. He says that, *for some people, its reassuring—that's who I am.*[18] Then he said, there will always be the other side—*we can fix this.* Dr Y is cautious about the promise of the body to provide a kind of liberation from social "identity", but also recognizes that for some people such a story provides much needed grounding.

Since the first publication of the *gay brains* studies, some people have read them as providing support for their identities. As Dr. Sheila Kirk wrote, in one of her ongoing columns "It's Time for Your Medicine" published in the magazine TG-TV Tapestry, "I believe strongly there was a gene responsible for both the transgendered as well as the gay population" (1993, p. 11).[19] Dr Kirk was the first transgender surgeon to serve on the board of the precursor to WPATH starting in 1997, and regularly updated readers with her interpretation of the latest studies as well as provided guidance on medical care. Her interpretation of these studies as a way of understanding gender reminds us of the ways that these narratives so often are taken up as positive indicators of the validity of gender identity and sexual orientation.

But what would would be the impact of locating gender identity, or transgender identity, on a gene, or in the brain? Dr Y worries about the possibility of *fixing*, the ways that such a move might create space for eugenicist practices that would eliminate, rather than support, trans people. The less extreme version of this fear was the possibility that such technologies would invite further policing of gendered diversity, as Dr Y suggested by rhetorically asking a parent, *are they going to start testing masculine women?* He is attuned to the potential of instruments of measurement and expertise to simply perpetuate GATEKEEPING in new ways, and to further erode the little authority that young people have to self-determine gender.[20]

---

[18] See, for example, (Serano 2016, pp. 81–82).

[19] TG-TV was a publication that changed its name several times, but began as a newsletter in the late 1970's. Its archives are available as a part of the Digital Transgender Archive based out of Northeastern University.

[20] To say little of the ways that the development of tools such as this are already integrated with gendered assumptions about what will be found; see, for example Sari van Anders (2013) discussing studies of

Conclusion: Knowing Gender

Rather than further entrenching the mechanistic logic of scientific objectivity as rendered into instruments like brain scans, or even formal assessments, what more often happens at the TYC is that the authority and agency of individuals to determine their own gender is upheld, even when it is difficult to render such disclosure into evidence that will satisfy skeptics. As Harley tells me,

> There's a big miss, as providers, both mental health and medical, about just asking. It doesn't matter how old somebody is, if you ask an 11 year old—and this is kind of how I explain it to parents who, who, who come in with this confusion about, um, you know, well, *is my child trans*? And if they're trans masculine, like, you know, *maybe they're just a tomboy*, right? This is something that comes up like all the time. And parents will project their own crap too. So, you know, a lot of times moms, the moms, it's always the moms.
>
> The moms will say like,
>
>> well, I don't like wearing heels and I don't like this,
>> so am I trans?
>
> And I'm like,
>
>> well, I don't know.
>>
>> Are you?

Harley's way of turning back the question to critical parent is part of performing the difference between what scholars such as philosopher of language Stanley Cavell have forwarded as the difference between "knowledge" and "acknowledgement". Cavell theorizes the philosophical problem of privacy by attending to how skeptics draw the inevitable gulf between individuals who cannot fully know each other's experiences (in that we cannot inhabit the minds of others). Yet he proposes the way out of this problem through the process of acknowledgment, which in the specific case of pain, is approached through the ethical call

---

testosterone.

to respond to it (Buchbinder 2015; Das 1996).[21] Acknowledgment is the process which does not try to erase that gap by either fixing individuals into legible subject positions or avoid it by denying their particular form of existence. Such denial, what Cavell refers to as a "psychic annihilation of the other" (2007, p. XII), has been part of what some anthropologists have ascribed to many of the modes of rending the suffering of others visible and legible to structures of violence, which often can, and do, include institutions of health and medicine (Das 1996; Garcia 2010; Stevenson 2013).

As Nina says to me, about the challenge of knowing gender, "pain is probably the closest thing because it's subjective. It's what you say it is how you feel it." Yet, to approach the process of attempting to know trans youth through such a lens doesn't require an assumption of incommensurable suffering, or pain beyond language, as an integral part of what it means to be trans. Rather, looking towards how experiences of pain have been theorized as a case which troubles our commonsense understanding of what it is know know gives guidance for how to analyze youths experience of gender as part of ordinary life that cannot be reduced, and how to enable forms of care that focus more on being present with, than with justifying. A form of care that does not simply aspire to identity and manipulate the future to be prevented, but instead is attuned to the potential of youth to name for themselves the role that gender plays in their lives, even if that name is just "a hamburger", while also remaining conscious of the challenges that current cultural and political trends pose to the capacities of institutions to offer material support to young people in the form of gender affirming medicine.

"Science"

> What little we have ever understood
> is like an offering we make beside the sea.
> It is pure worship when pursued
> as its own end, to find out. Mystery,

---

[21] "A 'failure to know' might just mean a piece of ignorance, an absence of something, a blank. A 'failure to acknowledge' is the presence of something, a confusion, an indifference, a callousness, an exhaustion, a coldness." (Cavell 1969, p. 264).

the undiminishable silent flood,
stretches out from where we pray
round the clear altar flame. The god
accepts the sacrifice and turns away.

-Ursula le Guin, in *Finding My Elegy*, 2012

***

INTERLUDE: ALL OF US

When I interview people who work at the TYC, I always tell them that they can share as much, or as little, personal information with me as they want. I'm interested in how people end up doing the work that they do. Sometimes people share things, unsure if its relevant, *and I reassure them that it's all relevant. Once I point out a resonance with someone's personal story and the work they do, and they tell me.*

I mean, I think that's kind of all of us, right?

Like if you talk to people, like you find little things; why things make sense, right?

***

When I came to California, it was the first time in my life I had a title to what I was—a trans woman. And I've never been able to claim that before because I've never knew who or what I was. All I know is that I started transition, not even transitioning because that's not what I knew to call it, then, I just—at the age of eight, I was done with pretending to be somebody I wasn't and I became the girl that I was meant to be at the time.

I grew up in Utah. I come from like a, uh, my family's pretty LDS, Mormon. Coming from a very, very conservative space, being, like, a queer person or like a questioning person—it just wasn't a lot of room for me or my identity. I actually left Utah when I was 17, a couple days after I graduated high school, drove my shit out in a car.

It was really hard being a minor here.

I'm the youngest of seven kids and there was a lot of—as a Latino, I think there were a lot of expectations, about kind of what that meant.

I didn't really have a path for myself and no one had, had gone to college. And so I just sorta thought, well, *this is what I want to do* and that's what I want to be doing.

I grew up in Oklahoma. My mom is from Italy. She emigrated when she was like, 20 something. I grew up kind of like in a single parent household. My dad is Black, but I wasn't raised around him.

I also didn't want to live like the way that I had grown up. I wanted to have a career.

Because she was, um, an immigrant and a single parent, we grew up pretty poor or like on food stamps, section eight.

We never, never got to a place where we had to potentially be homeless, but a lot of that, I think it has to do with the fact that my mom really hustled her ass off with like three jobs and things like that.

It's just a different dynamic I'd say. Then like, even just listening to some of the providers here, I'm like, *I don't know anything about that.*

***

It's so weird because a lot of the clients I work with, I was once a client with them.

It's hard when it's someone I knew from when I was homeless. It's hard because, it's like, *you got out of it, why can't I*?

Because I'm half White.

I was super spoiled homeless person. I never slept in a tent.

I was a patient of Nina's.

I was a patient of Dr. M's.

They kicked me out, when I came out. I was homeless for about a year. I met a friend, in math class, who was a mom. She took me in, to her place.

My family is Christian and Catholic, so that had a lot to do with their ideology.

I remember when I first came to California, we ran out of money and we had, I had, I stayed awake for days watching my friends sleep, watching our stuff—well, not our stuff, because we came with only the outfits on our backs.

***

A trans therapist or nonbinary therapist is one in a million, at this point. A cis person isn't going to understand what being trans is like.

Going into somewhere for help and first face you see is someone that's not of your own community. It's like, *Oh, this is interesting.* Or *the experience is going to be weird.* And so I remember going to hospitals and not seeing anybody like me.

I was supposed to work with a clinical supervisor and I told my supervisor, *no, I can't go see her and tell this woman all my problems.* She can't ever relate to anything. I'm going to be seeing her talking, telling her that things that's going on and she's gonna be like, *Oh, I'm sorry that's happening. I can't say that I know how you feel.* And that right there would irritate me.

So I would rather, and I know a lot of people would rather, when people have these type of life experiences, than someone who can just throw a textbook at them.

When I wasn't part of the community and when I was like on my own, but I was transitioning, I felt like I had to fit this box of masculinity, being a man and all these things, cause all the guys I hung out with were like that, and it was like, blending in to my environment. Whereas when I met more trans folks… it kinda gave me the fact to be like, okay, I'm trans, but I'm also non-binary, and I fall outside the box. Like, okay, I can be masculine, but I could also be in a nonbinary space at the same time, which kind of opened up the doors to me being like, *you know what*? *I like being out and open about my identity.*

***

A lot of medical providers, you know, don't live the same lives that a lot of these young people have lived. Not even kind of close.

Like they've had a lot of privilege. They don't really have to think about making a distinct choice between *I get to live in a house* versus *living on the street* for any particular reason. So I think it's hard for them to even conceptualize that a parent would do that. Like hang that choice over your head like that. And it happens a lot.

I was helping build cultural responsivity among people who are more senior than me.

Whenever like I have the chance, you know, like even when like these youth I see for research, like for like my study, I let them know, *Hey. I'm trans too.* I can do that stuff now.

***

We know our people. If you're of the community in general, not even just the trans community, we know our people. Sometimes we don't even have to say anything, they just tell us, themselves. But other than that—we notice. So like if you go into the room, and you, you just feel like, *Oh God, here we go.* A bunch of cisgender—straight cisgender people who could care less, you know about me. So yeah, it's easy to tell those feelings from other people.

If there's not a voice for this community, they will never be heard. Because some people just feel like, Oh, *we don't need to be angry* because *we don't want to sound like the angry trans person* or *the angry Black person* or you know, whoever. And I'm like, *sometimes you need to be angry.*

Yes, I assimilate to a certain degree because I know it's going to get me somewhere.

You've seen me in a meeting.

I'm like silent for like a good two thirds of it. And then I finally hear something that I'm just like *no.*

I'm like, *I've listened to everything you've said and now I get to* CALL BULLSHIT.

(Do you feel like you have to do that a lot, in this space? Like, CALL BULLSHIT.)

To an extent I feel like I have to. Because I feel like they haven't had anyone who will.

***

CHAPTER 4

JUST IN TIME

In the middle of a busy day of clinic, Nina tells Dr. Y she got an email from an 18-year-old who *wants a blocker.*

What do you think that's going to do for you? she rhetorically asks, the distance between Nina and the potential patient enabling a much more casual tone than she would take if she was talking to someone in clinic, or over the phone. Nina's skepticism stems from an awareness that an 18 year old, no matter their gender, has already experienced many of the physiological effects of their endogenous puberty. That is, their body already shows the impacts of the hormones produced by their ovaries or testes, and simply stopping the production of those hormones will not erase those impacts. Once puberty has progressed to a certain point, there is no moving backwards—only forwards.

Puberty blockers are a unique, relatively recent intervention in the field of gender affirming care, which have been used as a part of gender care since the 1990's (de Vries, Cohen-Kettenis, and Delemarre-van de Waal 2006). Blockers are often prescribed to young people like "the Littles", who have primarily relied on changes in name, pronoun, and dress to shift their gendered reception in the world, but whose capacity to do so is threatened by the bodily changes of puberty. After all, it is only with the advent of puberty that those with testosterone dominant bodies and those with estrogen dominant ones begin to sharply diverge. In the one, the potential Adam's apple, facial hair and more noticeable musculature. In the other, rounding hips, chest, and the more or less monthly bleeding.

For youth who are in care early, and who find the prospect of these changes distressing, treatment with gonadotropin-releasing hormone analogues (abbreviated as GnRHa and colloquially referred to as puberty "blockers") prevents the initial development of these characteristics. Many youth who begin treatment with blockers will progress to treatment with gender affirming hormones, a fact which has been weaponized by lawmakers attempting to conflate the use of blockers with an entire trajectory of gender affirming intervention. Antiaffirmative care activists and legislators have targeted puberty blockers in particular across the US and the globe, claiming that evidence which shows most youth who start on blockers continue a path of medical transition justifies their arguments that treatment with blockers increases the chances that children will be trans. Based in heavily critiqued scholarship, such detractors claim that the experience of going through endogenous puberty can have the effect of reconciling youth to their assigned gender, and thus advocate for youth to experience their endogenous gender as a mechanism for dissuading trans identity. Furthermore, these critiques suggest that if young people are not considered able to consent to all potential consequences of care, such as long-term effects on fertility for youth who begin medical transition in childhood, that they should not be able to consent to any aspect of that care, in this case, treatment with puberty blockers.

In this chapter, I argue that while blocking puberty seems so contentious at a policy level, in affirmative clinical practice, the intervention is understood and utilized differently, primarily because as providers describe it, the physiologic impacts of treatment with blockers are not permanent. Practically speaking, as Dr M puts it to the family of a young trans boy, this means that *if your kid decides, you know what, I'm going to* ROCK GIRL PUBERTY, which she says *is rare* but *does happen*, treatment with blockers can be stopped, at which point the hormonal processes that initiate the changes of puberty will resume. This possibility, that youth can begin treatment with blockers and still decide to ROCK their endogenous puberty, gives blockers take a particular temporal logic, one which is cautiously noncommittal about the relationship of the intervention to the eventual gender LANDING SPACE a youth will arrive at while nonetheless remaining intensely anticipatory.

According to Adams, Murphy, and Clarke (2009), "Anticipatory regimes offer a future that may or may not arrive, is always uncertain and yet is necessarily coming and so therefore always demanding a response" (249). Anticipation characterizes the way that puberty is predicted, paused, or prevented, and names the affective and epistemological orientations that providers, youth, and their families take on as they make decisions about interventions in environments where knowledge is tentative and futures uncertain. At the same time, this chapter describes how such pervasive and necessary speculation is managed by strategic reframing which clarifies the role of medical interventions like blockers as they relate to the material conditions of the body, and shortens the temporal frame at which they appear to act. In other words, rather than further tying together treatment with blockers with an eventual outcomes (particularly around identity), providers I spent time with focused on the capacity of youth to speak to their own desired around anticipated changes. As Dr M says, *what we're asking, at 11, is* "do you want to go through endogenous puberty?"

Shifting the scope as Dr M does, from making a decision about blockers into a question about puberty rather than a question about an entire gender transition, does not remove the anticipatory logics that saturate the practice of treating gender, but rather, reflects care rooted in potential as well as prevention. The benefit of blockers is understood through the capacity of such an intervention to sustain the possibility of multiple future trajectories, rather than materializing a singular future, even as benefits are also rendered through the perspective of preventing bodily development that is already known to be unwanted.

While many pubertal changes can be mediated or responded to through later intervention—beards can be shaved, breasts can be removed—others are less amenable to being reshaped. In this chapter I describe how trans youth who take blockers before beginning hormones and those who do not will often differ in two significant ways. First, youth who never go through their endogenous puberty will also never have mature gametes (ova or sperm) and thus will not be able to use their own genetic material to reproduce. Second, some bodily traits (such as the shape of the hips or the size of the hands), though not fully determined by the hormonal experience of endogenous puberty, are deeply influenced by it, which means many youth who only receive gender affirming intervention after puberty have to more actively mediate any gender incongruence they feel or are treated as having. Dr M describes this as living with CONSTANT NONCONSENSUAL DISCLOSURE. In other words, she sees one of the benefits of early intervention, the second impact I am describing, as the capacity for youth to enact more control over how visible they are as trans people in their lives.

Taken together, these two future impacts—future reproductive options, and being visible as trans—represent both hopeful and feared possibilities, each impacted by the provision of puberty blocking treatment. I argue such futures are also emblematic of cultural concerns with both social and biological reproduction. While some scholars have tended to emphasize how puberty suppression might foreclose differently gendered futures and reproductive potential (Sadjadi 2019) or how it might emphasize gender normativity, thus further marginalizing youth who bear the markers of later transition (Castañeda 2015), I find, as Travers (2019) writes about their own research, that “trans kids in my study experience puberty suppression not as a reconsolidation of the gender binary but rather as a desperately needed source of liberation and relief from gender dysphoria and/or nonintelligibility” (p 166). Furthermore, I am conscious of how some have attempted to critique medicalizing discourses without accounting or taking responsibility for the material effects their critiques have on the health care options available to trans youth. Thus, while in some respects I share concerns about how the provision of early gender affirming care might reinforce existing social inequalities, as Casteñada (2015) and Travers (2019) note, I am more concerned with how these and similar critiques have been taken up by those who would see this form of care excised completely. When I do point out the uneven distribution of resources among trans youth like healthcare, it is not to problematize the intervention itself as a normalizing or stratifying force, but to illustrate the necessity of broadening access to interventions for those who desire them.

While public narratives about the benefits of blockers often strategically utilize the framing of “reversibility” of blockers, to combat the argument that treatment with blockers is synonymous with an entire course of transition related procedures, I attend to experiences young trans people have around puberty in order to demonstrate the significance of such an intervention beyond simply stopping the clock. Rather that arguing for puberty suppression as a neutral intervention, an argument that is often made necessary in atmospheres which are intensely opposed to the notion that young people might exert control over their bodies at such a young age, I attempt to look more closely at the way that narratives and experiences of blockers can be a part of a care that is invested in the potential of the future, which in this case can involve remaining uncertain as to how young people might experience their gender in the future while still respecting the gender they experience currently. Thus, I show the impossibility of a neutral path in the time of puberty, and argue, as many of my clinical interlocutors do, that simply permitting natal puberty to progress is no less of a choice than initiating the suppression of puberty(Giordano 2008).

Perhaps more importantly, as I have throughout the dissertation, I read any demand for young people to shoulder the burden of trans visibility in service of a future that values visible trans people[1] as a unjust call that further erases the role of cisgender people in sustaining the social order of gender (Serano 2016; Valentine 2012). I therefore complicate any reading of the use of blockers as something akin to the "biologization of adolescence" (Béhague 2015), instead attending to the way that blockers can play a significant role in enabling forms of living that are driven by the needs and desires of youth. To do this, this chapters focuses less on the mere existence of puberty blockers or their strategic involvement in a course of medical transition as rendered by policy or protocol, and more on the specific practices and uses to which I saw them put, as well as to the particular experiences of young people around puberty and pubertal interventions as they were shared with me. By taking gendered experiences of the body as critical sites of subjectivity, which are both anticipatory and lived in the present, and identifying the speculative and material trajectories that emerge during puberty, this chapter illustrates how orientations towards time, reproduction, and visibility structure how intervention is conceptualized and used.

---

[1] In other words, to interpret the use of puberty suppression as preventing future trans visibility, which should be forgone in order to craft worlds that are more welcoming to visible gender diversity, which seems puberty suppression as an process of assimilating to undesirable cisgender norms.

Timing Puberty

Emma is 11-years-old, and has come to her appointment today with Mom, Dad, and her sister. Both girls have big, glittery bows clipped in their hair, and bare shins covered with the evidence of summer in the form of small bruises, scabs, and bandaids. They drove for hours to get here today, the appointment a full family affair.

Dr Y asks Emma how she is feeling

feeling great.

He follows up by asking if she is feeling anything changing in her body.

Well, Mom said I'm STARTING PUBERTY.

Mom explains that she has noticed Emma needing deodorant.

Dr Y turns back to Emma, asking if she remembers the physical exam they did last time.

oh yeah

To help remind her, Dr Y pull out a loop of wooden beads, ranging in sizes from that of a peanut M&M to a large chicken egg.

oh yeah

This is an orchidometer, used to measure the volume of testicles. Since testicular growth is one of the first physical signs of puberty, accurately identifying testicular size is those who have them is the first step in determining if a youth is entering puberty.

Is it okay if I do that again today?

Emma squirms.

I'm just embarrassed.

And he's not a part of my family . . .

Though her parents rush in to say he's a doctor! *Dr Y first affirms her response, giving her some more physical space and first telling her,*

That's right.

The pace of the appointment slows, retreating from permission for an uncomfortable exam back to a discussion of puberty itself.

Do you remember which one of these is when puberty starts?

Dr Y draws her attention to one of the smaller beads, the last of the pre-pubertal volumes.

Last time, you were like 2.5. . . .

Something from this clicks with Emma internally, and she sighs and fixes her gaze straight ahead. Her hands immediately starting to tug at the buttons on her pants, as she declares

better check

The room erupts with a soft flurry of movement and laughter as the curtain is drawn, and I see myself out of the room. When I return ten minutes later, the physical exam is over, and Dr Y is asking Emma if she thinks about puberty often. She's not quite there yet, but he wants her to know,

It's my job to worry for you.

***

Though early studies of growth in humans identified the existence of the pubertal growth spurt, modern ideas of puberty today are most heavily indebted to endocrinologist James Tanner, who undertook one of the most specific studies of growth during puberty that exists to this day. Tanner and his colleagues developed the metric commonly known as the "Tanner Scale", a qualitative scale which visually evaluates changes in secondary sex characteristics in order to place individuals along a developmental timeline (Tanner and Tanner 1990). By measuring and photographing young people over the pubertal process, Tanner was able to distinguish individuals in early and later stages of puberty, ultimately deconstructing puberty into five different stages. The Tanner Scale remains one of the most dominant models for the process of puberty because it identifies intersecting and observable factors that contribute to an individual's position in a trajectory of development to adulthood (Coleman and Coleman 2002). The photographs normalize a trajectory of growth that might not actually look the same across racial and ethnic groups (Gill-Peterson 2014), which is typical with most clinical standards, even those like scans of growth plates in the handbones which can indicate whether or not a young person might still be in the growing stages of development. Dr. Y had shown me those scans in his office once, noting off-hand how of course, the scans that are used as the standard comparison were drawn from White children, leaving open-ended the question of what significance that had for his use of the scans. The imperfection of standards like these aside, Tanner stages are relied upon as the main way of marking a young person's need for medication. As Dr M liked to say, *we don't like to use medication unless we need to;* before a young person is in puberty, nothing needs to be done to stop it. So young people like Emma find themselves in situations of monitoring, anxiously awaiting the moment when it might be clear that *something* is happening and thus *something* can also be stopped.

Like Emma, most of the people coming in to discuss or obtain puberty blocking medication are already living as their affirmed gender. At the 2019 meeting of the U.S. Professional Association for Transgender Health, I listened as prominent psychologist Diane Erhenshaft reported on findings from a study about the impacts of puberty blocking medication. She showed that 40% of the youth in their blocker cohort had been transitioned up to three years, with an additional 27% who were socially transitioned but for less than three years. This is notable because puberty suppressing treatments have been commonly discussed as a treatment that offers more time for decision-making about gender, built off of the assumption that young people shouldn't yet "know" their identity and are not prepared to make medical decisions about their gender. Yet, as the increased visibility of the young trans folks who are already living in their affirmed gender, and their insertion into the narratives and explanations of experts, show that the temporal effect of blocking puberty is likely less impactful than the prevention of secondary sex characteristics that are already known to be unwanted.

Puberty blocking prevents the development of those characteristics by constantly supplying an analogue of gonadatropin-releasing hormone (GnRH). GnRH is the hormone responsible for triggering the release of two other hormones, follicle-stimulating hormone (FSH) and lutentizing hormone (LH), from the pituitary gland. It is those hormones which make their way to the gonads, either ovaries or testes, and signal the increased production of estrogens and testosterone. GnRH is only produced intermittently, so in order to stop the cycle of hormone signals which begin and maintain puberty, all that needs to be done is to supply GnRH constantly. As Dr M says to parents, *it doesn't really block—it desensitizes.* Through the constant exposure to GnRH, or its synthetic analogue used in implants and injection (GnRHa), the receptors become desensitized and stop producing FSH and LH, thus, preventing the increase in sex steroids that lead to the bodily changes associated with puberty. *It's like if the TV is running all of the time* Dr M tells a parent, *then after a while, you stop noticing it. But if you turn it on.. And off... and on.. And off...*

Puberty blocking medications are widely described as "fully reversible", based on their use since the 1980's with young people entering precocious puberty[2] (Kaplan and Grumbach 1990). In this way, they are a largely preventative measure. When I asked Ryann, a 15-year-old, about what the blocker "did" for her (part of which was still IN THERE, she reminded me, fingering the inside of her bicep where a small portion of the flexible rod has broken off during its removal), she told me "it didn't do anything for me because NOTHING CHANGED.

---

[2] Precocious puberty is a condition where youth who are deemed too young by social, cultural and other normative standards begin their pubertal development. Though there are conditions which effect people with both ovaries and testes, most popular attention on early puberty has focused on girls (Roberts 2015) as well as explored possible environmental connections to earlier ages of pubertal onset.

Which is a good thing, because, NOTHING CHANGED.” Ryann later says to me,

> I just didn’t want to go through male puberty because then I couldn’t decide later [. . .] and I didn’t want a beard, I didn’t want to have to shave and stuff. I just knew that like - I didn’t really know what I wanted, but I didn’t - I knew that I didn’t want to be like, a man.

Ryann here describes what has been often leveraged as the benefit of puberty blockers; that it provides more TIME for youth and families to determine the next course of action, and for youth to increase their ability to KNOW what they WANT. She also describes the benefit which most gender affirmative providers are attuned to; the prevention of characteristics that are already known to be unwanted. It is this second aspect of the impacts of the intervention that perhaps more clearly demonstrates puberty suppression as not simply an absence but also an active presence. That is, the desire Ryann had to move through her early adolescence without having to shave, to feel like NOTHING CHANGED took an active intervention that shaped how she was able to interact with her peers. After all, even pre-pubertal youth are gendered in every day life, and thus, what preventing some of the bodily characteristics that would gender her otherwise enabled was further control and flexibility over how she would be seen and recognized in her life. Rather than simply being neutral, then, I hear in the NOTHING she names an anticipation of specifically gendered attributes that are unwanted, which can nonetheless coexist with the uncertainty she felt about what she did want.

The possibility of remaining uncertainty with regard to gender is often seen to be extended by the use of puberty suppressing treatments only because for so long the experience of puberty itself was assumed to provide the critical evidence as to the gender a young person did want to experience. That is, the process of undergoing bodily development would either enable youth to reconcile with the gender they were at birth or to be a source of incontrovertible distress that evidenced the depth of contradiction between the gender they felt themselves to be and traits their body was developing. In a sense, it is this presumption, that pubertal experiences form a fundamental and necessary process of gender identity formation and consolidation, that has long shaped debates in the field of affirmative care about the role of interventions for youth. In other words, the salience of puberty is also about the belief that for many youth, gender diverse expression and exploration is limited to A PHASE.

Desistance Debates and the Logic of THE PHASE

Clinical standards about which youth should be appropriately diagnosed with “gender dysphoria” have long relied on the metrics of CONSISTENT, PERSISTENT, AND INSISTENT to classify children who are more likely to be well-served by gender affirming interventions. Yet as Aydin, a clinical social worker and director of the LA Gender Center described to me in an interview, though such frameworks often are built out of a desire to improve access to care, they eventually get recycled into new barriers.

> Ken [Zucker] came up with this CONSISTENT, PERSISTENT, AND INSISTENT, that phrase. And that phrase was meant to, to use, to validate, to give young people access. Well, Darlene talked about this and taught me this, that not every kid has a temperament that’s going to include CONSISTENT, PERSISTENT, AND INSISTENT. And so something that was made, was presented as, like, uh, a new school of thought that was about including people, getting people care, was ultimately used to deny care to another group of people. And I think as providers, every time we talk about something new or something different, it’s helpful, and then it circles back around, and ends up being problematic in some spaces.

The framework of CONSISTENT, PERSISTENT, AND INSISTENT suggests that young people who are continually emphatic and clear about their expressed gender identity over some period of time are the ones who should be provided with gender affirming intervention. But the limitations of the framework, in particular the category of PERSISTENCE and its heavily weighted counterpart, DESISTANCE, have been under increased scrutiny by scholars, providers, and advocates who argue that holding too tightly to this framework prevents youth from being listened to and cared for.

DESISTANCE refers to the idea that some young people will reach a point in their lives where they no longer hold on to a trans identity. Distinguishing between youth who will maintain a trans identity (persist) and those who might not (desist) has been a major thrust of clinical and academic research into pre-pubertal gender diversity. As Aydin notes, the use of this framework in particular has been attributed to Kenneth Zucker (2018), clinical psychologist and former head of one of the largest Gender Identity Clinics in North America, first discussed in Chapter Two. In 2018, as a part of a series of commentaries about the use of DESISTANCE in clinical care for youth, Zucker wrote that he had first come across the phrases "persistence" and "desistance" as they were used in research on children diagnosed with oppositional defiant disorder, and that he thought they were "pretty cool" (p. 322) at the time. As categorizations which fit rather neatly into frameworks provided by developmental psychology, seeing childhood gender as a matter of PERSISTENCE and DESISTANCE nonetheless differs from the approach of some contemporary providers who emphasize the possibilities of a next "gender iteration", as psychologist Amy told me, or as sociologist Travers (2019) writes, gender "re-transition". These latter options pluralize, rather than schematize, the possibilities of the gendered future, but are nonetheless frequently subsumed by the powerful rhetoric of DESISTANCE.

Part of the reason so much attention is brought on the possibility of DESISTANCE stems from what Dr M attributes to as a *fear based model.* She tells me in her office one day how it is *easy to get swept up in* stories and online accounts that describe the *tragic nature* of decisions like the choice to utilize puberty blockers from those who *claim the label of desister.* Dr M is precise in her language, her critique leveraged at the framework more than any individual who finds their experience best described by it, even as she goes on to tell me that she wonders if for some, their desires to *claim the label* relies on a *poor memory of the distress they were experiencing.* In other words, she returns to the significance of DISTRESS,[3] in particular DISTRESS that may have been alleviated by gender affirming interventions, expressing her subtle skepticism that young people would have truly wished their DISTRESS ignored at the time in favor of a future where they may have felt differently about their gender.

---

[3] See Chapter 1.

Current conversation about gender affirmative care for youth is saturated with stories and speculations about the prevalence and possibility of DESISTANCE (primarily referring to youth who begin to identify with their gender assigned at birth before receiving any interventions) and "de" or "re" transition (which most often describes youth who are managing now undesired social or physiological effects of affirmative intervention).[4] In 2018, two major outlets—the popular news magazine the *Atlantic*, and the *International Journal of Transgender Health*[5]—took up the question of desistance, both documenting and inspiring debate about the notion that some young people who present with aspects of gender nonconformity in childhood will no longer maintain a trans identity as adults. In an initial commentary about "desistance theories" published in the *International Journal of Transgender Health,* the authors note how, "it has been widely suggested that over 80% of transgender children will come to identify as cisgender once they reach adolescence or early adulthood" (Temple Newhook et al. 2018, p 212), criticizing the circulation of this statistic and the grounds from which it was constructed.

This is no idle, theoretical argument, given the current legislative and policy driven pushback against the provision of interventions like blockers which draw on the power of such statistics to problematize early affirmative intervention (see interlude 2). Therefore, it was the intention of Newhook et al. to "raise questions about policies and practices that prioritize speculation about future identity outcomes over the present needs of children" (p 247), which they argue that such a singular focus on DESISTANCE rates does. Similarly, after the publication of Jesse Singal's 2018 *Atlantic* article emphasizing tactics of delay which result in youth reconciling with their gender assigned at birth (at least at the time of writing), and the stories of youth who come to regret intervention, responses pointed out the

---

[4] These overlapping concepts, imperfectly distinct, are also tied to separate material interventions, each which are permeated with their own affects and orientations. Here, I argue that puberty blockers and the rhetoric of desistance are bound up with the logic of THE PHASE, while in the following chapter, I discuss how interventions with hormones are understood with reference to feelings and fear of REGRET.

[5] The flagship journal of the World Professional Association of Transgender Health, then called the International Journal of Transgenderism.

implications of so heavily emphasizing the possibilities of DESISTANCE. A response authored by sociologist Tey Meadow (2018) articulated how such a narrative glosses over the reality of youth who are more likely to be ignored than they are to be affirmed, and fails to historicize the deep, problematic bias of clinical approaches that idealize gender normativity.[6]

Commentaries on the studies which have inspired the 80% statistic often discuss how youth who were lost to follow-up should be understood, and counted, as well the attempt to articulate how different models of care understand the impact that intervention or non-intervention itself has on a young person's gender trajectory. These conversations reflect in a public way what I was able to observe in my fieldwork. For example, Xavier, a clinical psychologist and the principal investigator on a new study tracking pre-pubertal youth through social and medical transition, was strategizing with other study staff at a research meeting about how to capture data on youth who might no longer experience gender dysphoria *without perpetuating the desister discourse.* He wondered if those youth simply *won't come back*, reflecting concerns with earlier studies that have sometimes categorized youth who drop out of studies as DESISTANT. Max interjects to say *that's why it's about setting it up*, reaffirming that they need data on all different types of developmental trajectories. Unsurprisingly, this is easier said than done—after all, in a study that aims to collect data specifically around the experiences of trans youth, it's challenging to write survey questions and recruitment materials that encourage youth who may no longer identify as trans to stay enrolled, especially without reproducing study designs that overly invest in the possibility of a cisgender future. At the same time, over on the clinical side, Dr Y tells me about parents that *feel like by intervening, they are making kid trans,* reflecting a belief that conflates permission for gender expression with encouragement for gender diversity, a belief which itself derives from models of intervention that suggest the best outcome is a cisgender future, which should be

---

[6] There has been and continues to be intense discussion of the 80% statistic as well as the framework of desistance itself. I describe these two as emblematic hubs, given the form of initial article and several responses. For more critiques in the popular press, see Ford 2017; Olson and Durwood 2016; Serano 2018, 2019. For further defense and objection in academic presses, see Ashley 2021; Drummond et al. 2008; Ehrensaft 2016; Steensma and Cohen-Kettenis 2018; Steensma et al. 2011.

prioritized over other potential futures.

This resonates with what Darlene and Aydin gloss as the parental fear that if options are offered, a child might actually *take you up on it,* which I described in Chapter 1. This fear, that affirmation offered too soon, or in the wrong way, could change the trajectory of a child's gender experience in a such a way that shifts the balance towards a trans identity, is an anxiety to which the framework of CONSISTENT, PERSISTENCE, AND INSISTENT responds. In temporal terms, this is the foundational concern, most often stemming from parents, that gender exploration is "a phase" (Ehrensaft et al. 2018).

Even when not stated directly, youth I interviewed often described their own sense that those around them were waiting for some evidence that their identity was permanent enough to act upon, either through explicitly invoking the temporality of THE PHASE or simply ignoring them. As Luke told me, reflecting on coming out to his parents, "I don't know if they were thinking that like, it was a A PHASE, it's not like they ever said that to me. They just didn't say anything. It was ignored, you know?" Brandon, talking about his father, told me "he doesn't say the word PHASE, but he'll be like, *permanence*, like talking about like, *if I want to take it back* or like that kind of thing, like, he won't say the word PHASE, but he's thinking, right." Zoey's parents responded to her assertion in freshman year that she felt "like a girl, stuck in a boy's body" with a "like, mmmmm, *that's not a thing.*"

"And I'm like, *yes, it's a thing.* And they are like *no, there's demons, go to church,* or whatever," Zoey says.

"did they—is that—I mean—I can't... is that, like, a joke, thing? Or they actually were like... *go to church*?" I ask, nonplussed by her deadpan delivery.

"No, they genuinely, they were," she tells me.

Zoey's parents ultimately tell her that she needed to wait "two years, to see if this is what I truly really wanted, because they wanted to make sure it wasn't A PHASE you know?" Similarly, Charlie told me that his parents were loathe to permit him to begin hormones because they "thought it was A PHASE—not that phases are bad, or anything." Yet, with his offhand correction, Charlie refutes the foundational temporal logic that prioritizes stability over change, and subtly denies that only sustained, or PERSISTENT experiences of gender should be met with the possibility of affirmative intervention.

While all of these youth had already started puberty before they begin to access gender affirming intervention, and for some, before they had started to understand themselves as trans, one of the peculiarities of the puberty blocker itself is the way that it materially co-exists with the logic of THE PHASE. That is, the unique reversible quality of blocking puberty enables providers to recommend interventions like puberty blocker without linking to a sense of security around a permanent gendered identity. In contrast to heightened political rhetoric that weds decisions about puberty blockers to the question of the REST OF YOUR LIFE, as illustrated in the following chapter, here I focus on showing how providers narrow the temporal scope of puberty blocking interventions, transforming decisions into ones that feel possible for parents and for youth. While this may indirectly endorse the possibility of THE PHASE it does so, not as a way of minimizing youth's self-disclosed identity, but in order to recognize, as Charlie does, how THE PHASE could be a valuable experience of gendered exploration and experience.

Technologies of Puberty Blocking

Early transitioning youth who are eligible for puberty blocking treatment are far different than the first waves of trans youth that the Trans Youth Clinic first saw during, or shortly after, the HIV/AIDS crisis. Dr N, the physician with the longest history in the clinic, told me about treating his first trans patient once when I spend the afternoon with him. While we waited for patients, he asked me, *so what do you want to know?* and I replied, *well, do you remember your first patient?* He told me about calling his colleague who worked at a different clinic, to figure out what to do with a young trans woman with AIDS. *She had AIDS - why wouldn't I give her what whatever she wanted?* This was, as he playfully reminded me, before it was easy to look things up on the internet and before processional networks within the United States existed to offer support and clinical guidance. The practice looks very different now—no longer are its main patients young women of color, engaged in sex work, unstably housed, and at risk for HIV. Instead, as Dr Y, who saw the majority of the new patients during the year I was in residence at the TYC, told me, he mostly saw White transmasculine people between the ages of 12 and 14. As the newest provider, he took on the most new patients, and it was during my days shadowing Dr Y that I was most likely to witness the explicit description of puberty, its bodily effects, and to hear the discussion of what puberty blocking medications could or could not do for young people.

Dr Y had a filing cabinet in his office with a row of rainbow color coded files, where he kept his printed handouts and resources that he gave to families. There were the formal consent forms, for each of the different specific medical interventions (blockers, estrogen, testosterone) as well as the flyers for Focus on Families, a support group run by parents of trans youth which also included several volunteer experts, some who also worked at the TYC. Alongside these many forms and flyers dense with information, was a handout with a picture of two bodies (below). It was this simple flyer that grounded the explanation of puberty to youth and their families, as Dr Y would mark up, in real time, the kinds of bodily changes they were anticipating.

> *Dr Y and I always meet patients in the exam rooms, rather than his office, which is rather small. As usual, he is sitting on a small swivel stool in front of the desktop computer, while the family fills in the chairs along the wall and the patient flops on the exam table.*
>
> The Physical Changes of Puberty *balances carefully on top of Dr Y's narrow, denim clad knees, as he asks the patient,*
>
> Do you know what PUBERTY is?
>
> yes
>
> no
>
> kind of?

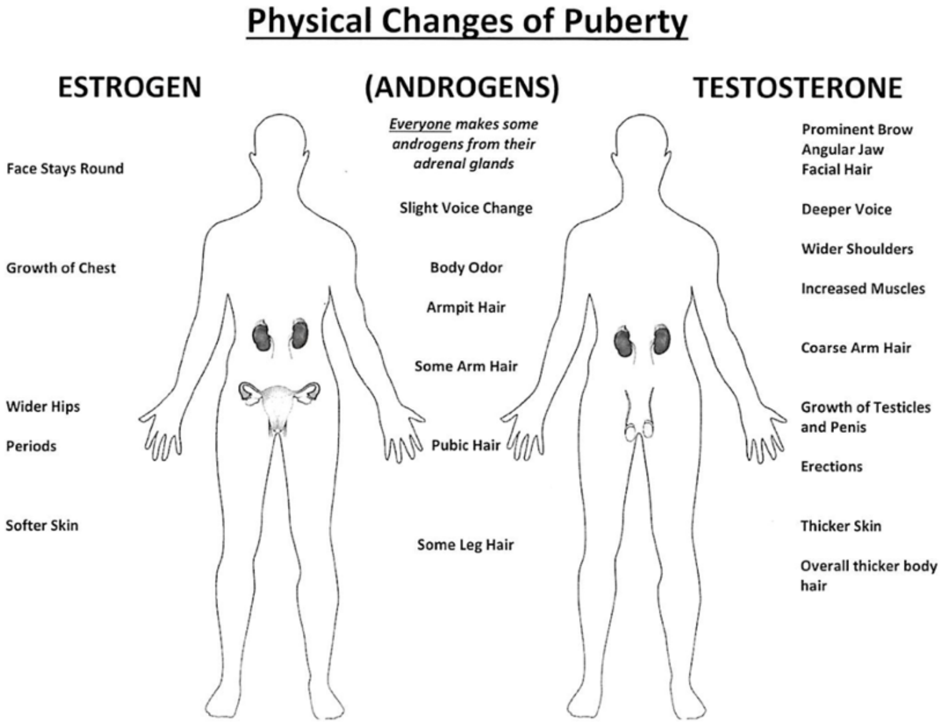


Figure 3: The Physical Changes of Puberty

Do you know what ones YOU have?

pointing to testes

pointing to ovaries

And WHAT is that?

a vagina

a wee-wee

a penis...

Starting with whatever sex steroid producing organs the person in front of him has, Dr Y begins to read the list of phenotypic changes, simultaneously drawing over the illustrations with his Muji .5 ballpoint pen, using a delicate hand to avoiding puncturing the paper.

Wider shoulder, more muscles, coarser arm hair, growth of the penis and testicles, angular jaw, facial hair ...

Chest growth, wider hips, period ...

and everybody's voice will change, a little bit, and everyone gets hair down there, and in their arm pits, and gets smelly. so that happens NO MATTER WHAT.

He slows, and stops, looking at the patient.

What do you think about those changes? Would they feel good to you?

***

Most of the time when a young person was faced with this question, they just shyly shook their head, not saying much more than a soft "no" or, "I don't think so," sometimes, "bad" and once, "interesting?" It was awkward, and uncomfortable, for many of the 6-11-year-olds to talk about this.[7] Their silences generally resulted in parents attempting to voice their

---

[7] Which would likely be true for many youth, regardless of their gender. I did not have the opportunity to ask providers if they used such tools with cis gender youth, or if they would expect enthusiastic responses from those who were cis, though it was often clear that young people had a preference for one set of attributes over another—this is ultimately what the exercise revealed.

children, describing what they had said or done outside of the appointment room that made the adults in their lives think endogenous puberty would be a good, or a bad, experience for them. It's worth remembering that most families only arrived at the clinic after months or years of conversation, often with the involvement of mental health professionals, and sometimes even to this clinic as well. So generally, people were here to get access to a kind of care they already had decided was right for them, because they already knew that endogenous puberty was not desired.

As Dr M describes to one family, data about the potential problems with GnRHa's are derived most frequently from the use of these medication among youth with central precocious puberty, that is, puberty that simply starts too soon. *If you start puberty at four,* she say, and are on blockers until twelve, *because that's the acceptable age to go through puberty*, that's *like a five to seven year span of time. And that's not going to be the case for your kid.* In this sense, she assuages worries about things like bone density and brain development by pointing to the temporary nature of puberty suppression for most of the patients she sees. At other times, Dr M has had to respond to concerns drawn from reports that conflate the use of these medications to prevent puberty with its use in cases of prostate cancer. This occasionally happens when outlets simply convey FDA reported "adverse events," which include death, even when that death is not medically linked to the use of the medication, as happened with at least one "viral fake news story" (Fitzsimons 2019) during my time in the field.[8] Outside of these intermittent disinformation campaigns, conventional medical knowledge describes blocking puberty as something that can always be stopped, and endogenous puberty resumed, with no effect on the bodily capacity to sexually mature. By simply stopping the supply of GnRHa, the intermittent release of GnRH will resume, the receptors

---

[8] In this case, the adverse events were likely death from advanced prostate cancer, where GnRHa are frequently used as a part of treatment. As Dr M explained it to me, when individual die from cancer, their death is nonetheless reported to the FDA as an "adverse event" which is linked to the different medications they are on. Thus, simply pulling data from the FDA on "adverse events" for a medication such as Lupron (one of the most commonly prescribed GnRHa injections) includes complications and deaths from those patients which are largely unrelated to the medication itself but is sometimes reported as deaths "linked" to puberty blockers.

re-acclimate, and the production of LH and FSH will resume.

While this narrative is limited to describing the view of interventions as medication with bodily impacts, the major effects of these interventions are often more diffuse and contextual. Whether giving Ryann the space to live without growing a beard, taking seriously the youth who express their ambivalence about the gendered experience in their future, or offering the promise of TIME to parents who find the impermanent bodily impacts of blockers more palatable than the more visible bodily changes enabled by treatment with estrogen and testosterone, what blockers do is more than just what they prevent.

Youth choosing to prevent puberty either receive injections or, more preferably, a small implant in the upper arm which releases a constant low dose of GnRHa and lasts for about two years. While the FDA approves no medication for treatment of gender dysphoria, the clinical diagnosis under which gender affirming medicine is covered by (some) health insurance companies, many California patients have their blocker covered after a back and forth of rejections, appeals, and eventual coverage. The implant is far preferred by the physicians at the clinic, both for ease of use and for its effectiveness; they spoke about the reduction in negative side effects, like *moodiness* and *weight gain*, when patients used the implant instead of the injection. Most of them had a sample in their office, a small flexible rod that they brought out and passed around for parents and young people to feel and marvel over. One mom takes out her phone, to take a picture to send to an absent father. *Better put a quarter by it, for perspective*, she says.

The implant comes in two varieties, with the exact same dosage and longevity, only marketed to two different populations. The one marketed for precocious puberty in children runs about \$40,000 out of pocket, while the one for prostate cancer is less than \$10,000.[9] Yet, because insurance companies are sometimes more likely to approve the more costly but seemingly more appropriate medication, providers try and prescribe the one which will

---

[9] As of November in 2021, the maker of the Vantas has discontinued it, citing issues in manufacturing (Lupkin 2021).

ultimately give the lowest financial burden to their patients, based on the likelihood that insurance battles will work out in their favor, or if parents are already resigned to paying out of pocket because of their anxieties about the time it takes to get medication covered, for example, time that might be felt as already too late.

> *Dr M is telling the parents about the negligible difference between histrelin implants; Supprelin LA used to treat precocious puberty, and Vantas, the version not specifically for youth. When she tells them that Vantas can run about somewhere around 8,000, and Supprelin for 40,000, Ricky looks shocked.*
>
> forty-thousand ? ?
>
> forty-thousand. . . .
>
> *He repeats the number to himself, looking at his father, whose attention remains on the doctor.*
>
> that's so much money
>
> Sssshhhh
>
> *Ricky's Dad shushes him. It's almost unimaginable, this sum of money. But just as unimaginable is his future life as someone who ovulates and grows breasts. Just a few minutes before, Mom had told us about how Ricky's grandmother, out of a concern about his potential medical transition, had recently taken him along for a drive and talked to him about* THE JOYS OF MOTHERHOOD.
>
> I'm not letting her take him alone again.
>
> *Mom turns to Ricky, asking*
> you're not concerned about carrying or making a child from your DNA, are you?

***

Because puberty blocking prevents the release of the sex hormones associated with the gonads, it also prevents the maturation of sexual material, like ova and sperm. For young people who do go on to take gender affirming hormones, like testosterone and estrogen, their gonads will never produce mature gametes. This ultimately means that their likelihood of genetically parenting a child is basically zero, unless they intentionally decide to pursue a course of fertility preservation which involves going through at least some endogenous puberty. Some providers I observed would emphasize that *we don't know exactly what will happen with your fertility in the future*, leaning on the possibility of current scientific advancement and the unknowability of an individual's futures desire, while stressing that *we can't promise it, just like we can't promise that anyone will have future fertility.* And this is true, in the sense that at the point of initiation of puberty suppression, young people may choose to go off of their blocker and enter puberty, thus maturing their gametes so that even if they later chose to use gender affirming hormones they would have a greater chance of being fertile. But despite the uncertainty about youths desires for future parenthood, the question of fertility was inextricable from the conversations about the current desire to pause, forestall, or prevent the development of distressing secondary sex characteristics.

All the consent documents include lines about fertility outcomes, as well as numerous other potential risks and side effects, some which are relevant to young trans people and some which are not. And even though many parents, speaking for their children, comment on how their kids would NEVER want to have BIOLOGICAL CHILDREN, contemporary research into family building desires among trans and gender diverse adults and adolescents shows that these desires can shift (eg Guss et al. 2021; Stark et al. 2021; von Doussa, Power, and Riggs 2015) especially as laws have shifted away from requiring sterilization as a part of becoming legally recognized as a gender one was not assigned at birth. Though sparse, research into the fertility desires of young trans people specifically suggests that young people often envision parenting in a way that aligns with the reproductive labor of their affirmed gender, rather than their sex assigned at birth, which complicates how fertility preservation is both conceptualized and conducted (Kyweluk, Sajwani, and Chen 2018). For Dr Y and others attempting to hold open a future dictated by what is possible, rather than what is eliminated, by the use of these interventions, their understanding is deeply shaped by the promise of technological intervention to reshape how we think about the ability to make children; but it is also shaped by a politics which rarely upholds fertility as a capacity to be protected at all costs. Despite these efforts, the sociopolitical climate of the US continues to emphasize the significance of fertility as an ultimate good, one which can only be impinged upon in the most dire of circumstances.

Imagining Future Fertility

In 2021, bills attempting to halt the provision of puberty blockers recycle the language of TRANSIENT OR PERMANENT INFERTILITY, STERILIZATION, EXPERIMENTAL despite the explicit provision of the same interventions for young people with intersex conditions or even "idiopathic short stature"; another way of saying that being short is so undesirable the medications which are too risky to be used for gender affirmation are certainly acceptable when the goal is to make a child taller.[10] These legislative attempts to ban affirmative care strongly rely upon normative assumptions about sexuality, family-making, and child-rearing, which also disregard the US imperial legacy of forced sterilization and reproductive injustice.

For example, in his work on the history of American gynecology, Snorton shows how integral chattel slavery was to concepts of sex and gender, arguing that experimental procedures performed upon the bodies of enslaved women relied upon, and materialized, ways of seeing and acting that enforced categories of gender. Snorton argues that in the development of reproductive and gynecological medicine, enslaved people, taken as "flesh", were the "capacitating structures for sexual knowledge through its constitutive position outside of the symbolics of the body" (Snorton 2017, p. 48). Thus, the racialized structure of gender, which

---

[10] See Arkansas Act 626 (*Save Adolescents From Experimentation Act* 2021), which was passed into law after overriding the Governor's veto and is currently prevented from going into effect by recent judicial decision. Copycat legislation was proposed in Louisiana in 2022. This practice of developing and spreading "model legislation", is increasingly common in the US especially for highly politicized issues; see, for example, the website "Promise To America's Children", which offers opportunities for legislators to download model legislation drafted by anti-LGBT organizations often classed as "hate groups" (Cretaz 2021).

takes some bodies to be disposable, situated only in relation to their functional reproductive and labor capacities, is part of the grounds upon which historical knowledge about sexual and reproductive capacities are founded. When taken alongside Jules Gill-Peterson's 2018 analysis of the history of endocrinology in relation to the treatment of intersex and trans youth, this historical context makes clear the ways that presenting youth's potential reproductive capacities as always worthy of protection by health care institutions is a practice of strategic erasure. In other words, such narratives do not take into account the ways that some people have always been treated as the appropriate grounds for experimentation, while others have been refused care on the grounds that their bodies are already too disruptive to normative structures of gender.

Contextualizing the use of puberty blocking medication and the arguments against its use within the context of reproductive injustice in the United States permits further interrogation about the way that the rhetoric of STERILIZATION in particular, is weaponized again the expression of bodily autonomy and can be used to erase the personhood of youth, instead rendering them into future reproducers. It highlights the irony and hypocrisy of conflating the history of forced sterilization with the current use of puberty blockers, as I witnessed one speaker do in a talk about gender affirming care at a biomedical ethics conference. As the provider who made that analogy argued, any treatment that restricted the reproductive capacity of the body was *against* the Hippocratic Oath, as it constituted a harm. Such an argument—that interference with reproductive possibility constitutes a harm if not medically indicated—demonstrates the relationship between interventions for gender with other kinds of reproductive health care, especially as in light of ongoing challenges to the provision of care such as tubal ligations, birth control, and especially, abortion.[11] It seems evident that these descriptions of harm are constructed less in relation to the potential that youth might be willing to accept the exchange of gendered synchronicity for biological parenthood, than

---

[11] This is especially relevant given the prevalence of Catholic hospital systems using religious exceptions around what constitutes "harm" to carve out what gets covered under health insurance what what doesn't, and which often glosses gender affirming interventions with other forms of reproductive health care.

in relation to a valuation of the inherent potentiality of reproductive life, which is protected even at the cost of eliminating other potential futures; even when the futures being protected are not those necessarily desired by young people.

For many trans youth, their desires or aspirations for parenting are filtered through the desires and aspirations of their families, such as with Ricky. As queer couples have gradually moved on from being in a position where their coming out was accompanied by the crisis of parents who would now *never get to be grandparents*, so now do trans youth carry the burden of their parents who see their gender identity as the end of their opportunity to continue the family lineage. One Dad, whose child was hoping to begin testosterone and who had gone on a blocker a few months before, emphasized to me what he saw as a specifically paternal, or masculine, investment in his genetic lineage. He told me, "I divorced my first wife because I wanted to have kids and already one of my kids is voluntarily removing themselves from the gene pool." The emphasis on children which had brought him and his child's mother together, and kept them together in some respects, felt contradicted by the imagination of his future as a parent to a non-reproducing child.

Dad tells me a story about a Chris Rock joke, which in the retelling is reduced to a comment that fathers wake up wishing their sons aren't gay. In my hearing, this seems to be simple homophobia, but in Dad's view this is best understood in relation to generational aspirations. In other words, as Dad describes it to me, the paternal anxiety about gay sons isn't about masculinity in behavior; "what what's really going on, is men are like, *Oh, I have a son! and one day my son will be married and he will have kids and I will have a grandson!* And it's, it's like A THING to guys, it really is." Dad disaggregates that feeling from what he considers is the unforgivable behaviors of some parents towards their children, turning towards me, mentioning how he didn't know how *your parents* were (having met my wife a few hours prior), but he just couldn't imagine abandoning your child. Still, he told me, "I don't think there's anything wrong with that emotion saying, *I want to have kids and I want my kids to have kids and I want their children to have children.* I don't think there's anything morally wrong with that. I don't think that speaks badly of a person."

Many trans people do have children, and many queer couples have children. Yet, it's true that the specific heritage of genetics may be less important to those who embrace less traditional modes of family making. While there are many popularized accounts of trans men carrying pregnancies, and technological advances that allow for even low motility sperm to be used fairly successfully, Dad's anxieties seem to be rooted in a very specific notion of what is it to parent and grandparent, which could reflect an entire network of kinship desires; siblings who grieve the perceived loss of their opportunity to be aunts and uncles, cousins who want their children to grow up with the children of their extended family members. Unlike Ricky's Mom, who easily pivots to a world where her son parents non-genetic children, this father is grappling with the transferral of his own deep rooted feelings about having children. But parents see their children's reproductive future through the lens of their own experiences as parents, which is markedly different than asking young people like Ricky about their family building expectations for now.

> *Dr. Diane Erhensaft is once again commanding a room of conference goers; unlike at USPATH, however, this room is filled with a lot more parents, and a lot fewer scientists. Still, she brings together current research on fertility implications with her own understanding of what, psychologically, we are asking young people to do when we ask them to consider their future parenting desires. Erhensaft calls it a* DEVELOPMENTAL DISRUPTION.
>
> Everyone is saying, you're too young to be a parent, don't have sex, don't even THINK about being a parent now.
>
> Then they turn around, and ask,
> So.
>
> Do you want to have kids?
>
> Are you sure?
>
> *Though she is a psychologist and therefore does not prescribe blockers herself, Dr. Erhenshaft tells us how she and many of her colleagues* have been accused

> of STERILIZING CHILDREN. *There's a reason that it comes up, again, and again, as the worst kind of health outcome. Then again, she says,*
>
> Very few people become suicidal about infertility. They do feel that way about dysphoria.

***

What Ehrensaft calls a *developmental disruption* is anticipatory thinking of a high degree—a mode of temporal existence which turns on the capacity to inhabit an imagined future self and make decisions on behalf of that future existence. In this case, she brings up suicide, or the risk of the life not lived, as one of the few preventative logics that can counter the persistent emphasis on potential fertility as a good that can only be impinged upon in the most dire of circumstances.[12]

Yet the conversation about fertility is almost always more complex than a simple choice between declaring ones desire to be a parent, or not. For youth who do go through their endogenous puberty, even if they subsequently begin treatment with hormones and stay on those hormones for many years, they can either take steps towards preserving their gametes through freezing, for example, or maintain the tissues that house those gametes. Even individuals who have been on hormones for a number of years have been fairly successful in temporarily stopping the use of those hormones and experiencing a return of fertility, as shown by Barnard (2019) and Nahata (2019). While clinicians are interested in the possibilities of fertility interventions for youth engaged in puberty suppression who plan to begin hormones, and have initiated study protocols such as that of Martin, Lewis, and Omurtag (2021), which reported successful oocyte retrieval and managed to minimize the development of undesired characteristics (like breasts) by keeping estrodial levels low during the retrieval. Yet, these are cutting-edge interventions which have yet to be widely adopted and whose long term success is still unknown. Thus, while the accusation that puberty

---

[12] The following chapter describes in more detail how gender affirming care is often constructed as suicide prevention.

blockers STERILIZE CHILDREN is false, the transition path most likely for those youth to take does frequently include an exchange of fertility for the benefit of more synchronous gendered embodiment at a younger age.

Only one young person in my project talked unprompted about the prospect of fertility preservation, telling me about the years between when he first came to see himself as trans and when he was able to actually begin starting T. Charlie was 18 when we spoke, but in this part of the interview was describing how he felt a few years earlier. He told me:

> during that time I had a lot of time to think about my gender and stuff. And I really like—at that time I was thinking that I really wanted to like, have like a normal, like, family. Like I wanted to have a girlfriend and get married and then - maybe not get MARRIED, cause I wasn't sure about like MARRIAGE because it was just kinda like, I was like, *I don't know if* MARRIAGE *is* like, *necessary.* Maybe for like taxes, but I don't know. But um, I wanted to have kids and I was like, I told my dad that, and I was like, *maybe I'll like, get, save some eggs or something from myself.* But then that was a whole horrible process. I was like, *I don't know if I can do that.*

"Wait—it was a horrible process, what part was a horrible?" I asked Charlie.

"Like, um, the process to take eggs and preserve them," he said.

"Yeah. So was it a process you actually looked into?" I asked, my interest apparent.

Charlie explained to me that he "didn't ever go talk to someone, but my step-mom, who works at a hospital, knows someone and she talked to them and she told me like, what would have to happen. I was like, *I'm definitely not ready for this.* Especially if I haven't even like gone on hormones, this would make me like super dysphoric, 'cause they have to give you like estrogen and go like IN THERE.

"Yeah."

"And I was like, I can't have anyone going IN THERE."

As we talked further, Charlie explained that even though he wasn't sure if he would "never take out my eggs," he was certain that he wasn't ready at 16 for the process it entailed—the hyper gendered anatomy it involved and the hormones he would have to take, which were precisely the wrong ones for the future he was envisioning. When I told Charlie that he was the first person to directly bring up these possibilities, Charlie highlighted his material circumstances and support, telling me, “I think it was also because I had the resources to do so [. . .] I knew my family had enough money to do it if I wanted to.” Despite how Charlie described his former vision that he would end up reproducing the heteronormative family form, “wife” and “kids” included, he noted now, laughing, that he was “engaged to someone that doesn’t want kids,” and uncertain about what that meant for his future. When we talked again, about a year later, his finance was still living in Columbia, and Charlie was more concerned with immigration possibilities and the struggle of managing an international relationship in a time of Covid-19 than he was about family planning.

For youth who do go through puberty, options for preserving fertility extend beyond the initial decisions to begin treatment with blockers and hormones. For example, another young person, Elliot, spoke with me almost two years after our first conversation. We zoomed from our respective bedrooms, chatting about the process of his recent hysterectomy. He was still recovering from surgery, and overall feeling good about it. One of the first things I asked him was about his decision making coming up to the surgery, that is, if he had known “for a long time” that he wanted a hysterectomy. He started by telling me that he did, but also that for a while he “didn’t know enough information about it” to feel confident moving forward. Elliot explained to me,

> I thought if I got a hysterectomy that I’d have to take testosterone forever, which isn’t a problem, but the one thing that’s always stuck in my head is *what if I lose insurance and I don’t have any estrogen to fall back on* because. . . bone density and all that. Um, and so I, so my doctor, she was like, *why don’t you just keep your ovaries and get a hysterectomy? You take out your uterus, you take out your cervix...* They took out my fallopian tubes because something about it leading more to cancer and I don’t really need them. Um, so she’s like *why don’t you do that. If you want the kids in the future, you can have kids in the future, cause I know you don’t want to carry your kids.* Um, and then I don’t get periods anymore. I don’t have to worry about like pregnancy scares and then, um, no pap smears. So, and then after that I was like, *it is not* THAT EASY, but it is THAT EASY. So, uh, so after that I was like, *that’s like the perfect option.*

Elliot articulates risks here as both related to the surgical intervention itself—the fear of being without hormones—as well as to the sociopolitical landscape of healthcare access which is frightening to rely upon. In this way, he expands the "risk" of these treatments to encompass much more than side effects and benefits, similar to what Sari Irni (2017) describes in her analysis of the risk of hormonal treatments in Finland. But one of the additional risks Elliot is managing here, which is less frequently discussed, is the risk of pregnancy. Though Charlie was also partnered with a cis man, only Elliot talked about this particular concern.

Elliot talked about fertility less in terms of maintaining a capacity to reproduce, and more through his awareness that he never wanted to be pregnant. He told me a story about being afraid of watermelon seeds as a child, because his dad "would always tell me if you eat a watermelon seed, then there's a watermelon that's going to grow in your stomach," and how he never "wanted to look like I was pregnant." So even since he was "really young," Elliot says, "I've never wanted to have a kid—like, I was like, maybe I want a kid in the future, but I never wanted to carry a kid."

The feelings that youth like Elliot and Charlie share about anticipated parenthood are in some ways only enabled by the fact that each of them went through endogenous puberty, at least partially as girls, who are tasked early on with the responsibility to prevent pregnancy. But their own experiences of puberty not only brought to mind their future fertility, but was an experience that needed to be managed in the present. And for many youth, as Dr. Ehrensaft referenced in her talk, puberty is a time of intensifying dysphoria and distress, a time when the flexible gendering of early childhood gives way to the more rigid and more visible categorizations of adolescence and adulthood.

Making Gender Visible: Experiences of Puberty

While for heavily monitored youth like Emma, Ryann, and Ricky, the significance of puberty primarily takes shape an an anticipated and forestalled event, for others, like Charlie and Elliot, puberty could be experienced as a time which initiated or amplified the dynamics of recognition and mis-recognition that allowed them to know themselves as trans. In fact, for many youth who didn't have access to blockers, their experiences of pubertal development often played a key role in their understanding of themselves, sometimes forming the evidence necessary to bring to the adults in their lives, and sometimes as simply the final step towards seeing themselves as gender other than the one assigned at birth.

In some approaches to treating gender, this experience itself a critical component of gender affirming care, especially relevant diagnostically. As a psychiatrist presenting at the USPATH Global Education Institute introductory training series, *a little* puberty is important for youth to experience. He suggested that *it's called puberty suppression, not puberty prevention*, and that we *need to give kids and youth at least a tiny bit of time to experience their bodies.* Even if parents don't like to hear that, he argued that *we need your child to experience some changes.* These changes might be as minor as the ones Dr Y and Dr M are on the lookout for, the slight indicators of a body just beginning to enter puberty, or they might be more significant[13]. The latter approach might also emphasize DESISTANCE theories that posit puberty as a time which leads youth back to their gender assigned at birth. But as providers at the clinic often emphasized, permitting puberty to move forward is *not the same as doing nothing*; rather, the experience of puberty could be exceptionally difficult for youth to manage.

Elliot was the only young person who ever directly emailed me to participate in the project based on a flyer I had been attempting to circulate and post wherever possible. In our first interview, we met at a Starbucks in his hometown, almost two hours by train away from the city. In the mostly empty, blessedly air conditioned cafe, I ask him to tell me about "when you really felt like, you were like, *I feel like I have a sense of what my gender is.*" Elliot immediately responds "Puberty" and begins to laugh.

"Puberty" I repeat back to him. "Tell me what was happening."

---

[13] This should recall the discussion of DISTRESS in Chapter One, particularly the disagreement over whether DISTRESS over bodily development is preventable or is necessary in order be diagnosed with gender dysphoria.

"Ummm... breast development," Elliot says.

"Yeah, for sure."

"I mean like, thankfully, like I'm Japanese, so like I'm Asian, but I'm also like White and, and [laughing] so like, it's like, literally didn't even... like, I didn't get that much breast development, but it was there."

Elliot tells me about how he "only fit into training bras" which was "good for me" even as it meant that "at the same time, like me trying to fit in with other girls, I was like—whaaaaaat. *This is weird.*" But then he says "periods came in."

"Then that was like, a whole like, I remember like the first time they came I felt so like suicidal."

"Yeah," I say.

"Like the first time, I was like, *Oh shit, what is* THIS."

Many other young people like Elliot describe the layered feelings they have about their own puberty, often referencing in close proximity the bodily aspects that they were negatively anticipating and hoping to avoid as well as their experiences with the changes they did experience. Some youth, like Katarina in Chapter 1, described the sheer power of will they felt they exerted to avoid unwanted gendered characteristics, while others, like Zoey and Elliot, point to genetic luck. Zoey who is "half Filipino and half Chinese," whose hair is long and very pink, says to me when discussing puberty, "I was a really late bloomer, thank God." When I ask Zoey about any worries she may have had about puberty during her freshman year of high school, in particular, she tells me "It was probably like—I mean, I'm Asian. So like I don't really grow a lot of facial or body hair, which is great, but I think it was like that." But Zoey also tells me that, having been an avid golfer for years, she disliked how her upper body was developing a certain musculature; how she always wanted to wear long sleeves and worried about the prospect of continued change.

While this shows the diversity of bodily traits that are uniquely felt and embodied, the advent of menstruation was perhaps the singular most discussed and managed pubertal trait in the clinic. I suggest this is both because of what I have previously described as the composition of the clinic, where the most common new patients were early teenagers seeking masculinizing interventions, and also because of how beginning to experience a cycle visibilizes feminine gender to the self (even if it is a pubertal sign that is relatively invisible in social contexts). Elliot was not alone in his strong reaction to the onset of menses. Luke, who was 17 during our interview, told me about his middle school years getting deeply immersed in different fandoms and in his drawing, which were all spaces where he could "visualize things that I didn't know, or didn't think were possible," basically "self-inserts" he calls them. He pauses his personal narration to explain the concept of a "self-insert"—basically a fictionalized version of yourself, that might be constructed by authors in their works, but for Luke, differed in the fact that he was creating the "Luke" version of himself, even before he was living it.

Luke says, "I was trying to like, put my, I dunno, like THE SELF into the, into THAT, like, instead of living—"

"Okay," I respond, leaving a space between the syllables.

"—and I don't necessarily remember doing a lot of things, like, like physical—"

"Yeah"

"—like walking around"

"Yeah"

"—and like going places. Because I know I was taken places—"

"Yeah"

"—to go see like movies or something like that, but I just like, I wasn't THERE."

"I see."

Luke goes on to describe his internal voice being like *you know you can't do this, right,* and he reminds me, "this is before I had even done any research on it. I was just thinking like *why don't I like* THIS.*"*

"THIS being..." I ask

"THIS being like, the female gender," Luke says.

When I ask Luke if there was anything happening in his body that was wrapped up in the THIS, he says, "well, I mean like, you know, of course, monthly, WHATEVER, not good." He goes on to tell me,

> it was never good. It was like the first time—It wasn't like, it's not that I'm freaked out by blood. It's just that, like, it was just completely, just completely wrong, and I was just like paranoid the whole week. But, you know, my mom was like, *Oh yeah, you get over it.* And I was like, *no, I won't, I'm stopping this.*

Periods were frequently discussed in the clinic as a trait that needed to be managed sooner rather than later, which is now reflected in the WPATH Standards of Care (version 8, currently open for public comment) recommendations that separate out the suppression of menstruation as an intervention from other things. Dr Y told me about one patient, a 12-year-old we were just about to see, that he had started on *Depo just to get the bleeding to stop.* They were *going to camp, and really worried about bleeding at camp.* Starting on progesterone injections to end the cycle was a quicker and easier intervention than starting on testosterone, and more appropriate that just using a blocker without adding in additional hormones for youth that have already started their development.

Menstruation stands out as pubertal experience that is saturated with meaning as it visibilizes, both internally and externally, a particular gender, and because people born with ovaries most typically enter puberty earlier than those who have testicles. But the experience of increasingly unsustainable development isn't restricted to those who menstruate. Zoey, for example, in her early years of high school attempted to abide by her parents' desire that she wait "two years" before beginning any transition type of care. I asked her how "serious" her parents were "about this two year thing—was it like, the sense of where you were looking at the clock, being like, two years is coming up, or did it kind of leave your mind?"

"Oh no, every day," Zoey tells me.

"I was like, mmm, *We're one day closer, one day closer, one day closer* and then eventually I just couldn't take it anymore. And I was like, *Oh, you know what? Like I have to* *do this now. Like otherwise I'm not going to be able to live with myself,*" Zoey says.

"Yeah."

"And they knew I was serious."

I took Zoey's description of "serious" to be a reference to the depression and self-harm habits she had already described to me as linked to how distressed she was feeling about her gender. Still, wanting to know a bit more about what she was feeling unbearable, and what the actions she envisioned taking, I ask her what she meant, and Zoey tells me, "I don't remember exactly what I said, but I was like, you know, *I have to start transitioning now* when I said like do this, whether I meant like medically or like socially or just everything in general, I was like, *I have to do this and start this now.* Otherwise I'm not going to be able to live with myself. Like, changes from puberty will become irreversible." Her anxiety about the "irreversible" effects of puberty are, in my understanding, anxieties that connect to the inevitable process of being "recognized", as Eric Plemons (2017) puts it as, as a gender in social contexts. This is the fear of living with CONSTANT NON-CONSENSUAL DISCLOSURE Dr M often calls, when someone like Zoey might lose control over when and where she is able to articulate herself as trans.

Scholarship of trans life have often highlighted experiences of "passing" (Snorton 2008; Stone 1992) and recognition (Plemons 2017), that is, of being socially legible as a gender other than ones gender assigned at birth, as central to the meaning of trans identity. Sandy Stone (1992) famously pinpointed passing as "the essence of transsexualism" (16), in order to then argue for the importance of refusing the imperative to pass, or to refuse to become legible in a gendered reality built on the impossibility of a trans subject position. Stone's claims take as foundational the relationship between medical interventions and the meaning of trans identity as built upon the imperative to "pass", which is also true in some more contemporary work that specifically takes up the case of puberty blockers. For example, scholars have suggested that the use of blockers emphasizes gender normativity, and erases trans visibility (Castañeda 2015; Sadjadi 2013, 2019). Yet others have also pointed out how such a reading of medical intervention unduly burdens trans people as the only subjects who should, or could, disrupt the oppression of binary gender, erasing the political work of "non-transsexual people" (as David Valentine (2012) puts it) in upholding gendered norms and expectations.[14] That is, it is not only trans people who have the capacity to disrupt expected gendered embodiment, with or without using the tools of medical intervention to do so.

Yet Snorton (2008) has also described the recuperative possibilities of broadening theories of passing to account for psychic effects, particularly for "non-operative, no-hormone transsexuals" whose experiences of "psychic dissonance, affirmation, disavowal and recognition" (87) shape the process of identification. Snorton understands passing as a "hopeful stance that sustains an ability to articulate a transsexual identity in the face of discourse of clinicization and social misreading," (89). This resonates with how young people, especially youth who experience the dissonance of pubertal development at odds with their gendered desires, describe the significance of gender dysphoria in understanding both their own specific gender identities and how some of them theorize about the meaning of trans identity itself. Luke tells me, about his own understanding of the meaning of gender dysphoria:

> It's just, um, like I don't, you know, it's like, *I don't want to live like this*, you know? Um, that, like, when I'm like sitting here and how people see me, I don't want them to see me. It's like, and like, I guess it's, you know, not everything has to be just like physical things that like, *Oh, I don't want this,* you know, like, cause some people might be like, you know, non-op, you know, or anything like that, but they still have like a social desire to be seen, uh, A WAY, you know, and that social desire, is from dysphoria, and I guess like maybe dysphoria gets like, um, is like so focused on the physical because of all the medical stuff, but even, you know, even if you feel like you have like no desire to like, spend all the money to do surgeries and everything like that, if you want to be seen in a different way, because you didn't like the other one, you know, and like you didn't like the other one enough to go through all of this to go change it, you know, and like to put yourself basically like in a very vulnerable position - for what, you know, like if there's no reason for you to do that, why would you do it?

---

[14] see also Serano on "subconsicous sex" as it applies to both trans and cis gender people (2016).

Here, Luke theorizes the core of trans identity as "dysphoria", but he also begins to disentangle the relationship between the use of medical interventions and the desire to "be seen A WAY." This was his response to the notion that others have raised, that one might be able to articulate a trans identity without experiencing DISTRESS, but as Luke points out, the desire to be seen "in a different way" is countered by a dislike for being gendered in another way.

As a young person who, despite the fact he has now had access to hormones and surgery, was still managing the effects of his endogenous puberty, Luke experiences the varied dimensions of passing that are not just about erasing his trans identity but about how experiencing himself as seen, not how he wants to be, but that could nonetheless continue to concretize his feeling of being trans. Puberty thus becomes an event that holds impacts both for processes of recognition that are oriented towards social reception and towards self perception, which is always part anticipation and part experience.

But even for young people that suppress puberty, and thus are able to forego some of the inevitable experience of misrecognition Luke describes and Snorton particularly links to "no hormone no op transsexuals", the option to forgo passing that Stone references is still a potential; but a potential that can be under the control of youth. For Ryann, whose early childhood was characterized by the freedom to grow her hair long and choose what clothes she liked, but who still "identified as a male until I was like 12," her decision to change her pronouns and her gender markers was shaped by her engagement with medical interventions.

Ryann and I were talking about her childhood in her relatively empty house, and I had asked her about a large framed family photo on the wall. She points out herself, "the little one right in the center," the oldest of her five siblings, but currently living with them are one "bonus child", as she refers to what sounds like a somewhat informal arrangement where they have taken in a young person who got "kicked out" of their home, and a college student who rents a room. It's summertime, so only the youngest are around, and they pop in and out during our interview, given that Ryann, who is 15, is ostensibly babysitting, or at least keeping an eye on things. When I ask Ryann if it was every hard to "be a boy with long hair and wore girls clothes," she says "Sort of. I was, like, homeschooled, so I didn't go to school and [have] people like pick on me for that. But yeah. But it was like just kind of hard when people would just say *she* and then I would just go, *Oh, it's he.* and then they were like—they were just confused. And it was just kind of hard to tell everybody that [...] I kind of always knew that HE was like more SHE, but I just was like, *I'll just hold off until I get the actual blocker and stuff to change it.*"

As Ryann describes it, "I kind of like always just want it to stay small. So I was like, *I'll just live like this until something happens* and I actually have to change it for like, what I want." For her, as for many, the "something" that happens was puberty, and she quickly got into care at the TYC and started a blocker. But as she tells me more, it's clear that as early as 5th grade, when she started going to homeschool group classes, Ryann was known by feminine pronouns, reasoning that, "I just liked matching, I guess." So though Ryann stands out in some ways as being someone who was perhaps ambivalent about attaching the label "girl" to herself in her early experience, she was, and is, also living a generally undisclosed life, which is enabled by the fact that early on she could access care that allowed NOTHING to happen.. Only two friends know she is a trans girl, and only one of those two is a person she choose to come out to, leaving a note in his backpack that said, *I am LGBTQ* with the T circled. This was a specific form of strategy, as she says, "If he lost it or showed somebody I didn't want it to be like, telling them. I wanted there to be room for me to play it off."

Ryann's ability to determine when and where to identify herself as trans allows her, in many ways, to "keep it small;" to allow her gender to become something, like another youth described to me, something you can stop talking about; "like, I found my jacket two months ago, I'm not going to keep talking about it, you know." But just because youth don't have to experience unwanted visibility doesn't eliminate their capacity to willingly disrupt assumptions about their gender. Many might, in fact, choose to be a part of a social category of transgender and thus shape the social reproduction of gendered life as one that is more, rather than less, expansive due to the potentials of medical care. And, I suggest it is this potential — that an individual's sex assigned at birth would remain, not as a public fact but as a personal information, thus limiting the ability of others to approach those people as trans people without their consent, which is part of what drives current attempts to halt the provision of gender affirming care, and the current rhetoric blazing across the US that poses young, potentially trans, people as simultaneously threat to, and threatened by cultural understandings about the meaning of gender.

A House on Fire

At nearly the end of our interview, Ryann's Dad calls her, and she apologetically lets me know that she has to take it on speaker, since her phone is "stupid" which I translate to, *broken.* After they check in about her siblings' schedules and chore lists, her father asks if he can ask me something, and instead of Ryann leaning forward to speak into the phone sitting on the living room coffee table, it's me. We've only briefly met once, and I've done all of my coordinating of this visit through Ryann, with her assurance that her parents both knew about and consented to my presence in their home, so I don't know exactly what to expect.

"Hi" he says.

"Hello!" I reply brightly.

"Is the house on fire?" he asks me.

"The house is not on fire."

"Ok, I think I trust you, so thank you so much," he replies, and I laugh a little, tell him "no problem."

Then he wants to know, "if the house is on fire, while you are there, will you put it out, or run into the street?"

"I will definitely try my best to put it out," I say, unsure how to answer even the hypothetical situation of emergency, unwilling to promise an outcome.

“I like that,” Dad says, “Whether you do or not, you will try your best.”

“I will try my best, and uh, you know, get living things out of the house.”

“Just get my dog out, that’s all I care about,” he jokes, and I laugh, and we all say goodbye.

Depending on who you ask puberty, and puberty suppression, represent the anticipation of a house on fire, and the necessity of a response to it. The prevention of the bad future, and the recognition of potential harm is a task that young people themselves are not exclusively responsible for, as I will further describe in the next chapter. Instead, providers and adults are engaged, as I am here, into a moral and ethical relationship with youth that is nonetheless contingent on how (and if) youth are understood as being able to take responsibility for the outcomes of their own future. Even when youth, like Ryann, are entrusted with a good deal of autonomy over their decisions to take on medical treatment for gender (or participate in a research study), their relational embeddedness shapes how the treatments like puberty suppression are understood and utilized.

Both prevention and potential exist at the heart of conversations about the use and necessity of both puberty suppression and puberty itself. As a time of potential crisis and potential gendered insight, entangled with the emergence of potential reproductive capacity, I have described blockers as an intervention that while “impermanent” is a significant part of care that works to maintain a plurality of future options for youth, even as their place in a transition trajectory entails some tradeoffs between what can be prevented through their use; that is, how the decision to prevent future CONSTANT NON-CONSENSUAL CLOSURE also often comes along with the prevention of future biological parenthood.

For those attacking the provision of puberty suppression as a treatment of gender under the guise of SAVING CHILDREN, the very relationship between gender/sex and reproductive capacity is at risk of being set ablaze, as is the myth that truth of gender (as defined by genitals) can be known by the social other. These fears ground legislative attempts like the

2021 Florida House Bill 1475 which writes in the necessity of medical genital examinations for any girl suspected of being born with a penis; a guard against the threat of trans girls who so normatively manifest their girlhood that there remains no other observable indicator of their difference.

Attacking early intervention is a way of attempting to eliminate trans people from public life and to create a new state investment into the superiority and preference of cisgender embodiment. Yet, those who insist upon the right of young trans people to be—to be in schools, on sports teams, in bathrooms, and in public life—have argued how refusing social recognition doesn't prevent young people from being trans but rather simultaneously hypervisibilizes their difference and erases the possibility of being seen *as trans* if they want to be recognized and respected (Gill-Peterson 2021b; Holt 2021).

This chapter has suggested that puberty suppression, as a mechanism that perpetually attunes to the potential that puberty could be experienced as a crisis doesn't need to situate providers as "saviors" as Sadjadi (2013) has suggested, but instead can be a tool of those who wish to attend to the needs of young people rather than leave them to fight fires on their own. Rather than pivoting to the needs of a future and recentering the normative good of reproduction, interventions around puberty enable youth to exert control over how they will be visible to others, and separate the act of forgoing passing—of being seen as trans—from aspects of medical intervention. But as I have already discussed, these interventions are uniquely temporally limited, thus permitting fantasies and experiences of THE PHASE even as they anticipate and materialize gender trajectories. In the next chapter, I turn to interventions with gender affirming hormones, to show how the prevention of regret, and of suicide, dynamically engage the logics of permanence and irreversibility that saturate their use.

INTERLUDE: CONSENT

CONSENT / PERMISSION / ASSENT TO PARTICIPATE IN A RESEARCH STUDY

You are invited to join a research study led by Paula Martin, a graduate student research with the Adolescent Medicine Division at The Hospital, and a PhD candidate at the University of Chicago. The faculty sponsor at the AMD is Dr. M, and the faculty sponsor at the University of Chicago is Eugene Raikhel.

You are invited to join this study because of your involvement with the Trans Youth Center as a patient, the parent of a patient, or a staff member. Please read the information below and ask questions about anything you do not understand before deciding whether or not to be in this study.

PROCEDURES

If you volunteer to be in this study, we will ask you to do one or more of the following things:

Participant-Observation

Permit the researcher, Paula Martin, to sit-in on and record observations during your regular activities at the clinic. You will not have to do anything you would not normally do during an appointment. The researcher will not interfere with your treatment, but she may ask questions.

- You may choose not to answer any questions, take a break from being observed, or ask the researcher to leave during any portion of the observations.
- Provided your doctor and parent or guardian has also agreed to participate in the re-

INFORMED CONSENT FORM FOR HORMONE THERAPY

This form refers to the use of estrogen/ testosterone by persons who wish to become more feminized/ masculinized to reduce gender dysphoria and facilitate a more feminine/masculine gender presentation. While there are risks associated with taking estrogen/ testosterone, when appropriately prescribed it can greatly improve mental health and quality of life.

This form covers the known and unknown benefits, risks, and changes that may occur from taking feminizing/ masculinizing medication. If you have any questions or concerns about the information below, please talk with the people involved in your care so you can make fully informed decisions about your treatment. It is your right to seek another opinion if you want additional perspective on any aspect of your care.

Risks of Feminizing Medications

The medical effects and safety of feminizing medications in youth younger than age 18 are not fully understood, and that there may be long-term risks that are not yet known. You are strongly advised not to take more medication than prescribed, as this increases health risks. Taking more than prescribed will not make feminization happen more quickly or increase the degree of change. Also, extra estrogen can be converted to testosterone, which may slow or stop feminization.

Estrogen minimally increases the risk of blood clots, which can result in:

- pulmonary embolism (blood clot to the lungs), which may cause permanent lung damage or death search, the researcher will record observations about your interactions.

- The researcher is collecting data on activities she is present for, unless asked to stop.

POTENTIAL RISKS AND DISCOMFORTS

- There is the potential of accidental release of confidential information. You are providing highly sensitive, personal information in this study. If people not connected with the study learn this information, you could have problems getting a new job, keeping your current job, finding housing, or getting insurance (health, disability, or life insurance).
- There is the risk of feeling uncomfortable talking about sensitive topics.
- There may be additional risks of being in this study that we do not know about and therefore cannot describe.

ANTICIPATED BENEFITS TO SUBJECTS

You should not expect any direct benefit as a result of participating in this research.

ANTICIPATED BENEFITS TO SOCIETY

Researchers in this study hope to learn more about how youth, parents, and providers are accessing and utilizing medical services for gender. This may help us understand more about the relationships between gender, health, and medicine. The researchers will use their finding to create resources for other young people and families.

- stroke, which may cause permanent brain damage or death
- heart attack
- chronic leg vein problems

If you experience any of the following symptoms, you should call 911, or go to the emergency room:

  - Unexplained shortness of breath
  - Rapid breathing
  - Chest pain
  - Rapid heart rate
  - Light headedness or passing out
  - Leg pain or tenderness, especially in the calf
  - Leg swelling

The risk of blood clots is worse if you smoke cigarettes. Please be advised that you should stop smoking completely if you start taking estrogen.

Feminizing medications will result in changes that will be noticeable by other people, and that some transgender people in similar circumstances have experienced harassment, discrimination, and violence, while others have lost support of loved ones.

Risks of Testosterone

The medical effects and safety of testosterone use in those younger than 18 are not fully understood, and there may be long-term risks that are not yet known.

You are strongly advised not to take more testosterone than prescribed, as this increases health risks. Taking more than prescribed will not make masculinization happen more quickly or increase the degree of change: extra testosterone can be converted to estrogen, which may slow or stop masculinization.

YOUR OPTIONS IF YOU DON'T WANT TO BE IN THIS STUDY

As this is not a treatment study, your other option is to not be in the study.

COSTS TO YOU FOR BEING IN THIS STUDY

There are no costs to you for being in this study.

SIGNATURE OF RESEARCH SUBJECT (If the subject is 14 years or older)

Your signature below indicates

- You have read this document and understand its meaning;
- You have had a chance to ask questions and have had these questions answered to your satisfaction;
- You consent/assent to your participation in this research study; and
- You will be given a signed copy of this form.

The following are potential medical risks of testosterone:

- Increase your risk of heart disease, including:
    - decreasing good cholesterol (HDL) and increasing bad cholesterol (LDL)
    - increasing blood pressure
    - increasing deposits of fat around your internal organs

  Your risk of heart disease is greater if people in your family have had heart disease, if you are overweight, or if you smoke.
- Increase the red blood cells and hemoglobin, and while the increase is usually only to a normal male range (which does not pose health risks), a high increase can cause potentially life-threatening problems such as stroke and heart attack.
- Increase your risk for diabetes by decreasing your body's response to insulin, causing weight gain, and increasing deposits of fat around your internal organs.
- Lead to your cervix and the walls of your vagina becoming more fragile, and that this can lead to tears or abrasions that increase the risk of sexually transmitted infections (including HIV) if you have vaginal sex.
- Cause headaches or migraines.
- Testosterone can cause emotional changes, including increased irritability, frustration, and anger.

Testosterone will result in changes that will be noticeable by other people, and some transgender people in similar circumstances have experienced harassment, discrimination, and violence, while others have lost support of loved ones.

CHAPTER 5

FOR THE REST OF YOUR LIFE

Leo's Mom has a lap full of paper. These are all of the consent forms Leo needs in order to begin testosterone, already filled out, though Mom notes the signatures are in the wrong spot.

Sounds like we're ready to start,

Nina, the nurse practitioner, comments. But first, Dad has questions. He wants to know if the injections will be subcutaneous, or IM [*intramuscular*]?*Nina describes how most patients prefer subcutaneous weekly injections in the belly, rather than biweekly intramuscular, trading the increased frequency for smaller needles, and less painful injections. She also mentions a gel option that peaks Dad's interest more than Leo's, who is* thinking shots. *Dad looks at his child.*

You're going to have to inject yourself, you know.

I'll do it
if
it's something I care about.

Nina amicably comments that the injections can get fatiguing, after a while, describes the topical gel option, reminds them that it's not a problem to switch back and forth if you need a break.

Mom knows that Leo wants to walk out of here *having his first injection.*

That's what you said!
I know.

As Nina looks to see if Leo is scheduled for time with the nurse to learn and practice the protocols for self-injecting, Dad asks,

Leo will have to do this,
FOR THE REST OF HIS LIFE?

I know the answer.

But I have to ask that OUT LOUD.

***

Around this same time, but many thousands of miles away, the parent of a young person on the waiting list at the National Health Service Gender Identity Development Services in the United Kingdom was filing a legal complaint against the Tavistock clinic, alleging that the clinic provides hormonal interventions in the form of puberty blockers to young people who cannot legally consent to the treatment (Hurst 2019). This was the beginning of what would becomes the infamous case of Bell v. Tavistock, a case which was decided in December of 2020 in favor of the claimants. At the point of decision, the most vocal spokesperson for the case was not the anonymous mother, Mrs. A, but 23-year-old Kiera Bell. Bell was treated at the clinic for several years starting at age 16, first with puberty blockers, and subsequently with testosterone. She also pursued and received a double mastectomy when she was 20. Now, Bell is public as a "detransitioner". She expressed her satisfaction with the courts decision to the BBC, saying, "This judgement is not political, it's about protecting vulnerable children"(Holt 2020).[1] The decision effectively halted the provision of puberty blockers to young people in the UK unless they could obtain a ruling from the high court as to the competency of youth to consent to treatment, ruling not on the medical legitimacy, safety, or appropriateness of the treatment but rather on the capacity of youth to understand the potential future implications of the treatment they were about to undergo. It was a decision which highlights the impossibility of insuring that youth will not become Kiera Bell—adults who REGRET the interventions they received, and looked towards the clinic, and the state, as responsible parties who should have prevented them from moving forward with their gender affirming care.[2]

---

[1] This sentiment can be ripped right from the first page of Lee Edelman's "The Future is Kid Stuff" (1996). I follow Edelman's analysis in noting that such a claim as Bell's is "political insofar as the universalized fantasy subtending the image of the child coercively shapes the structures within which the 'political' itself can be thought" (19). It is also political in the sense that the movement of "gender criticals" (Ahmed 2021) in the UK and elsewhere is desperately attempting to erode the material rights, including access to health care, public space, and legal protections, of people who do not identify with the gender they were assigned at birth.

[2] Interestingly enough, with little consideration of the role of Bell's parents in this instance, who as I

The decision was overturned in 2021, on the basis that the court overstepped in its ruling; that despite the fact that Tavistock was, in some ways, providing care which did not align with international recommendations (including lengthier wait times, more required psychological testing, and sometimes leaving young people on blockers longer than recommended in standards of care) there was nothing illegal about the way the clinic was working. Rather, the appeals court judges stated that "The fact that the report concluded that Tavistock had, in certain respects, fallen short of the standard expected in its application of the service specification does not affect the lawfulness of that specification; and it would not entitle a court to take on the task of the clinician" (Siddique 2021). Taken as a win for supporters of affirmative gender care for youth, and others invested in protecting the legal standing of youth to make decisions about clinical care, the decision reinstates the clinic, rather than a court, as the appropriate arbiter of young people's capacity to be responsible for assuming the risks of treatment.

The US and the UK have a markedly different legal apparatus for managing the medical treatment of young people. While in the UK youth can consent to their own medical care in many instances, in the United States each state determines if, and how, youth can consent to some forms of treatment (primarily reproductive health care and substance use treatment) without parental knowledge (Weisleder 2007).[3] This has not yet applied to any form of gender affirming care. No young person I saw below the age of 18, save for one youth who was legally emancipated, was accessing intervention without the consent of at least one parent or legal guardian. In practice, neither were the patients at Tavistock. As Dr. Helen

---

will show throughout this chapter, are deeply embedded into the legal and moral architecture of dependence and responsibility that structure how youth are able to access interventions.

[3] Youth aged 16 and older in the United Kingdom are largely treated as adults in their capacity to consent to medical care (*Gillick -v- West Norfolk And Wisbech Area Health Authority and Department of Health and Social Security* 1985). The standard of Gillick competence, decided in a case in the UK House of Lords in 1985, enabled doctors to prescribe contraceptives to people under age 16. This standard, used not only in the UK but in Australia, Canada, and New Zealand, allows for young people under 16 to consent to treatment given their capacity for understanding the treatment and its impacts, with specific rulings now applying to sexual and reproductive health matters, which further entrench the rights of young people to access contraceptives and similar health interventions without informing their parents if they so choose (Commission 2021).

Webberly (2020) described in her analysis of the initial court testimony, Tavistock defendants simply noted that they had never provided hormones to a patient without both youth and parental consent. Young people deemed incompetent to provide such consent were either dismissed from care or provided supplemental information until they were considered able to give such consent.

Despite the contextual differences between the legal working of the US and the UK, the impact of the Bell v. Tavistock decisions reverberated globally, given the network of professionals working in the relatively small and specialized field of gender affirming care. Importantly, the case frames the use of puberty blockers as inextricable from a transition pathway that includes hormonal treatments with permanent effects, despite the more impermanent effects of the blockers themselves. Making the consent process for blockers into a consent process for all future transition care transforms the treatment of puberty, in this case, into a treatment that will shape THE REST OF YOUR LIFE. This move resonates with the one Leo's father makes OUT LOUD, in the exam room, collapsing the beginning of treatment and the imagined, or unimaginable, end, and revealing the temporal nature of the negotiation over how youth access gender affirming interventions.

Reading THE REST OF YOUR LIFE as an index of temporality and responsibility, in this chapter I argue that the logics of prevention and potential shaping decisions around hormonal interventions are bound up with negotiation over who, or what, is to be held accountable for taking on the risk of future harm. Exploring how youth are entwined in networks of dependence and yet often insistent on the importance of their irreducible, singular life, this chapter extends and complicates the temporal dichotomies between reversible/irreversible, permanent/impermanent, introduced in the prior chapter, while also attending to how negotiations over responsibility for preventing unwanted future experiences are often also negotiations over the boundary between childhood and adulthood.

I begin with the prevention of REGRET as a foundational logic in the field of gender affirming care (Velocci 2021). Temporal and affective, REGRET encompasses a range of bad outcomes possible from undergoing care. As experienced by Keira Bell, the Tavistock plaintiff, REGRET names her orientation towards the procedures she underwent in pursuit of masculine embodiment. Her REGRET, that the impacts of surgery and hormonal therapy with testosterone will shape her FOR THE REST OF HER LIFE, is what justifies restricting the provision of this form of treatment to others who could always, potentially, be like her; that is, could be someone whose future perception of self, the pronominal HER, no longer aligns with the interventions previously sought.

The material presented in this chapter illustrates how prevention logics surrounding REGRET and other bad futures are managed by those for whom young people are dependent on in order to access care: by providers, who must develop their own approach to surety; by parents, sometimes unconvinced by their children's certainty; and even by THE STATE, as structures such as the legal age of consent shape youth's ability to access intervention. Looming over these negotiations about whether or not young people will *change their mind*, or even have minds capable of being responsible for future outcomes, is the threat that should they be disallowed from accessing care, they may no longer find life to be livable. Thus, counterposed to this need to prevent REGRET is the need to prevent suicide, a need which has lurked around the edges of all of the chapters until this point.

Suicide is the often invoked future of DISTRESS that goes without response, the worst possible outcome that, when relied upon as a form of prognosis, (Jain 2007), presents a future that must be prevented at all costs. Without discounting the severity of suicide, I nonetheless look beyond the tragedy of loss in order to explore how relying on suicide prevention to ground the importance of affirmative care can unintentionally reinforce youth as those which are only entitled to protection, rather than agency. Furthermore, I argue that classifying gender affirmative care as suicide prevention care creates circumstances where the experience of suicidality after transition can be taken up as evidence that gender affirmative care is ineffective, despite the many reasons such a feeling may persist (Chu 2018; Malatino 2022). However, I also propose that turning towards a logic of potential, as incipient as it may be in this context, provides an accompaniment (if not an alternative) to such preventative aims, which allows for the uncertainty of youth's future outcomes without taking that uncertainty, or the potential of the bad outcome, as a cause to further restrict access to intervention.

Conceptualizing Youth: Futurity, Dependence, Autonomy

As with many categories, the concept of "youth" might be most visible in situations of its contestations and negations. Despite the fact that up until now the young people included have seemed to be perhaps unambiguously understood as youth, I argue that it is in the negotiation of treatments only available to older adolescents, and in the debates over the who holds responsibility for their futures, that I am able to illustrate most directly the notions of childhood that structure the provision of gender affirming care.

Studies of young people have often described how youth subcultures represent larger social anxieties (Cohen 2002) and contend that studying youth provides deeper insight into how individuals become socialized into the norms and expectations of their culture (Benedict 1934b; LeVine 2007; Mead 1928; Skinner 1989). Psychological theories of development frequently uphold the importance of transitions to adulthood known as "adolescence" in the US (Erikson 1994; Hall 1904; Owen 2014). Yet, understanding how youth manage social expectations about what constitutes adulthood despite changing socio-political structures that can limit their abilities to reach typical, often gendered, milestones demonstrates the diversity of developmental trajectories as well as call into question assumptions about the linear progression of aging, as well as the relationship between age and process of becoming both increasingly independent, or responsible for their own futures (Halberstam 2005; Mendoza-Denton and Boum 2015; Parikh 2016).

The relationship between the sociocultural and biological processes of development, and powerful narratives of the "neurochemical self" (Rose 2003) are as palpable in adolescence as during any other part of the life course if not more so. Some have suggested the possibility of a "biologization" of adolescence itself, seeing a growing tendency to understand problems as emergent from problems with the body and solved through pharmacological intervention, even in contexts where such epistemic frameworks are less powerful than they are in the United States (Béhague 2015). Though present here as well, particular in relation to the potential of brain development on decision-making capacity, I am also invested in understanding how the constant deferral to the future, whether made in terms of reference to a future where a youth experiences more neurological development or via other normative claims towards adult inclusion, also recenters heteronormative trajectories. In this way, my work provides further evidence for arguments laid by queer theorists about how the figure of the child represents embedded values of reproductive potential and productive capital (Berlant 1997; Edelman 1996).

This chapter argues that part of what motivates much of the concerns with the future self is an insecurity around the meaning of childhood itself. In particular, I argue that within the constant deferral to future forms of the self is a cultural presumption about the inevitable process of aging, and the recruitment into a form of being called "adulthood" that, for some, is in part defined by the release of the desire to transition. Such a configuration means that by the very expression of such a desire, youth find themselves even further removed from being seen as people with the capacity to make decisions about their futures, a circuit which is fundamentally enabled in the construction of a child who needs to be protected. Ultimately, I suggest that to break this circuit, one must do more than appeal to other forms of risk that youth have to be protected from, as politically inevitable as that appeal might currently be.[4]

---

[4] Lauren Berlant wrote that adult citizens necessarily forget, or forgo, "utopian political identifications in order to be politically happy and economically functional" (1997, p. 29). This is part of what sets apart adult citizenship from the form Berlant named as "infantile". Bracketing the question of citizenship, but maintaining the focus on the political (insofar as the figure of the child is part of what enables speculation about political futures and that determining what is thinkable is also the realm of politics), what I propose could also be being created here is a way towards seeing a political subjectivity shaped by adolescents who are neither willing to slide into jaded adulthood, or to say, as Lisa Simpson does in Berlant's essay, "The system works!" (p. 47). They do not see their desires as utopian forms of magical thinking, that open them up to easy manipulation, and neither do I.

Preventing REGRET: Entanglements of Responsibility and Dependence

Much of gender affirming care for youth is oriented towards the possibility of transition related REGRET, which scholars researching in the Canadian context have noted is often described as a "life-ending" REGRET (MacKinnon et al. 2021, p. 7). Aversion to REGRET is, in part, what shapes the desires for etiological explanations of gender diversity alluded to in Chapter Two, processes of assessment detailed in Chapter Three, and emphasis on the "impermanence" of puberty suppression in Chapter Four, all components of a prevention logic that orients the value and success of affirmative care towards the future that is not experienced, rather than the one that is. The consistent focus on REGRET tends to flatten out the many other bad feelings that might be attendant to trans (and human) experience, none of which, as many have argued, should necessarily be taken to indicate that transition procedures are unnecessary (Chu 2018; Malatino 2022). Nonetheless, I begin with the task of preventing REGRET as it remains a major orientating and organization principle of care. However, I do not focus on youth who have experienced REGRET, but instead, how the potential of REGRET appears as a future to be prevented, and how very often, the management of that potential produces conditions where it is the confidence and certainty of the adults around them which determine whether or not youth are able to access intervention.

The SURETY of Providers

For many providers, both medical and mental health, the early days of their care were characterized by what Dr M described as the *paralyzing* fear of getting something wrong. During one of our many moments waiting in her office for patients to arrive, she talks to me about doing CLEAN-UP at other clinics. Her Harry Potter action figures line the windowsill, as does a small plaque with her name on it confirming an award, and framed photo, while the full bookshelf holds heavy medical textbooks alongside some celebrity's book club choice nonfiction about trans families.[5] The posters lean towards the affirmative and politically suggestive; as I find out, much later in our work together, Dr M is proud of her roots in progressive politics and rarely squeamish about sharing her views on Trump, the border crisis, or racial inequality with those around her. Some days while we wait she's too busy to talk, and I re-read my own notes while she catches up on charting, the incessant ping of a new email alert or a calendar invite a constant reminder of her densely packed work calendar. Other times, like today, she tosses commentary back over her shoulder, narrating for my benefit as she answers emails, listens to voicemails, calls pharmacists and views charts in preparation for clinic.

Dr M has been in THE WORK long enough to have patients who have switched providers, due to insurance or geography, and the growing availability of transgender care. Nonetheless she still receives occasional emails or calls from former patients, especially when there is concern about how the care is moving forward. This morning Dr M references a clinic which is *relatively new to transgender care in general, and especially in youth.* She goes off to retrieve a chart, telling me she'll finish her thought when she returns, which she quickly does, while tut-tutting at the level of testosterone the young person is currently at. People who are new, she says, *when they come into the work, they tend to do—what I think they would endorse as* " CAUTIOUS" (which she air-quotes) *but what is really*FEARFUL. They're either giving people too much, or more often, *not enough* she tells me. *People are just paralyzed by,* WHAT IF THEY REGRET IT. What if it's the WRONG thing to do. *And it's just, it's really paralyzing.* This observation wasn't only shared by Dr M, as Dr N, too, had told me about the prevalence of programs who offer care but are nonetheless preoccupied with the possibility that they might be *doing the wrong thing.*

Writing the management of uncertainty in the field of gender affirming care, stef shuster

---

[5] The ongoing work of J.K. Rowling, author of Harry Potter, to align herself with "gender critical" activists in the UK was a source of deep unhappiness at the TYC, as many providers found their shared appreciation of that particular magical world to be a source of camaraderie and connection with patients. I wouldn't be surprised if now, two years later, they have moved on to other, less problematic, favorites.

(2021) shows how providers cultivate and leverage evidence that supports their positions as experts and as gatekeepers. shuster shows hows similar to other medical fields, providers approach tools like clinical guidelines either rigidly or flexibly, describing how providers who are more oriented towards REGRET often adhere more strictly to guidelines and thus more tightly police the boundaries between the right and wrong kind of trans patient. While the clinical approach at the YGC had adopted a flexible approach to guidelines, such that all of the providers expressed a confidence in their capacity to provide quality affirmative care which, at the time, necessitated pushing back against what they felt was unreasonable or inappropriate GATEKEEPING.[6] But all of the clinicians were new to the work at one time.

In my one-on-one interviews, I asked providers to reflect on their years providing gender affirming care, which for some was in the single digits and others in the dozens. When Nina, the nurse practitioner at the TYC, reflected on her early time as a part of the gender clinic, she described the same worry that Dr M and Dr N point to as characteristic of providers just starting out in the field. She told me,

> so I think, you know, when I first started, the only kind of worry I had was like—and I think this is probably true of everyone—is that, THAT SURETY THING. Like, am I sure that this is what they should be doing, or, or, you know, are they trans enough. I don't know if that's the thought I had, but like in essence, like, do I know how to assess a person well enough that—to see if this would actually be a good idea or not. So I think that was a little tricky for me. And also at the very, very beginning of when I started though, we were still kind of using—I'd say here and there, we're still using some, um, what do you call it? [. . .] like some sort of assessment from a mental health provider.

Mental health providers have been, for many years the cornerstones of programs providing

---

[6] This frustrated some other providers I knew, who wished that everyone simply followed the WPATH Standards of Care (SOC) to the letter. They believed such cohesion was not only desirable from a clinical standpoint, but would also it easier to combat political efforts to restrict care, such that they could answer fear-mongering rhetoric about the sterilization of children, for example, by pointing to the age the SOC recommends for different interventions, confident that their claims that *no one* was getting hormones at 13, for example, would be true. This was also built out of a trust in the scientific process which constructed the guidelines, though as I discuss in Chapter Three, the process of expert consensus used and the historical trajectory of the creation of some of the recommendations make it understandable that other providers challenge the relationship between the guidelines as they are written and what various forms of evidence say about good clinical care.

gender affirming interventions. This is no longer true at the TYC (as I described more in Chapter Two). Although social workers were central members of the team, and were still the first person new patients would usually meet, medical providers prescribed blockers and hormones based on their own assessment of appropriateness and the informed consent (or assent) of patients and parents. There were open lines of communication about new patients between the social workers, Alex and Harley, and the medical team, and often patients with more complicated relationships to gender or in challenging family situations were often discussed at the weekly team meeting. Yet, as Nina recalls, this is not the same as relying on an external assessment to stand in for THAT SURETY THING, as was done in her first years.

Current practices at the TYC rely on the prevailing sentiment that medical providers are experienced enough, and young people explicit enough, to work on an informed assent/consent model of care, while many other clinics still maintain a firm reliance on mental health providers.[7] Experts disagree about the necessity of mental health providers as a part of gender affirming care; not because they do not recognize the benefits of mental healthcare for those who opt in, but because they might characterize such reliance as maintaining a cultural stance towards gender diversity as a pathology, or associate the use of mental health assessments with GATEKEEPING, as I described in Chapter Three. This is also tied to a longer history of what shuster 2021 calls the "legitimacy wars" between physicians and mental health professionals, as well as "epistemic clashes" between the psy disciplines in the 1960's and 1970's. Though such border wars were somewhat resolved into the current team based approach to trans medicine, they exist still in the forms of the disagreements I just described. But this is not just about domains of professional power and cultivating the right kind of trans patient; it is also about managing a sense of responsibility for taking on the risk of providing care, in particular, the task of preventing future REGRET (Velocci 2021).

In one of my conversations with Sarah, a clinical psychologist working outside of the

---

[7] Yet informed consent itself is "performed" differently in different settings, as shuster (2019) shows, and when it comes to the under 18 crowd, it is parents who must provide the actual consent on behalf of their children.

TYC, she told me about the anxiety of feeling that "it really came down to sort of what my recommendation was in the end. [...] Everyone was looking to me and my assessment to decide, *is this kid a good candidate for moving forward?"* She was describing her first clinical role in a very early gender clinic, which she was part of developing after spending a few weeks in the Netherlands training on the Dutch Protocol. At that time, she remembers getting "kind of backlash, you know, just the media and clinicians... like, you know, a very senior psychologist in the community who were calling me and questioning like what we were doing." Sarah was early in her career, "so young" as she says, and "so new to this work that I didn't have a confidence" and she starts laughing a little, "like just to be able to , um, you know, I don't know, defend myself in the way that I can now."

Sarah ultimately decided that the protocol of the clinic was too focused on her as "the only person, you know, making this judgement call." She decided "like, okay, we got to like revisit this protocol because I cannot be responsible." She chuckles a little over the phone, telling me, "like, it just felt like too much." The "too much" that Sarah describes here was lessened through the distribution of responsibility, where she decided that at least one other mental health provider would need to be a part of a young person's care, someone who she could talk to and see what their impression was. While Sarah is also adamant that in the current iteration of her practice, the recommendations are done in a way that collaborates with young people, in her description of learning to do gender affirming care the confidence that is under scrutiny is not a youth's, but rather, a provider's.

Making decisions about medical intervention into gender is, in many ways, about the responsible relation of providers to the potential future outcomes of intervention, which when seen primarily as a task of prevention, keeps providers attuned to the ways that care might fail. As Dr M will often say, with a note of irritation in her voice, *the science of trans care isn't the problem.* Confidence in science aside, she doesn't think that *the problem* is that prescribers don't know what the appropriate hormones levels are and how to maintain them. To return to Nina, the movement away from reliance on mental health providers turns responsibility for those futures back to the prescribers, who no longer can look to the mental heath gatekeeper to answer the question Sarah put as, *is this kid a good candidate for going forward.* Nina says about her anxieties in the early days, "as we were moving away from that, then I kind of like, you know, a lot of that kind of came to me to decide, right. And then I was like, OH I DON'T KNOW, WHAT I'M DOING... Um, so I feel like that was where my biggest fear was rather than like... medical options," an upswing at the end of her comment indicating, to me, a note of questioning if this, really, was her "biggest fear". What isn't said is what must undergird that fear of deciding, on the behalf of youth; that persistent question, WHAT IF THEY REGRET IT, and the possible implications—from being liable medically in the highly litigious US medical context, to the feeling that one had caused, rather than alleviated harm—that REGRET has for their own practice and for their patients. But of course, youth are also playing a role in the determination of certainty, and alongside them, their parents.

Showing Certainty

Dr Y asks the patient, Tyler

what are we doing here today? Are we starting T?

And Tyler responds

probably not.
I need to THINK MORE.

After a bit of mild probing from Dr Y, Tyler tells us,

Well, they just kinda said,

> it's just a BIG DECISION TO MAKE AT 16.

Dr Y asks both Tyler and Mom about if there was a time frame, *their* thoughts.

there is a lot of stuff going on. . .
. . . decision-making, learning to drive. . .

Mom rushes in to say, attentive to the possibility that

next year

he will

decide it's all a whim

drawing on what she sees as her child's obsessive *but inconsistent desires, the* shows *he gets so into and yet so quickly moves on from.*

Tyler plays with a he-him pronoun pin in his lap, short hair blurring the view of his face, flipflops dangling off the edge of the exam table.

Mom insists they aren't stopping anything.

We totally support the journey.

After all, she keeps asking him—

> DO YOU WANT TO BE A BOY?
>
> A MALE?

***

Though one may consider every gender care related decision *a big decision to make,* at any age, the move from the decisions that characterize life before puberty, often conceptualized as impermanent to the decisions about hormonal treatment and surgery that emerge after, are marked by an increased emphasis on permanence, both in terms of the expectations parents have about their children's identity, and how the risks of treatments with hormones like testosterone are conceptualized.[8] When a parent such as Tyler's mom maintains her

---

[8] This gloss is perhaps best considered a strategic framing, which focuses on reducing barriers to care by showing the ways in which intervention can be undone, rather than directly naming the potential of

support of *the journey,* yet holds a skeptical stance towards the possibility that her child's desire for gendered intervention is something other than a *whim*, she is articulating, without naming, the fear that Tyler will obtain the features of masculinity and yet find himself in a future where those features are unwanted. That he, and by association she, will have to live with REGRET.

Some parents manage their anxieties about the future they feel responsible for by looking for the children to perform a level of certainty that is nonetheless undercut by any other aspects of a youths lives that seem to reflect mutability—the importance that Tyler's mom puts on *asking*, but her hesitance to see in any answer permanence which is not, in her eyes, reflected in other areas of Tyler's life. I say the "performance" of certainty not to undercut the very real confidence that many youth do have in their own gender identity, but instead to draw attention towards how that certainty is both validated and evaluated by others, in order to become actionable. This sense, that youths' confidence in themselves is persistently scrutinized for any hint of doubt which is then used to limit access to intervention, is problematic such that it contracts, rather than expands, the possibilities for youth to engage in honest and open reflection about the process of bodily change with their parents and care providers.

As Dr M tells me, in one of our many office conversations, *young people are deprived of the opportunity to have a conversation with themselves when they have to be so certain*, stressing that such an emphasis results in a *false assertion of certainty,* because being certain of your gender is *a moving target for trans folks.* Her analysis resonates with what Julia Serano has written about the process of experiencing bodily change as critical to the understanding of self identity. Serano writes, "Transsexuals will often say that they can never know for

---

treatments like puberty suppression to shape futures without overdetermining them, as I describe in the previous chapter. Though I am interested in exploring the temporal logics at work within the categorization of interventions as reversible, or not, I want to nonetheless acknowledge the important differences between treatments that block puberty and those that promote the development of specific gendered characteristics, which are imperfectly captured but still pointed to through these frames. I do not support treating puberty blocking medication as those like Bell and other critics would like, as an intervention that requires the same standard of consent that hormones do.

sure whether they should physically transition until they begin taking hormones—if they find that they like the changes in their body and they way they feel, then it was the right decision; if not, then it was the wrong one" (2016, p. 86).

Conflict over certainty in the clinic is also a conflict over whose certainty matters, and how, particularly in the case of youth who are dependent on their parents' legal permission to begin any medical transition processes, the certainty of parents is placed in relation to the certainty of young people. Dr M was more likely than most to shrug off the significance of parental doubt, at least in the abstract. As another provider once brought up in Huddle, a parent who was now *in extreme doubt over T*, to which Dr M simply answered, laughing, *well, she shouldn't take it*, then. But Dr M's easy way of putting aside a parents discomfort was often easier said than done. Even further, her approach towards isolating youth as the ones who truly were in her care, clashed with the approach of other providers, largely not based at the TYC, who saw their work as treating parents as much as treating youth.

Take Dr K, a psychiatrist who has been a part of several different major gender clinics for youth across the United States. He described himself a "doctor of process" as well as a "doctor of content". For him, this meant that he saw his work as managing, without coercing, families' process of coming to eventually arrive at the same decision to treat a young person. He told me one story of a young patient waiting for his parents to come to terms with his identity, which took years longer than either the patient or Dr. K would have liked. But as Dr. K saw it, it allowed the "quality of their support" to remain high, despite the fact that they did not permit him to begin testosterone and "would mis-gender him, but they were trying." The evidence Dr. K provides for the general success of his model of intervention comes when the patient and him are co-constructing a letter of readiness for top surgery. He tells me, "I looked at him, I was like, *can you believe that you've been on testosterone now for, for already, almost over a year or over a year?* And he looks at me, he's like, *I can't believe it. I remember how much I needed it and wanted it, but* he's like, *you know what? I am glad I'm waited. I waited because my parents like truly see the benefit* *in this.*"

Dr K contrasts that with a situation that he says he's both experienced and heard about from other clinicians, where years down the line, problems emerge in a young person's life which might not have much to do with gender but get attributed to it. Then Dr K describes, parents who were previously silent, those "who never fully came to terms with this" will "in a moment of anger" say something like "see, I knew we should have never started hormones," seeing in the medical affirmation of gender an explanation for other issues.

In this way Dr K is concerned with preventing the REGRET not only of a young person but of a parent. He sees the sacrifice of the years where his patient really "needed it and wanted it" as in service of the future where parents see the benefit. For others providers, this approach asks young people to bear an unnecessary level of DISTRESS, largely to serve the needs of those around them. It contrasts with an approach to care which is oriented towards the potentials that those at the TYC were attuned to; specifically, the potential that it would be through starting care with hormones or other interventions that parents would be able to see the evidence that it works, as their child experienced the benefits of embodying gender in the way they desired. Given the impossibility of eliminating the chance that parents could turn on the moment of intervention as the source of future problems, and no ideal timeline that would guarantee the unconditional support of a family, many providers might choose to focus on the possibilities that such a care offered. Amy, a well-established psychologist in the field, challenged the view of waiting as largely not harmfully. As she put it in our interview,

> **Amy**: Why would you hold somebody back when they could live a full life right now, in their gender? And we talk about the teenage years, peer relationships are so important, so is symmetry, in those situations as well. So, I've seen this work wonderfully with youth around being able to take hormones. I know, the refrain is, *But what if they change their minds*?
>
> **Paula**: That is the refrain, yes.
>
> **Amy**: So what I say is, first of all, that, we can't predict that won't happen. We try to be very careful, that this is a long term, um, decision, that is, that there is a vision into the future and a real understanding of the present. But we

> cannot guarantee it. If they were to change their mind then we would help them in the next gender iteration. There is nothing tragic that will have happened as long as they have the social supports to do it and the understanding that gender pathways are lifelong and they can change.
>
> **Amy**: Let's then ask the other question. What if you held all the kids back just in case they change their minds? Where would we be? I would say we would have more evidence of anxiety, depression, and suicidality among youth [. . .] because now, in 2019, everybody knows these interventions are available and if you're told they're available, but you can't have them. . .

Despite Amy's first appeal to the potential, the possibility of full life now, she pivots towards what more commonly is leveraged in opposition to the risk of REGRET; the risk of the tragic future, or in the worst case, the future foreclosed due to to suicide—the risk of the life not lived. But before turning towards an understanding of this second preventative logic, the one that hinges on the need to keep young people alive, I want to ask, what after the persistent refrain: *But what if they change their minds*?

Hormones and THE REST OF YOUR LIFE: Temporal Embodiments

Ethan came to the clinic for one final time, before he and his family moved to the Southeast US, to be closer to family and somewhere cheaper to live, now that his father was on permanent disability due to a construction accident, and his mother needed to go back to work. Recently finished with high school, Ethan wanted to join the military, but was planning on doing so as a woman, given the constraints of joining up as a man without having had phalloplasty, and the overall feeling that he would be *safer* with women. He was a little concerned, however, that he was DEPENDENT on testosterone. Dr M's articulated her concern with his plan to stop taking T differently, more worried that he *has gender dysphoria* so might *feel really crappy*, if returning to an estrogen dominant milieu.

While Ethan is describing his concern within the register of medication, chronicity, dependence, Dr M translates it as a question of identity. And this pulls together multiple fantasies alluded to when providers are asked if patients will have to take hormones FOR

THE REST OF THEIR LIFE; the fantasy of the self as free from dependent relations, to substances or to the people that facilitate their access to them, and the fantasy of transition as a process with an ultimate end.[9] As Dr M says to one patient, in response to his girlfriend's pose of the question, *you need some hormones* to stay healthy, but *if you feel good, and want to stop, you totally can.* Yet she also suggests that even with the relatively permanent changes available, like facial hair that will continue growing, a lower voice, even a hysterectomy that keeps the ovaries if he wanted to stop his menstrual cycle without medication but keep producing estrogen, *most people stay on T their whole life. They feel better on it. They think better.* Then she chuckles a little bit. Depending on how you think about it, people are *always transitioning, or never.* While she goes on to clarify that he is *well through his second puberty*, the distinction she draws on highlights the separation between conceptualizing transition as a process that ends with an arrival to a place of being finished—with the doctors, with the process of coming out, or coming in, the medications—or as a process that never fundamentally changes who one was, and thus might not be thought of as much of process at all.

Much focus on both the prevention of REGRET and the attempt to distribute responsibility for potential future is tied to the vision of transition as an event, rather than process. In this way, disrupting a temporal logic also shifts what it means to ask providers to be sure, and parents, or young people, to be certain, before initiating any kind of medical care beyond the suppression of puberty. As Dr Y describes it to Tyler and his Mom, *families get caught up, that once they start there is* NO GOING BACK.

No, he tells them. *That's not true.*

---

[9] Managing the chronicity of being beholden to exogenous hormones has been identified as part of the very risk of hormone treatment itself, as Sari Irni (2017) has shown in the Finnish context. Irni argues that considering the risks of hormonal treatments from a trans/feminist perspective requires attending to context and to how risk materializes for trans patients, which is often less about the interior biological risk of a hormonal treatment but fears about being mistreated in clinical spaces, being pushed into claiming a binary gender identity to receive care, and the insecurity of needing to rely on clinical infrastructure to access their medications. Understanding the risk of hormonal treatment in this way, as a process which materializes existing inequalities, also exposes the embedded fears of chronicity which emerge in conversations about the futures of trans youth.

While he then goes on to list things that won't change back, if Tyler begins taking testosterone, things like *hair growth, voice change*, he reminds them that these things all take time, between three to six months on average. He also says that *clinically, we have a really good track record,* maybe *.5 percent of people who have come off* of their hormones, but then again, I DON'T HAVE A CRYSTAL BALL.

Dr Y details some of the specific bodily changes here in order to give a fuller representation of the potential changes Tyler could experience, but separates his distinction of the future embodiment Tyler might experience from the question of whether or not Tyler WANTS TO BE A BOY. Far from unintentional, in his framing Dr Y is discretely working against a logic that collapses gendered bodily traits with identity, and thus, in some ways working against the sentiment that the traits he describes would inevitably be unwanted *if* Tyler is not, actually, A BOY.

This helps to expose a somewhat paradoxical truth about the relationship of gender affirmative interventions to the world of flexible gender expression: that advocating for more expansive understanding of what gender bodily traits might socially signal can be used both to hinder access to medical interventions for youth, by way of cultivating them as unnecessary, as well as to combat the notion that any change in someones gender identity *after* an intervention with permanent effects constitutes a failure of care, insofar as that change is necessarily associated with REGRET. Let me explain.

While there are a number of current legislative efforts in the US and elsewhere that attempt to re-contextualize puberty blocking as an intervention which constitutes putting young people on a path towards further gender affirming care, and thus should be treated as "irreversible," standards of clinical care sharply distinguish between interventions like blockers and treatment with hormones like estrogen and testosterone (Coleman et al. 2012). Unlike treatment with puberty blockers, which have few long term effects that are known to outwardly impact the body, when youth begin taking estrogen or testosterone, there are more tangible long-term impacts of such medications, attributes like voice changes and hair growth, that will not revert to their prior form should a young person stops taking hormones. These are the things that Dr Y lists when going over the consent form for testosterone and its list of *irreversible* effects. But as he also comments, *irreversible* isn't a framing he fully buys into. *What that means is more that it would require another intervention to change,* he tells them.

In this way, that the relative permanence or impermanence of any intervention might be better considered a "matter of concern" rather than a "matter of fact" (Latour 2004), not easily settled by turning towards scientific authority. Parents and providers who consider themselves generally affirming, who find it easy to agree to puberty suppression, can find themselves increasingly tentative when it comes to medical intervention deemed more permanent, confronting a bias against allowing young people to "irreparably change their natural body," (as one supporter of Montana's House Bill 1113, which would have banned gender affirming care for youth, put it during the live-streamed 2021 hearings). Parents might wonder, especially in the sanctity of parents-only support groups, or interviews, if their child couldn't just be happy as a boy who just so happens to *have breasts.* Yet, other parents see their child who has started hormonal treatment question why they wanted so badly to transition if they were still going to *paint their nails*, or wear earrings, or decline to participate in stereotypical masculine behaviors. [10]

That this contradiction is only rarely perceived *as* a contradiction speaks to persistent, shared beliefs about both the desirability of cisgender bodies as well as the unreliability of youth. It is these investments which ground the continual appeal to the prevention of future

---

[10] This largely reflects anxieties and fears about people assigned female at birth starting treatment with testosterone, which is an emphasis that reflects more of the patients and parents I saw, as well as a current focus in public conversation, where protecting "girls" from "irreparable harm" is a far stronger narrative than preventing "boys" (Shrier 2020) from medical transition, though it is trans women who are most vulnerable to social violence and harm. This focus may be in part because of the widely accepted advantages of masculinity giving rise to an anxiety that individuals are choosing trans masculinity for some social reason and might feel differently in the future—recall, in Chapter Two, how Leah notes for her parents that it was *easier to be a boy.* In addition, there is anxiety over chest surgery outcomes and impacts of testosterone that are understood as being more permanent. Given how tightly the bounds of femininity are policed, and the risks to those who do not align with them, this may cause excess worry about the implications for youth assigned female at birth who might, as Amy said, "change their mind."

REGRET. More specifically, what is exposed through the desire of parents to “affirm” their youth until that affirmation includes intervention with far-reaching effects is their desire to preserve the body’s capacity to return to cisgender status; that is, as much as one can support *the journey* in theory, as Tyler’s Mom does, they restrict that journey to one that can be erased.

The irony of this desire to avoid even the possibility of REGRET, and the simultaneously rendering of the deepest REGRET being as one which is tied to losing the ability to return to cisgendered legibility, is how these desire produce a material reality that mirrors the reality those who are prevented from accessing intervention are foisted into (Travers 2019, p. 164). In other words, delaying intervention in order to avoid the possibility that youth might experience REGRET requires more trans people to manage the impacts of undesired bodily development, what Dr M sometimes puts as CONSTANT NONCONSENSUAL DISCLOSURE.

Atypical gender expression narratively appears in this way as a possible alternative to providing material support through medical intervention, at the same time as a future of atypical gender expression due to intervention is assumed to be a source of traumatic REGRET. A parent wishes their child could be content as a man *with breasts*, in order to prevent the future they imagine where one might live as a *hairy* woman. In both scenarios, the experience invoked is that of living with physiological traits that do not conform to gendered expectations. What is being negotiated here is the identity of a young person and its permanence, as well as the desire to maintain a cleanly matched, binary identity (DO YOU WANT TO BE A BOY?), without visible signs of gender diversity, particularly when those signs stem from interior sources; not nails but beards, not clothing but chest size. And, it relates to the stigma and opposition to intervening upon the natural body, which sometimes appears as a concern with hormones as another form of “medication”.

One parent, her non-binary child with their glasses perpetually slipping off their nose sitting a few feet away, is disinclined to start them on an allergy medication for persistent post-nasal drip. She doesn’t *like medication*, she says, which draws Dr M’s eyebrows up as she questions how such an outlook matches with the patient's current prescriptions for both gender and mental health. Yet another mother described to me in an interview how her in-laws consistently struggled with the medication aspect of the transition care her daughter, Rachel ,was receiving. As Rachel's mother told me, "like, nobody should be on medicine at all, for anything [. . . .] And so now *you're giving her a medicine forever and ever*, and *she's young* and *you're messing with her body by giving her medicines.* That would be my in-laws thing. But they're very much in the same thing as true for mental health. She's literally texting me right now about like mental health medicines. [. . .] Any medicine is not ok."

Rachel's Mom describes how her in-laws are struggling to reconcile their desire to support Rachel with their feeling that medical intervention for either mental health or gender will be detrimental to Rachel's well-being. This diverges from the preventative logic that shapes so much of the concern with REGRET, in that the relation between medication itself and the possibility of REGRET is more subtly communicated. But it is about THE REST OF YOUR LIFE, a temporal container defined by its perpetual futurity, but which takes on different meaning if youth are considered to be near, or far, from the possibility of the end of their life. This does not always mean invoking the risk of suicide, though it often does; instead, sometimes this means seeing young people as in bodily flux, beholden to the vagaries of adolescence, even as they are recognized as holding stable authority regarding how they want to be treated for gender. After all, even as young people must show constancy when it comes to their gender identity in order to receive care, this does not mean that trans youth, as with any other youth, are not sometimes caught up in patterns of risky adolescence, with troubles that are sometimes attributed to un-finished neurological development.

Myelination

As Dr M had told me about a handful of her several hundred patients, sometimes the goal was simply *to keep them alive* UNTIL THEIR BRAIN MYELINATES. It's Halloween, and in between patients Dr M is in her office with a glue gun, sticking lines of redacted text back on her black T-shirt; she's going as the Mueller Report. Myelination refers to the process when connective nerve fibers in certain brain areas become sheathed with myelin, a substance which enables the electrical impulses to transmit faster and with less energy (Spear 2013). Paired with imaging studies that have shown that adolescence is a key time of development in brain areas which "may impact self-control, decision making, emotions, and risk-taking behaviors" (Arain et al. 2013), the reference to MYELINATION was often repeated as an appeal to the future where youth would be more capable of recognizing the risk inherent in some of their decisions and choosing otherwise. In my observations at the TYC, this was never about gender identity or gender care, but about the myriad other "risk-taking behaviors" that a youth might be engaging in. That is, the notion of *brain development* or FRONTAL LOBE MYELINATION most often emerged in the context of discussing youth struggling to manage their lives in responsible ways or adult ways, who were more emotionally volatile, or using substances or sex in ways that had their providers anxious about their safety.

On a day known for highlighting the possibility of raucous behavior from young people, a reference to MYELINATION also felt like an attempt to read between the lines Dr M was so carefully arranging. That is, it was another way of describing the impossibility of knowing the relation between what was happening inside a young person's brain and the way they were relating to the world. To draw from Lauren Berlant (2011), it might be another way of formulating an optimistic attachment to the future outside of adolescence run through the register of science, when adolescence is perceived not as a persistent childhood but as an impasse. As Berlant writes, "An impasse is a holding station that doesn't hold securely but opens out into anxiety, that dogpaddling around a space whose contours remain obscure. An impasse is decompositional—in the unbound temporality of the stretch of time, it makes a delay that demands activity" (2011, p. 199).

> *Fi is our third patient of the day, who calls her mom* sis, *whose father is in treatment for cancer in Arizona, and who recently got out of a stint in rehab coupled with a few days in an inpatient psychiatric facility. She's only 15 but if Dr M hadn't told me before I met her, I would have assumed she was older by*

several years.

Fi greets Dr M by calling out her full first name, which Dr M rarely goes by, the vowels long and exaggerated.

Hello, love.

She is proud of the fact she's lost weight recently; Dr M finds it concerning. Fi is quite thin, with tattoos on her pale skin which are recognizable as stick-and-pokes, the kind you do at home with a basic needle and india ink.

it's better than cutting

according to Mom.

When Fi tells Dr M that she wants to take Adderall*, Dr M responds,* listen to me, no one is going to give you. . . *they both start laughing. . .* you just got out of rehab. . .

I quiiiiiit

I'm not using it!

Though she explains that she didn't stop using in rehab, saying

yeah I got sober,
but I wasn't sober in there

Fiona is frank about her desire to get on pre-exposure prophylaxis to prevent HIV, which both Mom and Dr M are glad to hear, and seemingly willing to talk about her substance use, but all of this is somewhat besides the point.

Real talk, real quick.

I'm going to sit up.

Rising up from where she has mostly been laying back on the paper covered exam table, Fi talks about the constant self-scrutiny she feels,

I look at myself
ARE YOU A TRANNY? ARE YOU A TRANNY?

> *She gets bullied, she gets death threats on SnapChat, and after the last ones, which measured in the hundreds, according to Mom*she wanted to kill herself. *Even though Fiona also says,*
>
> I pass really well.
>
> I can tuck that shit into the gods, mama.

***

Fiona was perhaps the only patient where her desire for a gendered intervention was met with attention to the other aspects of her life that needed to change before she might be able to move forward towards it. The concern was less about her young age but rather the laundry list of concerns her mom had presented—not only rehab, suicide threats and attempts (even as Fiona argues her attempts were strictly strategic), self-harm, but also a recent arrest, running away (*trying homelessness,* her mother says), which causes Dr M to ask Fiona what recovery would even look like for her. *There are a handful of things you need to get under control before surgery,* she says, *can you guess?* And gently teases, *you're a lot of things; you're not stupid.*

Dr M clarifies that *she's not opposed* to referring Fi for surgery, but she also wants to discuss with Fiona what a vaginoplasty might look like in her case. Fiona was an earlier transitioner. This means that she went through an estrogen dominant puberty, and doesn't have much penile tissue, according to her self report. This doesn't bother Fiona, who is game to use tissue from other parts of the body, but pragmatically complicates an already serious surgery, particularly in terms of healing time and preparation. And in fact, as the first cohort of early transitioning youth manage their desire for other sorts of intervention, specifically vaginoplasty, this has emerged as an increasingly important issue to manage. As Dr M describes to Fi, she had one patient use scrotal expanders to stretch the skin which could then be used to construct a vagina, a tedious and uncomfortable (at best) process that Fiona does not seem interested in. There are a few other options, all of which are less common and in many ways less ideal than the method typically used, which has further raised the question for some providers about the trade-offs between early transition with puberty blockers that often give youth the capacity to *pass really well*, and the desire that Fi has now to pursue a surgery that had traditionally relied on the bodily development that comes along with having a testosterone dominant puberty.

For older adolescents considering phalloplasty, an even more complex procedure that generally involves several stages of surgery and revision, the traces of prior decisions and experiences shape their future differently. In another appointment, Dr M and I meet a patient with a stuffed blue Peep hanging from one ear and double studs in both corners of his mouth, faint scarring along his arm exposed by his black tank top. Later, Dr M asks me if I've met a different patient, someone *cut from the same cloth.* I hadn't, but nonetheless she goes to to say that in one of her recent conversations with him, he told her that *unless they take it from my back, I'll have self harm scars on my penis.*

I don't have a response.

The hope that Dr M puts on myelination here is related not directly to the gender identities of her patients, but to their ability to manage the stress and growth of adolescent, to make it safely to the other side, out of the impasse. She often sees gender affirmation care as a critical component of the support necessary for youth to manage their other stressors, and rarely advocates for withholding care until other issues are uniformly under control, a dynamic sometimes referred to in the TYC as *carroting* a youth. [11] Yet, for many youth, it is not the slowly unfolding and highly individualized process of biological brain development that they are dependent on in order to access gender affirming care, care that could, in some instances, prevent the experiences of DISTRESS that lead some youth to engage in riskier or more harmful behaviors than they might otherwise. Rather, they are reliant on the social and legal category of age, which once marking them as able to consent to their own care, can reshape how youth choose to engage with hormones, even if they had been prevented by

---

[11] A reference to the carrot, and the stick, and the myriad other concerns of adolescence. It might go something like this: *Want to see the doctor about hormones?* Better *get your grades up*, *do your chores*, *avoid detention*, and *stop begin depressed*, first.

others until that point.

The Age of Consent

"In common law, the age of this, signaling adulthood, is presumed to be 14 in boys and 12 in girls." This statement was offered up on a 2015 episode of Jeopardy, to which a contestant named Tom answered, incorrectly, "consent", rather than "puberty", to laughter and some reasonably founded shock. Briefly trending on Twitter, circulated as a meme and entered into a longer lists of "game show fails", the incident was glossed by some news outlets as "awkward" or "creepy", (Cutway 2015; Mullins 2015) for the mistaking the signifiant difference between the bodily, biological processes of reaching reproductive capacity and the legal categorization of a young persons capacity to willfully engage in sexual activity.

Though perhaps most frequently used in the context of sexual decision-making, the concept of an "age of consent" is critical in shaping medical practice.[12] Yet, the reliance on age as a proxy for developmental maturity is a contentious object for the management of gender in youth, and for the management of youth more broadly, which cuts both ways. As Dr Y put it during one clinical consultation, there *is no magical age, 18 means nothing*, while other adults are insistent that inclusion of youth in adolescent medicine until age 25 indicates developmental immaturity until at least that age. Furthermore, it's widely understood how gender and race shape the social recognition of a young person's capacity to take on responsibility for their actions.[13]

---

[12] It is impossible for me to consider the age of consent without also invoking the English rock band New Order's "Age of Consent". Their own analysis, opaque as it remains to me, manages to call upon, in its chorus, the push and pull of entangled dependence and autonomy that the young people in this chapter, and this section particularly, are grappling with; go listen, if you haven't. "And I'm not the kind that likes to tell you /Just what I want to do/ I'm not the kind that needs to tell you/Just what you want me to" - from *Power, Corruption and Lies* (1983).

[13] Some are aged up, while others receive the permissiveness granted children far longer, often along racialized and gendered lines. Consider the difference between how young Black people are more likely to be transferred to adult courts (Lehmann, Chiricos, and Bales 2018; Social Workers 2017) and how current Supreme Court Justice Brett Kavanaugh's nomination process relied upon invoking an understanding of his past behavior as shaped by a prolonged adolescence and the clear differentiation of legal adulthood (Farrow and Mayer 2018). When it comes to affirmative care, the current trend among some more conservative

When it comes to gender affirming health care, youth are often caught between their desires for peer concordant puberty and the relation of those interventions to standards, legal and professional, that may make it difficult to access hormonal intervention before the legal age of consent. Fortunately for many youth, those for whom peer concordant puberty is an option are often the "Littles", who arrived before puberty accompanied by parents willing to provide the necessary legal consent for first blockers, and then hormones, given that a professional is also willing to prescribe them. Dr M told me about one such patient, her *third trans girl,* who was starting high school, frustrated with her prepubertal body.

I'm in high school, I look 10, Dr M parroted.

Then she tells me, *I started her on hormones.*

14 might be lower than the expected age for some clinicians, but the frustration that Dr M and other providers like her have is that waiting until an arbitrary age to begin hormonal intervention is based more in the what they see as a politics of fear, and what I attribute to the need to prevent REGRET than the sense of biological appropriateness of intervention. As she tells a family, *the initiation of puberty is a range... it's very individual.* Many of Dr M's patients and their parents are sympathetic to this logic, eager, even, to let their youth start hormones early in order to maintain a peer concordant development. But youth that expressed their trans identity later, especially in their mid to late teens, after puberty, were more likely to confront tactics from their parents which skeptically reinstated the view that gender expansive identification was itself a marker of childhood that would go away in time. If it didn't, parents could rely on the formality of the age of consent in order to abdicate their own responsibility for the prevention of their child's future REGRET, calling upon the legal structures that enforce their children's dependence on them for medical care to erase, in

---

providers has been to reach towards the age of 25 as a more meaningful time to transition from parental to youth consent. This would disrupt much of how health care is managed on college campuses, for instance, where currently providers are prohibited from disclosing private health information to parents without the explicit permission of youth, and though argued for by some (Anderson 2022), I find it troubling that gender affirming intervention is singled out as uniquely dangerous, despite all the life changing decisions youth have access to starting at age 18 that there is little concern with.

some forms, their active participation in the limitation of their children's bodily autonomy.

Sometimes young people like Camilla, a 17-year-old immigrant from Puerto Rico, can attempt to legally extricate themselves from their family context in order to make medical decisions for themselves. Camilla had brought with her, to the clinic, a letter from a lawyer in New York that described legal separation and financial independence; not a document that Nina and Alex, the two providers attempting to help her continue the medical care she had started in New York, were used to working with, but one they hoped would be grounds enough to permit Camilla to manage her own care should it be challenged. But Camilla was a rarity. For most youth who are without parental support, they must manage their dependence by simply waiting until the time that the legal structure of THE STATE no longer recognizes parents as the ones responsible for the future outcomes of intervention.

I interviewed Charlie over a hurried breakfast we managed before he went off to pick up a friends for a big queer celebration happening in the city we were about an hour away from. He was in college, near home but no longer living there except when he was dog-sitting. Charlie was studying journalism, and described himself as White and, "pretty binary, male. Trans male, I guess."

When I ask Charlie about experiences of gender, if he had early memories of "feeling a sense of gender," he tells me, "Yeah,"

"once my, my chest started coming in—"

"uh-huh," I murmur.

"I was like—no"

"UH-HUH"

"Yeah."

"Okay."

Charlie goes on to explain to me what he calls, "a whole issue", in other words "the TRANS MAN THING where you kind of like, you present really male for awhile, like, cause I thought I was like, like a really masculine lesbian or something… and then I realized that

I wasn't and I was male, but then I didn't really want it, so I tried to be really feminine to like, like go against that because I felt like, *Oh, this is not good, cause I don't even know what this is.* And then I watched trans videos and I was like, *Oh, okay.* So then like six months later I came out. And that was like, okay with my dad, not okay with my mom."

Charlie's mom struggled in particular with his age at the time he came out, which was, according to his recollection, about 13 or 14, which we agree, was "not a good time anyway". Charlie came out to both of his parents, who are divorced, ("they hate each other") at the same time, but remembers "so many arguments" with his mom. "Like every year I would have an argument where I would tell her, or twice a year maybe, where I would be like, *Hey, you need to call me by these pronouns and this name,* like*, I changed it."* Unsurprisingly, then, when Charlie wanted to begin medical transition processes, his mom became a barrier to the consent process.

"She prevented me from having everything until I was 18," Charlie said.

"Really."

"Which was like a whole argument thing."

"Including any hormones?" I clarified.

"Yeah," he said.

"Yeah" I echo.

"Which kind of sucked," he says, and my lilting, "yeah" in agreement interrupts him as he tells me, "because I was like really struggling."

Charlie and his dad first went to the clinic when he was 15, without his mother's knowledge. He tells me that he decided he would wait and try to bring his mom in next year, "because I've already had too many arguments this year." So Charlie took both his parents in when he was 16, and described their questions as "bad," how he thought *you haven't done any research on this, have you.* When I ask him if he remembers any of these questions, he says that it was like "isn't it just a PHASE?" and told me how he and his doctor tried to help them see, *why would I inject myself with a needle for a* PHASE.*I'm afraid of needles.* The appointment didn't end with anyone starting on hormones.

"So my mom was like—her whole thing, which was just because she didn't want me to do it, was that she didn't want to be responsible for if I didn't want hormones"

"Uhhuh," I murmur.

"And I was like, this has been two years, c'mon—"

"Yeah"

"—and hormones aren't even that bad—"

"Yeah"

"—it would just mean, my voi—if I got off of them, my voice would just be changed—"

"yeah"

"—And like some more hair—"

"Yeah"

"I dunno."

Taking a break from my endless murmured affirmations, I tell Charlie, "I see. But that was her kind of logic where she was like, *I'm not going to be responsible for this* but because you're 16, I have to sign off."

Charlie agrees in this case with my gloss of the situation, which amplifies what he first mentions about his mother's concern about being the one held responsible for the future where Charlie *doesn't* want hormones any longer. Elided here is the possibility of being responsible, at least partially, for enabling Charlie to experience his body in the way that he wants. More so, Charlie had the feeling, which is often widely shared among trans young people and providers, that the structure of transition he wanted was for her, not for him. When he described to me how his mom had reacted to his change in name and pronouns, it was once again, about her. Charlie said,

> I told her, to like, use certain pronouns with me, and she wasn't at the time. So I was like, *Oh, I just need to give her time* because it's been like a month. And so, I was like, and at that time I wasn't used to my pronouns and name anyway, so it wasn't that bad. But I told my school to call me—my teachers and

> my friends—to call me by the right pronouns. And then she found out about it somehow. Like someone called me, he in front of her or something. And then she kinda like freaked out and she was like, *you didn't tell me*, like, *you have to give me time.* And I'm like, *this wasn't*, like, *about you.* This was about them, using my right pronouns.

The next year, when Charlie is 17, he once again brings both parents to meet the doctor and discuss the medical interventions he wants, and once again, his mother refuses her consent. I ask Charlie if he has a sense of what brought her to the appointment, time and time again, what possibility she was holding onto that failed to manifest, year after year. He tells me that he thinks that partially she wanted to understand, and on the other hand, also she wanted to "appear like she was trying." For him, it seemed more like she was oriented towards appearances, and what others may have expected to see from her.

Charlie started hormones on the day he turned 18 and no longer needed his mother's all important signature. And they have maintained their relationship, with her most recently accompanying him when he went in for chest surgery, though he didn't initial invite her given the context of her approach to his desire for gender affirming intervention. Not all youth are so tolerant of a parent seemingly preventing their care based on what feels like the arbitrariness of the age, or willing to wait for "process", as Dr. K called it, to bring them around.

Ken had been in foster care for several years at the time he was beginning a medical transition, but still needed his father's consent to begin taking testosterone. In many ways Ken was similar to Charlie; their narratives of tomboyishness as a children, their first identification with queer sexuality, the post-pubertal determination to try and be exceptionally feminine to please other people in their lives and perhaps convince themselves that they were not *really* trans, and the significance of seeing other trans people, mostly through Youtube or Instagram, as opening up possibilities that they might have taken years to understand otherwise. This is one of the trajectories most attacked by anti-trans activists attempting to delegitimize the identities of trans young people, who are especially concerned with the possibility of the "rapid-onset gender dysphoria" (ROGD), (Littman 2018) or dysphoria that fails to present at a very young age and is thus stigmatized as a potential "social contagion"—what one father in an interview with me glossed as "stupid smart phones".

Critics have noted how the original study promoting the concept of ROGD was drawn from only parental reports, with a sample recruited online from sites specifically catering to parents who oppose their children's identity (Restar 2020), and have suggested that the project effectively weaponizes the rhetoric of science to combat growing empirical evidence of the benefit of gender affirming interventions (Ashley 2020a) as well as constructs a form of "pathological untimeliness" where sociality serves "as a contaminant of sex-gender" (Pitts-Taylor 2020, p. 16). The fear of social contagion came up in a number of conversations with youth about how their parents responded to disclosure of identity by looking towards their school or friend environment, even as Ravish told me, "blaming the music I was listening to." Yet, as Amy described it, we don't find it shocking that "cheerleaders hang out with cheerleaders." She thought it was more likely that "they found like-minded people where they could begin to open up, and so the reason they're hanging out with THOSE KIDS is because they are THOSE KIDS.[14] Nonetheless, the concept of ROGD and the fear of social contamination has continued to grow in popularity in conservative circles, cited in policy work and follow-up projects that largely intend to find alternate explanations for why young people in their teens might claim a trans identity, to the surprise and shock of their parents. This strand of investigation is somewhat coterminous with literatures that emphasize the possibility of de-transition, material that Charlie says his mom attempted to use to support her failure to consent to his care. As he said "she would bring me this research and say like *what if you don't want it any more,*" looking for evidence about the possibility of the future where he desires otherwise, as well as insisting on relationships between hormonal treatments

---

[14] This should also resonate with the arguments in Chapter Two regarding the importance of youth presumed to the evidence of innate gender identity due to their age, which are here contrasted with young people deemed to have displayed gendered DISTRESS too late. In other words, we have here another version of the fear of the SOCIAL CONSTRUCTION of gender, this time coming from the temporal location of later adolescence.

and cancer, and "mourning the child, mourning the daughter thing, and like losing someone who looked like her."

The parents of youth like Ken and Charlie were rarely a part of my work, given that we often met at the clinic where they were already independently managing their care. Most of the parents I interviewed had young children, or at most, early teenagers. Thus, most of my understanding of how parents reacted in these situations are drawn from youth reports; in some ways, turning the methodological problems with Littman's (2018) study on its head. Yet, given the amount of work which utilizes parental reports to access youth experience, this lack at least may also help compensate for prior oversight, as well as provides insight not just in what parents do or do not do, but in how they are received by their youth as being affirmative, or not, particularly when it comes to parental decisions about permitting or preventing access to medical care.

Ken told me that if he had known earlier that he could have legally emancipated himself to begin the processes, he would have. When we had our interview, at a coffee shop in the suburbs a short skateboard ride away from the group home he was currently living in, Ken was also 18 years old. He described to me the attitude he had towards his father in during their conversations about whether or not he would consent to Ken's starting to take T. Ken said, "I asked him to, y'know, sign off for me to get testosterone, and this was like a month or two before I was going to turn 18, I told him, I was like, *if you're not going to do it, then you can just fuck off*, because *I don't need you*."

Ken emphasized what he saw as his power over maintaining a relationship with his father, which had long been contentious. He told me that he had "cut him [Dad] off for 6 months" after too many experiences where his father didn't use his correct name and pronouns, but that he "still wanted Dad back," because he missed him. Ken also tells me that his dad "needs me too much, I help him out with a lot of shit," describing how it seems they both desire a relationship of mutual support, yet cope with a reality that often turns sour, and sometimes abusive. When it came to the final say on testosterone, Ken used the impending possibility of engaging in care autonomously to make clear to his father that withholding his permission wasn't going to prevent him from accessing T. He could either consent, "or *I'll just wait until I turn 18, this is going to happen regardless*. So he eventually consented, so I started it like a month before I turned 18."

After the Age of Consent

Though both Ken and Charlie leverage the power of the age of consent in order to begin their transition procedures, and in doing so, manage to maintain their family ties while exerting ever more independence, not all young people experience the passing of the age of consent in the same ways. For some families, age is really "nothing but a number" (Aaliyah 1994), where it seems a near impossibility for youth to ever reach a time at which their parents deem them capable of taking on the risks of the future. Furthermore, continued material reliance on familial support in many ways shapes how youth decide to take on the risks of treatment, as they weigh their desire, or need, to prevent parental censure against their own understanding that affirmative gender care offers new potentials they are eager to experience. This happened to be especially true when talking with two young people who, like Ken and Charlie, came to understand themselves as trans in adolescence, but who unlike Ken and Charlie, did not experience a simple release from the control of their families even as they reached the age of majority.

Cam, a 24-year-old second generation Mexican-American, fit in an interview with me one morning after long night as a shift foreman at a bread manufacturing company. Cam didn't access any transition related care until well after he was 18 years old, at a time when he was living with his father and step-parent. After several months of taking testosterone, he moved back in to live with his mother again, without saying anything to her about his gender transition. Cam finally decided to tell his mom after she started commenting on changes in his voice, once his repeated insistence that "I'm sick" (his voicing of it causes us both to laugh) started to feel insufficient. Cam tells me, small pauses and shifts in inflection changing when he voices himself and when he is speaking for his mom,

> And I told, mom, *can you please sit down*? And she sat down and I told her, *I started transitioning already to male four months ago.* She cried. She cried and told me *why, why didn't you tell me this? Why couldn't you wait? Why couldn't you wait for until at least you were 26, 27.* And I looked at my mom like, *why? 'Cause then you'll be older*, you know, *if this is what you really want.* I'm like—

I interrupt, "but you were already 20, right?"

"I was already 20."

Cam's mother, in this instance, implies that if only he would wait longer, he might come to a time when he no longer desired these intervention, that he might "want" it now, but only in the future would he know if he "really" desired the masculine embodiment he has already begun pursuing. I suggest that in these cases, the expression of the intent to reshape their body is itself taken as a marker of immaturity; a desire that serves as evidence of childishness set in opposition to the presumed adult-like acceptance of gender as it was assigned at birth.

In another case, Ravish told me about his process of coming to terms with his identity in high school. He described being immediately struck with the anxiety of what being trans as a second-generation Indian American meant, growing up in what he experienced as a conservative, tight-knit community with rigid gender norms and expectations. In therapy for depression as a teenager, he came to understand himself as trans. This felt like a crisis; that it would require material, financial things, like health insurance coverage, which he felt would be unavailable to him for many years. With low expectations that he would be able to rely on his parents for this support, he made small changes in his gender presentation but largely kept quiet about his gender identity until after he went to college. After several months of living in a queer themed dorm during his first year, Ravish "decided to come out to them through a letter I typed up. I didn't want to do face to face." When I asked him what he had expected, he told me "I was expecting the absolute worst [. . .] I thought they would just like cut me off, or like kick me out of the house [...] which in retrospect, I feel like getting kicked out might have been better, given what I've been through."

Rather than disconnecting from Rav, which in someways would have relieved him from the burden of managing his family's expectations and needs even as such a rupture would have instated many new burdens, particularly financial ones, his parents responded by intensifying their connection, emphasizing the relationship or the claim they had to each other. As he tells me, "my parents ended up coming to my dorm that night. So they were like, *we're here. We want to talk to you.* It's like.. Um.." And Rav laughs a little bit, "Yeah. Like my heart dropped, it's like, *oh, god.*" After several of these conversations, the content of which Rav mostly says he has "repressed" but centered around *where did this come from, what are you doing, you need to stop,* they told Ravish he needed to move home. He told me, "they were like, *no, we need you back home.* Like *we need better control over you.* Like *I need to see what you're doing.* You know?"

Ravish did move home. After talking with his RA and case workers at school, realizing that in the event his parents stopped paying for his housing he would no longer be able to stay there, he felt he had no other options. Rav was still living at home at the time of our first interview, the fall of his sophomore year of college, and during our second a year later, when his plans to move out were derailed by the emergence of Covid-19. And he was still living at home during our third call, when despite his parents' resistance to top surgery, he was nonetheless recovering from the procedure that he had finally obtained after numerous delays and interruptions due to Covid-19. His parents were still insisting on their obligation to him through the process, despite his sustained feeling that his home was neither safe nor affirming. He explained the dynamic between their attempts to dissuade him from obtaining the surgery, yet insisting on their right to care for him. Rav tells me his father approached him "with saying the whole, like, *why are you doing something so permanent* and *you're already on hormones.* And I was like, well, *how am I supposed to, have you help me?*" His voice shifts quality as he remembers this conversation for me, slowing down, truly questioning *how* he could receive care from them as care; how he might see their work on his behalf as help, rather than as a continued barrier to the life he wants to live, a life that is ultimately his.

Cam and Rav describe their entangled dependency on their families, even as Cam experiences a level of financial independence that Rav does not. In either case, what is evident is that the legal apparatus of the age of consent only mediates the way that youth are understood to be dependent, and capable of making medical decisions that impact their futures. The age of consent is also one apparent way that more intangible structures make themselves felt in the clinic; structures like THE STATE, which shape not only how care can be provided in the abstract, but must be embodied in situations where youth have no parents able to make decisions for them.

Depending on THE STATE

So far I have described dependence and youth as understood in relation to singular adults that exist in the lives of youth. However, alternate modes of dependence also shape how care can be provided, and how youth are able to cultivate themselves as responsible. In particular, some young people's trajectories are deeply shaped by their engagement with THE STATE. Others see, within the material conditions of treating gender medically, risks related to the association of hormones with other drugs, licit or otherwise, and the potential for chemical forms of dependency which could be detrimental to their futures.

As a part of the daily life of the clinic, a hospital is already enmeshed with the THE STATE insofar as reference to THE STATE indexes a complex set of institutional norms, legal requirements, and a potential payer. For in the United States, the absence of a robust or sometimes even visible, social safety net, which provides things like access to health care, means that many young people's care is informed by the state only in terms of the fundamental ability to access care. In other words, is it a state where legislation mandates private insurance include provisions for gender affirming care? Or do they permit "carve-outs", explicit language that allows certain companies, particularly religious ones (which include the some of the largest health care providers in the United States) to exempt coverage for procedures like gender affirming care? Is it a place where THE STATE is a part of the attempt to ban affirming care for minors?[15] Or where there are legal options for nonbinary gender markers? Are public schools explicitly enabling the participation of trans youth in sports, or banning?

Most of the time THE STATE figures into transgender care as a primary blockade to intervention; when anti-trans care politicians who believe that THE STATE has a responsibility towards protecting youth from what they see as detrimental forms of medical treatment draft and pass legislation that criminalizes or bans gender affirming interventions. Such moves are resonant with the mode of seeing youth as political futurity itself (Edelman 1996) (which also ground attempts to eliminate abortion and other reproductive health), and cultivates public sentiment about the idea of a child, with very little regard for the real young people harmed by these forms of legislation. This is THE STATE at its most exceptional, despite the fact that this exceptional is, in fact, completely ordinary.

More often, dealing with THE STATE in the clinic meant dealing with one of two things: the foster care system, otherwise known as the Department of Child and Family Services (DCFS), and public insurance, or Medicaid. Interacting with THE STATE is not merely an abstract or structural, in the senses I have described, but made through the common interactions with "street-level bureaucrats" (Lipsky 1980). Rather than focusing on policy as it is drafted, as if power simply exerts a downward force from some unseen but omnipotent place, illustrating the mundane ways that THE STATE manifests as the responsible entity for managing youths's care shows how dependence is enacted along the way. Furthermore, drawing connections between how youth assert their independence in this context of state care shows how youth can be simultaneously rendered as subservient to the needs of others and yet required to take responsibility for their own futures, which is especially visible in the cases where youth are largely without parental support.

One week, Nina describes a *spicy* 15 year old, who had recently met with her and the

---

[15] See, again, Interlude 2: LEGISLATION

nurse to begin his testosterone injections. He did *amazing*, Nina told us, *just stabbed it right in.* The injection route wasn't their first time they had tried to begin the patient on testosterone. He had first been prescribed testosterone gel, often preferred by newer or younger patients who might find injections more intimidating. But when the social worker got the prescription, according to Nina, they wouldn't give it to him, because they *didn't have the instructions. Even though it's in the box...* Dr M comments skeptically, while yet another voice chimes in to relay that it was a new DCFS worker, though it was unclear to me if this was meant as a way of forgiving a misstep or of expressing exasperation as the constant cycling through of impermanent staff.

The social workers who are tasked with the attending to the needs of patients are not always as difficult as the new worker referenced here, though Ken, too, described his anger at the group home workers who he felt prevented him from accessing his medication. More often, it was easy to see how the burden of working in an under-resourced system, with high caseloads and youth who, as Nina sometimes put it, have *a little feistiness,* does little to support individual workers in providing high quality, consistent care.

One day Nina and I wait in the nursing station and front office area for her next patient to arrive. She is the only provider I shadow who doesn't usually return to their office in between patients, instead preferring to use the spare desktop behind the check in desk. There I can perch on a small wheeled stool, as have many other shadows, on other days. We are waiting for a patient that has a follow-up visit scheduled with Nina. Last time she came, she brought her boyfriend, and had just run away from a group home she was supposed to be staying with. Foster youth are supposed to be accompanied by a caseworker, but as Nina tells it, sometimes that devolves into, *Oh, I'll just meet you there* and ends with *You can get home on your own, right?* When she does arrive, she refuses vitals from the medical assistant, who is a man, and Nina idly wonders if it's about his gender, or that she just didn't want to do them, relatively unbothered. She turns towards me, *I wonder what she'll say about you, then.* I wonder, too.

Carly looks back in the mirror behind herself every few minutes, fusses with her dark pony tail and purses her red-lipsticked mouth, both in high contrast to her pale complexion, as she updates Nina on what has been going on. She keeps mentioning that she might

Go AWOL

She speaks more for herself than nearly any other 14-year-old I have met, whether it's describing how her now ex-boyfriend scratched her name off of her last prescription, preventing her from taking her medication into what she calls

a shelter

but her case worker refers to as

a group home

Or talking about the possibility she might leave the home she's currently staying with to see her mom, who might be getting out of jail soon, or has recently gotten out of jail.

Because she hasn't had her prescription for a while now, Carly wants to know if she can get a longer prescription, to keep her more consistent in the event she does leave her foster home, and if taking her hair and nail vitamins will interfere with her estrogen. Nina tells her it won't, and also offers to switch her from taking spirolactin to block the production of testosterone, to a newer option of bicalutamide that they have been trying recently, which seems to promote more chest development and have less side effects.

So, the T isn't going to be blocked.

Nina clarifies that the effects remain blocked, *but describes how testosterone itself will still be produced. They talk about the body shifts she is anticipating.*

So, hourglass.

Nina reminds her, it takes time; you're not going to look like Beyonce in 3 months. Your face will round out out more.

Carly asks,

What does that mean?

she laughs
You're saying I'll have like a double chin?

They briefly chat about the other medications Carly has been on, if they should try to schedule her with the psychiatrist, try something new. The caseworker starts to waffle on her own capacity to bring Carly to such an appointment, as Carly looks in the mirror, touches up her hair again, turns back around.

I have three social workers.

I need one of them to be available.

When the case worker defers yet again, Carly brushes her ambivalence aside.

We're here for hormones.
Let's talk about that later.

***

Part of the reason Carly is even talking about switching medication stems from the fact that she is in foster care, and thus, has public insurance. As Nina tells me, THE STATE almost never approves puberty blockers, particularly the implant, which may have been the most useful for Carly, given the challenge she is already experiencing to stay consistent with medication. Still, providing her with a low dose of estrogen alongside a medication that prevents the effects of testosterone is a workable solution, if Carly takes the daily pills. Nina asks her if she had noticed any side effects, any nausea, or hot flashes, or other things that might need management. Carly tells her, *I feel like I was happier on it.*

With her constant invocation of GOING AWOL, Carly presents her refusal to be controlled; that is, at the very least, she is naming the possibility to remove herself from living situations that don't suit her, even her imagination of such an escape isn't aligned with the reality of it. Yet she is not able to shed her dependence, for Carly is unlikely to be able to fully extricate herself from the structures that feel constraining and yet also provide care. Of course, this positioning is not restricted to youth who rely on THE STATE for their needs, but rather, characterized the conditions of living where entangled forms of dependence are always present, even in a highly individualized context such as the contemporary United States. However Carly's particular imbrication in these structures of dependence force upon her a form of responsibility that many might see as premature, despite the fact that she is still unable to legally make decisions for herself. Despite her youth, she has to, in many ways, function as an adult when it comes to her care, unable to fully rely on the patchy supports of new foster parents and overwhelmed caseworkers.

Clinical staff often find themselves in not only the role of the prescriber but also an advocate, which is true in many cases regardless of whether parents are involved but can, in some instances, become a circumstance that pits the expertise of the clinician against the authority of the parent, and where the THE STATE functions as an arbiter. In one of my first conversations with Alex she described to me her recent experience testifying as an expert witness in the case of a youth who, though being a technical ward of the state, has parents who were attempting to prevent their children from accessing affirmative gender care. Alex, functioning as advocate for the young person, was asked to testify about affirmative care, its value, and appropriateness. In our conversation about this case and about my project, she invokes the concept of the logic of preventative care, as we discuss concepts of the phase, of what it is that individuals are actually afraid of, and she says, *what's the bad outcome, is that your child is trans? Or dead?*

Alex's comparison turns on the embedded and assumed desire to prevent REGRET, matching that preventative desire with alternative need. It reflects how, so often, the possibility of affirmative care is rendered into an option only under duress, where the threat of the life not lived is so great that it overtakes any concern about futures where youth *change their mind.* Yet, the reliance on the threat of suicide also removes the more difficult negotiation with young people's access to agency and choice, and can constrain the set of outcomes within which affirmative gender care is either said to work, or be valued. So while I believe Alex and others are often invested in articulating a space for practices of affirmative care that are less fixated on prevention as it pertains to REGRET, what I want to show, as I turn to the rhetoric of and experience of suidality and suicide prevention, is how merely replacing the object of the future to be prevented might re-inscribe, rather than release, dependence on the foundational logic of prevention.

The Threat of Life Not Lived

At the clinic there was an outdoor deck off of the staff break room, one with a view of the city, which often hosted my interview lunches or the occasional celebratory event. Around the periphery were potted plants of various shapes and sizes that I never paid much attention to until Alex told me how some were once purchased in memory of patients they had lost. *It used to be we got plants, but now we get planters,* she said, not needing to detail how this is about lessening the recycling of loss and trauma which plays out should something should happen to the plant, a something that often did.

In August, during one my my days following Dr M, she tells me, *we've lost three to suicide;* two who had aged out of care, none of whom *had gotten into care early.*

In September, the number increases by one.

When Nina shares the news at the staff meeting, it is largely met with silence; silence that sits with us, weighty. Dr X reminds all present that it can be easy to blame yourself, that his door is open, a psychologist's offering. The quiet grows, and grows, until someone comments about its awkwardness. Someone else *doesn't mind it*, but they understand how others might.

The risk of the life not lived is the risk that most often emerges to counter the fears of REGRET, the anxieties about side effects, and the concerns about the future where youth resent the institutions which permitted their access to intervention on the basis that it now limits their life in other ways. Suicide, as the risk that can supercede all others, emerges in its bluntest form as WOULD YOU RATHER HAVE A TRANS KID OR A DEAD KID. Not all providers draw on such comparisons. Some actively push against it, like Dr K who told me in our interview that when providers are overly insistent on such a threat, “they’re just creating this heightened sense of stress and anxiety in all the people around the young person.” Scholars such as Sahar Sadjadi 2013 have further expressed the concern that rendering puberty, in particular, into a “crisis”, problematically renders doctors into saviors of helpless children. Yet the reality of suicide risk among young trans people (Thoma et al. 2019) persists, and can become the final word that transforms the worry of the future into the worry about *now*. There is no REGRET from young people who are no longer alive, when THE REST OF YOUR LIFE has been abruptly shortenedTHE REST OF YOUR LIFE has been abruptly shortened.[16]

In exam room 5, the one in the corner I rarely visit, Sam and I are chatting after filling out the usual set of consent forms and HIPPA waivers. It’s smoky today, at least one wildfire at some not quite settled amount of containment, and already one patient has abruptly left their appointment in order to evacuate their house. Sam is in his early twenties, and as we wait for the appointment to start, I ask him, cheerily,

How are you?

Not great.

That’s why I’m here.

I’m put back on my heels a bit. Though it might be the case that in many clinical contexts, not great *is a good assumption, in my experience so far young people coming in for gender care were more often excited about the possibilities, or else simply bored by the mundane aspects of a check in. Sam is clearly dealing with something else, which becomes apparent as soon as Nina arrives, and he tells her,*

---

[16] In Lisa Stevenson’s (2013) ethnography of the suicide epidemic among Inuit youth in Nunavut, she describes the violence of demanding that young people remain alive under conditions of colonial dispossession, especially when the demand to live as a responsibility of the state strips away personhood. Drawing attention to the possibility that time, and death, might be understood differently, even as she feels strongly the desire to keep young people alive, Stevenson shows that it is possible to look at suicide not only as a totalizing event, marking a boundary between alive and dead (categories themselves whose meaning varies by context), but as a psychic refusal of a settler-colonial, “biopolitical” (Foucault 1977) imperative. Most of the young people I saw in my clinical observations were White or White-passing, and I am not attempting to extrapolate from the particular indigenous context of Nunuvut as a way of making meaning of death and suicidality among non-indigenous trans young people in my fieldwork. Instead, I want to use Stevenson’s work as an example of what it could mean to approach suicide risk among young people as not only simply something to attempt to reduce but as an reality that can be attended to, and which I can stay with, both ethically and ethnographically.

I don't think we've ever had a detailed discussion of my mental health.

I was a very sad kid.

With that, Sam launches in to a narrative about his depression: when it has been better, when it has been worse, the euphoria *of starting testosterone, which faded after half a year, his feeling after top surgery.*

Fuck yeah, I'M CURED!

A feeling which also passed, after time.

His coping strategies, being mostly sober now *but how he was, not so long ago,*

a multiple-times-a-day weed smoker.

And self-harming

really only to make sure I didn't do something else.

The thoughts scared *him; he was afraid of how he had* developed a mindset, that I'm not going to make it though the next six years, *the time it will take to get the graduate degree he wants, if he continues juggling full-time restaurant shift work and full-time academic work.*

*Sam tells us, despite the nice plans he has with his boyfriend for the upcoming weekend, that he's into*whatever will make me feel better.

Because I'm not feeling LIKE I CAN BE HERE.

Oh.

And I think I need another refill on my T.

***

From a prevention aspect, Sam's gender affirming care had not been the *magic bullet* he had perhaps once envisioned as CURE. Clinicians often remind young people that though there are many things that might improve with gender affirming interventions, *being trans* is not one of them; that reality persists. For youth expressing a waning tolerance for BEING HERE, there are often stages of feeling that interventions have substantially shifted how livable their life feels, which can be reduced when met with the ongoing reality of an often intensely transphobic world, as well as the many other hardships they may already be managing. After all, like cis youth, trans youth also experience intersecting hardships of mental health, structural disadvantage, abuse, poverty, addiction, racism, and trauma in infinitely unique configurations and contexts.

The therapists and social workers on the team often discussed, during Huddle, the tolerance, or rather, the intolerance, that many health care professionals have for suicidal ideation. What is so often delivered as two poles of a spectrum between wanting to live and wanting to die, or being DEPRESSED or being HAPPY, is rarely experienced or manifested this way. Sam both wants and visions a future where he has a different career and community; he has plans with his romantic partner, and is invested in attempting to feel differently. At the same time, he is experiencing a frightening level of disconnect from this future, the feeling that he won't actually be around to see it, as well as a deepening intolerance of the present, the *not feeling* LIKE I CAN BE HERE.

In the moment I describe above, Nina lets Sam talk. She hears him out, asks more questions about his feelings about his psychiatric medications. Sam describes the sense that the medications have worked but then given him a feeling of the DROPS, of being TANKED. Nina takes notes, asks for Sam's permission to talk with the psychiatrist about medication options, given that Sam does not want to meet with him. They safety plan—walking through what supports are in place and ensuring Sam knows who is on call, making a time to check in on Monday. He thinks he'll be *okay*.

Staying with the threat of suicide is difficult, heart-breaking work. Yet, what I want to attend to here is the entanglement of gender affirmation, the desire to live (or not), and the ways in which operationalizing gender affirming care as suicide prevention work, while true in deeply nontrivial ways, nonetheless threatens to maintain a logic of intervention which subsumes youth's right to gendered embodiment and the potential for youth to take on the risk of living to the investments of others in keeping young people alive. Additionally, when suicide prevention is marketed as a primary driver of the value of gender affirming care, when youth like Sam continue to experience on-going mental health crisis even after intervention, that care can be interpreted as a failure.

Those who seek to stop the provision of gender affirming interventions are quick to point out any sustaining suicidality, in particular, among those who have received care as a testament to that care's ineffectiveness (Anderson 2018). While these commentaries often stem from notoriously anti-trans sources (such as the Heritage Foundation), they often draw on research that compares the rates of suicidality among trans people post intervention (often genital surgery) to the general public, as opposed to trans or gender expansive people who have not received care (Dhejne et al. 2011). The public uptake of research on outcomes like suicidality, depression, and self-harm, among others, is understood this way in part, I suggest, when the justification of gender affirmation primarily stems from the ability for that care to transform young people who don't want to be alive, into those that do, without adequate attention towards the context within which that life takes shape.

The current political climate around gender affirming care for youth easily renders any indication that affirmative care does not transform transgender youth into cisgender youth, in terms of their expression of well-being or their rates of distress, into evidence of failure. This is so well known that in meetings about the results from the HOPE study, team members sighed over how, when, and in what context to provide their data on suicide and depression. They invoked the way these numbers would be picked up, to either claim that intervention causes poor outcomes, or at the least, doesn't actually help to reduce them. At the same time, they thought creatively about what outcomes could be shared in potentially new ways, for example, a suggestion that talking about the future was a sign, to them, of *positive gender health.* Inversely, they didn't see the failure to see the future as synonymous with suicide, saying *not being able to see the future is not the same as wanting to die,* somewhat critically evaluating the measures that are frequently used to report on levels of depression and suicidality.

For those who do not see an inherent value to gendered embodiment, it is unequivocally true that often the strongest, clearest statement of value is to say that this care is *life-saving* care. With the risk of REGRET exerting such a strong pull upon adults envisioning the futures of youth, the most obvious way to overcome hesitation among those preventing youth from accessing intervention is to make it clear that at least youth living with REGRET are alive to REGRET something.

But REGRET and the possibility of the end of life can also work to amplify the importance of living in the body one wants in the time that they have. As scholar Vanessa Fabbre (2014) has show in her work on queer aging and later life transition, many older adults who decide to transition do so out of an understanding of limited time, and a desire to fulfill an authentic identity before it is “too late”. This formulation of the relationship between REGRET and life similarly is also present in youth whose lives are expected to be short, such as youth with terminal illnesses. One such patient of Dr M’s was given six months to live at 17. As Dr M described it during a weekly meeting, she was called to oncology to talk to *this patient, who says they’re a girl.* Voicing her patient, Dr M says,

> If I’m going to die, I want female hormones.
>
> If I’m going to die, I want a vagina.

In these cases REGRET is rendered irrelevant through the shortened expectation of time, where both living and dying as a gendered person can be meaningful. Dr M’s patient was still living, far past her initially predicted time, and was accessing care for both gender and cancer.

Yet, as Hil Malatino writes, “Transition doesn’t have to be wholly curative, or even minimally happy-making, in order for it to be imperative. It doesn’t have to guarantee survival in order to be necessary” (2022, p. 3). Malatino is attentive, as I want to be, to the many ways that gender affirmative care can be good, still necessary, without requiring the defensiveness of the appeal to suicide prevention, or seeing in the persistence of bad affects the negation of the purpose of transition. Structuring the choice to move forward with gender care as a choice between preventing REGRET and preventing death effectively erases the potential for young people to be seen as active agents, entitled to make decisions about their bodies, even ones they may feel differently about in the future. And, as such, it also relieves parents and institutions from insisting on a more radical commitment to facilitating youth's choices, rather than simply manifesting a bio-political imperative to "make live" (Foucault 1977; Stevenson 2013). Suicide as the threat which cannot be argued against turns what could be an exploration of potential (even negative potential) into a conversation about necessity, given life as an inherent good, and sustains an understanding of trans life as good only in the context of a non-living alternative. But the overwhelming cultural approach in the United States is to treat youth as fundamentally unable to make these choices. Thus, any truly responsible entity that attempts to reinstate the autonomy of youth has already failed; that is, has already broken the subtle contract that protects youth from themselves.

Yet what resources could Nina pull on to help Sam, if she thought he presented a more eminent threat to himself or to others? How should she protect him from the risks of the future? As Alex had brought up in meetings months before, she profoundly felt that there was nowhere to *keep people safe* in the youth clinic. By this she meant that there was no room that could be safely sealed, where there would be no items that could be used to harm, things as normally innocuous as pens or windows. Furthermore, this launched a series of conversations about the hospital's emergency room protocol, the county's lack of psychiatric crisis resources for adolescents, especially trans ones, and extended long-standing discussions about the role of safety and security in the clinical space itself.

While the team had worked hard to train front office workers to be mindful of names and pronouns of youth, they had little expectation that the main hospital several blocks away would be as conscientious about the importance of correctly gendering patients. They had even less faith in the county hospital a few additional blocks from there. Even so, team members who worked in the community, especially those who were Black and trans themselves, often described the violent level of surveillance and harm they felt from the security personnel at the clinic. So when Alex describes her frustration with the lack of safety she can ensure for a young person in distress, this is also naming a problem which for others is continually present—that there is no space in this institution that feels safe, or could be made to feel safe, without substantial investments into infrastructure both material and otherwise.

In a meeting with social workers from the main hospital emergency room to discuss the protocol for managing a young person in psychiatric distress, it became clear that what is being negotiated is not just a protocol for a thing that they *shouldn't do* (given the feeling that the emergency room is also not equipped for people on psych wards, given the risk to providers who shouldn't be leaving one outpatient facility to walk their patients to another building) but the distinction between who was at risk, and from what. In the eyes of the ER social workers, the toddler with a broken arm comes to a children's hospital needs to be protected from adolescent in distress, particularly an older transgender adolescent in psychological distress who is portrayed in this moment as a frightening adult.[17]

So in many ways, the appeal to gender affirming care as suicide prevention might also further erase the important differences with the experience of the diverse youth accessing care, as well as to a false sense of security that the bodily changes wrought by medical individuals would be enough to keep youth safe. And, it exposes some of the problems inherent in appealing to the need to *protect* youth, rather than trust them, and recognize their strength and capacity. As Cara, a health educator at the TYC told me, "this world, I honestly say that this world, not even the world, but this country, isn't meant for different

---

[17] This is a similar phenomenon to what Savannah Shange describes, in her work in a progressive school, as the determination between the quiet kids and the loud kids—racialized categories—as being a coterminous with determining those who are "kept safe" and "kept safe from"(2019, pp. 104–105). This question of safety not only impacted youth but also shaped the experiences of staff in the clinic, differentiating between who the security guards made sure to show the location of panic button (for example, me) and who was misgendered and misrecognized as being an employee (several of the health educators).

people to actually survive and prosper." Yet as she also says, "If you leave out the house as something that society says you shouldn't be, or if you defy any type of rule and you're living in your truth, I'll call that strength."

I'll call that strength.

Conclusion: "It's My Happiness I Live With"

One day in clinic Dr M tells me, laughing a little bit, not at all unkindly, about a parent who got their child's birth name tattooed on them. She thought it was ironic, that one makes the choice to record the name of a child, rather than a romantic partner, for example, as a commitment to permanence, only to find oneself in the position of supporting a child who rejects the name they were given along with their gender assigned at birth. Tattoos were an easy, if sometimes misplaced comparison to bodily changes of gender affirming intervention. Caleb brought it up in our interview, when he narrated how his father worried about Caleb's future potential future REGRET, saying, "he was also, you know, scared of, you know, what if in 10 years, like just with tattoos and stuff, like what if in 10 years, you know, or when your skin gets saggy, you won't like that Mickey Mouse anymore. And now it looks like a dead dragon—you know what I'm saying?"

Though Caleb had waited until he was able to consent to his own care to begin taking hormones, he also described to me his sense of being unwilling to move forward with care until his parents could support him. He needed them, and their support, and was willing to wait until they provided it, much like the patient Dr K described to me. Caleb told me that his father was "very, very scared" with what would happen if he didn't provide his support, that even though "we didn't talk about this stuff, my mom told me that he thought about that, you know, he couldn't live with me, obviously, being gone." While it may have been the power of the threat of suicide that once again emerges to counter the risk of REGRET, Caleb focused on transforming how his parents were envisioning his future, trying to show them how he considered the possibility of REGRET. Caleb said that his parents were scared of what he thought all parents were afraid of, when their children come out as trans and "especially when they want to do hormones," namely, "*In twenty years are you going to* REGRET *this? Are you going to wish that you spend the other twenty, you know, your twenty years as an actual female?"* He went on to recall their conversation to me:

> I told them *no.* I said, *even if…* I said, *even if I do* REGRET *it*, I said, *at least I, at my age I took that jump* kind of. *And maybe even if it isn't the right jump for me, I still tried it*, and it, you know, it's like everything in life. You know, if you don't try it, and you don't like it, then you just kind of, not move on to the next thing, but try another thing. And I said, *you know what,* I said, *also, it's not your guys',* you know, REGRET.. REGRET *or happiness.* You know, *if I, if I love it in twenty years and I'm still doing it, then it's my happiness I live with.*

Caleb pulls on his own understanding of his father's REGRET, in particular, at not pursuing a military career, to try and share with them his belief not only that this would make him happy now, but that if he didn't go down this path now, he felt confident that he would REGRET holding himself back. It was this REGRET, this very present one, that shaped how he imagined a future where he no longer wanted to live with the effects of the interventions he was currently pursing. Caleb tells me, even in that future, "you know, I'm not going to look at it as more of a REGRET. I'm going to look at it as, okay. At 18 years old, when I'm, let's say I'm 46. Okay. At 18, I at least did something that I thought was going to make me happy. And I did it, you know, and I did to the—not fullest extent, but I did it to the best that I could."

Caleb's articulation of what he sees the benefit of "taking the jump" reflects how he sees his life as *his*, a form of independence he nonetheless needs his parents' support for, as well as a understanding of his life as oriented towards the potential inherent in process, rather than only with outcomes he needs to prevent. He shares his parents' ability to speculate into the future, a futurity which then turns back on itself in order to ask youth what kind of past their present threatens to become. This is the temporal logic which relates to the "lost chance" of medical malpractice suits (Jain 2007) and the way that the uncertainty of prognosis asks for simultaneous inhabitation of multiple temporalities. As Jain writes, "one's future will only be absorbed into the truth of prognosis, a truth that recursively projects a future as it acts as a container for a present" (Jain 2007, p. 79).

Dr N says, to a patient, their parent, and sister, *a lot of parents, they want to know, will they change their mind.* In his experience, he affirms, this would be the case for *less than* one percent. *Every once in a while* it happens, *usually in the first couple of months.* If they are 12 or 13, *maybe two percent. But 17? One percent. At best.*

The reassurance Dr N is attempting offer in the form of the aggregate so often desired by a scientized public and those desirous of something that feels objective.[18] But it is always doomed to insufficiency, such the person whose life is under examination is always alive, or not, regretful, or not; predictive, statistical accuracy is "simply an illegible concept for the individual living within its parameter" (Jain 2007, p. 88). I suggest that prevention narratives and discourses similarly remain subservient to such an "illegible concept". When any statistic above zero means that some trans youth experienced REGRET, or did not find in their experience of gender affirmation a reason to stay alive, it is easy to imagine that zero percent should be the intention. But this would only be possible with massive reduction of access to gender affirming care, or perhaps the elimination of it altogether. Therefore, it seems critical to begin naming the value of gender affirming care through the framing of potential, rather than simply that of prevention. Shifting practice norms towards more visibly recognizing youth's entitlement to bodily autonomy can simultaneously expand opportunities for providers to collaborate with youth in the pursuit of crafting the gendered lives they desire as well as more generally broaden the way that medical decision-making in youth itself is understood.

---

[18] See Chapter Three

CHAPTER 6

EPILOGUE

All that you touch, you Change. All that you Change, Changes you. The only lasting truth is Change.
- Lauren Olamina (Butler 2000)

Leaving the TYC

When I said my goodbye to the clinic in December 2019, at an office holiday party with funny sweaters, raffle prizes and and great selection of cookies, neither I nor anyone else in attendance could have imagined what was to come next. I had intended to return for a good portion of the following summer, to do follow-up interviews, meet more youth, and resume observations with both clinical and research teams. When I described this intention to the research team, someone lightly commented that they would still BE THERE, rebutted by someone else, *but hopefully we'll be finished with 36 month survey*, a note of panic shifting the comment from a note on the probable to a expression of an aspiration that was in no way assured. Max told me and several others standing near us that she was proud that they didn't do any thing *differently* for me, that she felt like what I witnessed would have happened even had I not be present. Dr Y and I made sure we had each others cell numbers, and looked forward to a day when we might both be in Chicago, as he regularly travelled to the Midwest to see his family. Or at least, he did.

I though the worst thing about returning to Chicago was going to be that my wife and I brought bedbugs back with us from a very cheap motel near the Grand Canyon, which I saw for the very first time in a snowstorm, and for the second time, in the cold, clear, dawn, alongside a handful of elk picking their way through the snowdrifts.

Instead, March 2020 rolled around, and with it, a pandemic.

This dissertation was written largely from my home, which, like many of us, I have left sparingly over the last two years. My follow-up interviews took place virtually, as did class, as did therapy, as did social hour. My friends and colleagues at the clinic shared me with how the dramatic shift to tele-health and the ongoing management of bureaucratic and public health safety measures had brought both headaches and new potentials. Dr Y was finally able to see a patient who, because they lived in a shelter separate from their parents, had never been able to manage coming to the clinic all together, as required for a those under 18. Providers who had long pushed for video visits were pleased, even as negotiations about the necessity of physical exams and in-person measurements persisted.

Youth changed too, especially in the summer of 2020. Many transition related procedures were put on hold, like Rav's top surgery, even as others went forward. Some young people were relieved to stop dealing with the social dynamics of school or work, while others, particularly those who had spent time in inpatient or intensive therapeutic settings, struggled with being stuck at home. One youth I spoke with was continuing a partial hospitalization program virtually, participating via their bedroom with the small semblance of privacy it afforded, unable to put into practice their new plans for social and community engagement due to concerns about the spread of Covid-19. Others were branching out, finding new avenues for their skills, sometimes engaging with publicly with broader issues of social justice. Charlie has his first encounter with the cops, avoiding arrest during a mass demonstration about police violence and racial inequality. Zoey staring posting TikTok videos translating safe protest tips into American Sign Language. Sometimes when youth were talking with me about the future they saw for themselves, they were also started talking about the future they saw for the world.

This dissertation has argued that the practice of gender affirming care are practices that invoke, inspire, and materialize forms of the future. Utilizing the concept of *potential* to reference the ways that care can enable and leave uncertain the possibilities for the future, and the concept of *prevention* to describe how care is so often made meaningful through that which interventions promise to eliminate, I have shown how gender affirming care are rendered meaningful to those who offer and receive them. The practices I have described range from procedures of diagnosis and assessment, to the specific interventions of puberty suppression and hormonal, therapies, all which take place in a sociopolitical context that values scientific objectivity and sees, in youth, the condensation of familial and cultural values, and the embodiment of the world yet to come.

Throughout my ethnographic chapter and interludes, I have attempted to draw out resonances and logics that travel between clinics, patients, and families, while nonetheless remaining committed to description as a practice that, at best, can get at a fundamental incommensurability between individuals, which I take not to be a flaw but an important ethical and representative practice. In other words, I do not intend for this project to provide the last word on what it is to provide or receive gender affirming care in the United States, though I hope that the data I have presented makes a compelling case for seeing, at the minimum, the value and and necessity such care has. In addition, this project, like all, has key limitations, some which are coterminous with some of the limitations of the TYC and the HOPE Study, and some which are unique to this dissertation itself, derived from my own choices and capabilities as a researcher and writer.

Limitations, or, Why Oakland is not the Answer

In HOPE Study meeting, the perennial problem of the overwhelming Whiteness of the study participants was never quite resolved. As Megan, a research manager, told us, *we've got to figure out how to diversify, and Oakland is not the answer.* Xavier answers with a subtle agreement, extending further as he notes that *Oakland is not what it used to be.*

Trans studies, and trans medicine, suffer from a paradoxical racial problem. As was the case with the founding of the TYC, many of first people to advocate for gender affirming care and receive this treatment were those people were considered by public health institutions to be most at risk of HIV, patients who *looked very different* from the patients of today, as Luis, the program manager, once told me. In this lineage, the archetypical trans patient and the historically centered figure in public health narratives and contexts where health disparities are highlighted, is the Black trans women. Trans youth, especially those who are pre-pubertal, on the other hand, are often White, and in recent years, increasingly likely to identify as transmasculine rather than transfeminine (Arnoldussen et al. 2019).[1]

This has meant that both the clinical practice of the TYC, the HOPE Study, and my own research project, present a view of trans medicine that is primarily about White people, and increasingly about trans masculine people, a limitation which though does not erase the important work done at the TYC, nonetheless deserves attention. Though racial disparities in patient and participant populations (See Table 1 for new patients data) was widely perceived as a problem across both the clinical and research sides of the TYC, no one every seemed quite sure what to do about it.[2] Part of the draw for my own project to the TYC was the fact that as a clinic in California, they served individuals who had only public insurance, and that public insurance was mandated to cover affirmative gender services.[3] This meant that more marginalized youth, such as those in foster care, even some who were experiencing homelessness (if they were over age 18 but younger than 25) did come to the TYC for their

---

[1] As I have already described, this has often been unhelpfully translated into a concern with saving young White girls from the social contagion of gender, as in the case of Schrier (2020). At the same time, legislation limiting the participation of trans youth in sports, for example, have disproportionately focused on sanctity of "women's sports," which is threatened by the inclusion of girls assigned male at birth — see, for example, Missouri Senate Bill 781, "Save Women's Sports Act," sponsored by Senator Moon. This makes for a confusing combination that nonetheless coheres around a particular inclination to police the bounds of femininity and "protect" girls assigned female at birth, whether or not they consent to or desire this form of protection.

[2] This was sometimes named as such, and sometimes seemed to stand-in for a an entire host of differences indexed by race; assumptions about wealth, parental education levels, and other family level attributes could get collapsed into a vague reference about Whiteness, even when White patients might have differ more than they relate based on other attributes. In other cases, the entanglement of race and gender often meant that conversations about how to address one gap ended up discussing the perception of another, particularly the sentiment that no one had been, or was, *talking about* trans masculine people, and their specific health needs, or talking about race in vague terms when really the disparities at hand were most experienced by Black youth, and wouldn't be resolved by reaching more Asian youth, for example, though that would also increase the diversity of the patient population.

[3] Though coverage for gender affirming services in California has a long and at times contentious history (Coursolle 2018), key guidances in 2012 and 2016 have prohibited insurers from discriminating against trans patients in their coverage of procedures such as hormonal replacement therapy if those procedures are covered for conditions other than gender dysphoria. In 2018, California became the first state to explicitly cover these gender affirming services for youth in foster care ("California Law Affirms Gender-Related Care for Foster Youth").

care, as the TYC was often able to see patients sooner than the clinic at the nearby Gay and Lesbian Center. The sheer population density and the fact that California serves as a epicenter for many forms of queer life meant that the TYC did not *only* serve middle-class White families, yet, they remained the most present, both materially and in narratives about what the TYC did and who it was for.

Those at the TYC both noticed the absence of youth of color in the clinic and in the research project, and hoped to address this both from a stance of equity, and justice, as well as from an epistemic perspective. Researchers were particularly attuned to the way that their study findings could fail to be seen an generalizable if their population was too White; yet also realized that their project recruited patients from clinical populations that were already skewed. Even having clinical sites in geographic locations known more for *diversity* wouldn't increase the diversity of study participants, if those youth weren't looking for clinical care for gender. Thus emerged the feeling that appealing to *Oakland*, as one of the HOPE sites, would never be *the answer.* Furthermore, as Max said once, she wasn't just interested in recruiting youth as a part of the study; rather, she wants to know, *where are they getting their healthcare?*

What, specifically, prevents youth of color from accessing clinical care for gender at expected rates was a question that neither my project nor any existing project at the TYC had an answer to. Some scholars, have critiqued the narrative of these research participants as "hard to reach" (Everhart et al. 2022), noting how often this can be resolved though hiring staff who are a part of the community among other things, a strategy used by the HOPE study to enroll youth in their own project. But as Everhart et. al. note, interest in services may far outweigh interest in research, meaning this could be a difficult question to answer if one assumes it requires further emphasis on building research structures rather than increasing capacity to offer desired services.

Brian, who worked on the HOPE study, with the support of Max, hoped to start some focus groups that might begin to get some insight into what he saw as various barriers to care. In an interview, he spoke to me about the topic in terms of barriers that extended beyond gender affirming care, but could be compounded in light of gendered medicine.

As he said, “There’s barriers to healthcare in general where you’re like, you don’t want to access healthcare because you might be undocumented and you might be all these things. Um, so you go to health clinics and stuff like that in the community, but the health clinics don’t have the resources where they are like, *Oh you feel like a trans person, here are the resources.*”

“ Like I, I went to my school counselor and I told them how I felt and they said it was A PHASE and that was it.”

As someone who was both in community and who worked in research, Brian was interested in exploring, with Max, focus groups that discusses racial gaps in the access to blockers in particular. If it was up to him, though, he “wouldn’t just do blockers, I would just do everything health care in general, racial gaps accessing trans health care in general.”

“Yeah, it’s hard to separate-” I begin.

“Yeah” Brian affirms.

“-out blockers from the larger context, right?” I said.

“Yeah,” he agrees, and says, “because I’m like *blockers.* Okay.”

“That’s if kids understand that they want to transition at a younger age, before they hit puberty. But everybody realizes it at a different age, whether they reach that when they’re like 15... and stuff like that. How do they reach out at that point? 12, 13, what if they’ve already gone past puberty and they’re like, *okay, I can’t stop puberty. I want to change it to, I want to go through the other puberty.* So it’s more like how do we reach those communities that we don’t see here often.”

“How do we reach the Spanish speaking community? How do we reach the Black community? How do we reach all these? How do we reach homeless youth?”

Brian’s own experience, as a non-binary, trans masculine, person of color who attributed his families difficulty in supporting him during transition to their strong religious views, shapes how he can already speculate on some of the difficulties that youth might face should they hail from these communities. Of course, these barriers are not restricted to communities of color — poverty, inaccessability, and anti-trans religious views exist across racial and ethnic groups — but he sees some intersections that reflect life in the US, and his own experience.

The other possibility that Brian doesn't name related to the potential for living a good gendered live that doesn't rely on the medical tools of the clinic to do so. Such lifeways might be more available in communities I did not engage with or explore. I say this not to reduce significance of these real barriers that could, and should, be addressed, but instead to remain conscious of one of the major boundaries of this specific project, which looks not at all potentials for the future related to gender, but focuses instead on the specific ways that practices of medicine are taken up and make meaningful in relation to the desires for gendered embodiment.

In some ways, this project has described medicine as one tool for living a good life, but the alternate interpretation is also already there. That is to say, is medicine merely a tool for living in an otherwise unlivable world? I have proposed that we see medical intervention for gender as not simply a strategy for coping, but instead, as it can be engaged towards making the world different; where it would not always be necessary to draw upon medical practice or uphold binary gender norms in order to access these forms of care, but that it would nonetheless remain an option for those who desire to do so. In this way I suggest that rather than dichotomizing medicine as a tool that either gives strategies for bearing the unbearable, or remaking conditions into that which could be withstood, that it must be capable of holding both together; that in order remake the conditions of gendered life, people also have to survive conditions as they are, even if survival itself cannot always be the goal. Such tasks are inextricable from each other.

An additional limitation of this dissertation is that it has remained focused on one of the most developed interdisciplinary clinics in the US. Despite the affordances of such a choice, which has enabled the analysis of scientific practice and trainings alongside the observation of many more clinical consultations that I may not have had access to otherwise, most trans youth living in the United States do not have access to such a site, if they have access to care at all. So in many ways this project has not been about, and cannot draw conclusions about, the general relationship of a trans youth to health care, or the general meaning of gender identity itself. Instead, I have tracked a particular formation of gender affirming care, one that is more about a subset of providers who are looked to as experts in the process of developing and consolidating the purposes and practices of gender affirming care and the young people whose needs they are trying to orient towards. And, it is about the experiences of those young people who have sought out that care, and the futures they are trying to bring about, and the ones those around them are trying to prevent.

My attention on limitations not intended to either minimize or overtake the many significant accomplishments of the TYC providers in extending affirmative care to more youth than any other individual site in the United States, and in a way that so often attempts to foster potential in youth. Instead, it is a recognition of how much work remains to be done, even as it is an acknowledgement of how much work they continue to do.

The Future of Youth, the Future of Gender

In Octavia Butler's Parables series, Lauren Olamina is the conduit for a new form of spirituality called Earthseed. Bulter's fiction, and the Parables in particular, skyrocketed in popularity during 2020, the whiplash of Covid-19, the last year of the Trump presidency, and an unfinished surge in racial justice organizing, rattling the sensibilities of many who had perhaps not considered as seriously as others that the end of the world could be rather near.[4] Like many, I revisited the Parables as guides during times of crisis, and as notes towards the possibility of a future. But they were also meaningfully tied, to me, in the process of writing this dissertation, to the protagonist Lauren Olemina as a person who is,

---

[4] That is to say, though it was a spike in popularity, Butler's work has been at the center of much scholarship and creative praxis for years; see, for example, (Brown 2017; Imarisha et al. 2015).

critically, a *young* person, specifically, a teenager. That these fictional worlds are often first led by young people demonstrates how powerful the the cultural understanding of youth as figures who have the innate capacity to see the world as it might be otherwise, and as often being those who are tasked, divinely or otherwise, with the project of bringing that world into being. These tropes are linked to the weight that adolescents carry in our present world, the generational promise of change, and what some argue are the biological traits of the adolescent brain, hardwired for risk-taking, attuned to justice, and capable of refusing the imperative to simply accept conditions are *the way things are.*

If we locate in youth an innate capability of change, which is not the same as ceding responsibility for such to them (as happens all too often), we can also start to see why their actions are so tightly policed, monitored, and controlled. There is a fear undergirding the attempts to erase trans youth from existence, a genocidal impulse that hinges upon the possibility of a "functional change in sign system" of gender itself, which will always be "a violent event," according to Spivak (Spivak 1988, p. 197). It would be beyond the scope of this project to articulate how and if this might be possible, but it is hinted at, when providers think about the future where we might *laugh* at the idea of a conference that focuses strictly on trans health, or aspire to times when their professional expertise is unneeded, because pediatricians everywhere are unafraid to listen to youth, and treat them accordingly. That future is one where even as gender, and gender affirming medicine, persists, the functional meaning could be quite different, no longer the grounds upon which ideological battles about the sanctity of reproductive capacity, the inherent irresponsibility of youth, or the sanctity of identity, untouched by social experiences, are being fought.

REFERENCES

Adams, Vincanne, Michelle Murphy, and Adele E. Clarke (2009). “Anticipation: Technoscience, Life, Affect, Temporality”. In: *Subjectivity* 28.1, pp. 246–265.

Agamben, Giorgio (1999). *Potentialities : Collected Essays in Philosophy /*. Meridian (Stanford, Calif.) Stanford University Press,

Age Ain't Nothing But a Number (1994). In collab. with Aaliyah.

Age of Consent (1983). In collab. with New Order.

Ahmed, Sara (2021). *Gender Critical = Gender Conservative*. feministkilljoys. URL: `https://feministkilljoys.com/2021/10/31/gender-critical-gender-conservative/`.

Alcoff, Linda (1991). “The Problem of Speaking for Others”. In: *Cultural critique* 20, pp. 5–32.

Althusser, Louis (1971). *Reading Capital /*. Pantheon Books,

Amoore, Louise (2013). *The Politics of Possibility: Risk and Security beyond Probability*. Duke University Press.

Anderson, Erica (2022). *Opinion: The Health Establishment Is Failing Young Adults Who Question Their Gender*. The San Francisco Examiner. URL: `http://www.sfexaminer.com/opinion/opinion-the-health-establishment-is-failing-young-adults-who-question-their-gender/`.

Anderson, Ryan (2018). “Sex Reassignment Doesn't Work. Here Is the Evidence.” In: *The Heritage Foundation*. URL: `https://www.heritage.org/gender/commentary/sex-reassignment-doesnt-work-here-the-evidence`.

APA (2013). *Diagnostic and Statistical Manual of Mental Disorders*. Arlington: American Psychiatric Publishing. Washington, DC.

Arain, Mariam et al. (2013). “Maturation of the Adolescent Brain”. In: *Neuropsychiatric disease and treatment* 9, p. 449.

Arnoldussen, Marijn et al. (2019). "Re-Evaluation of the Dutch Approach: Are Recently Referred Transgender Youth Different Compared to Earlier Referrals?" In: *European Child & Adolescent Psychiatry*. DOI: `10.1007/s00787-019-01394-6`.

Ashley, Florence (2019a). "Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising". In: *Journal of Medical Ethics* 45.7, pp. 480–482.

— (2019b). "McGill University's Hiring of Sahar Sadjadi". In: *Medium*. URL: `https://medium.com/@florence.ashley/mcgill-universitys-hiring-of-sahar-sadjadi-e98f72b2bc6c`.

— (2020a). "A Critical Commentary on 'Rapid-Onset Gender Dysphoria'". In: *The Sociological Review* 68.4, pp. 779–799.

— (2020b). "Accounting for Research Fatigue in Research Ethics". In: *Bioethics* 00, pp. 1–7. DOI: `10.1111/bioe.12829`.

— (2021). "The Clinical Irrelevance of "Desistance" Research for Transgender and Gender Creative Youth." In: *Psychology of Sexual Orientation and Gender Diversity*.

Barad, Karen (2007). *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*. duke university Press.

Barnard, Emily P. et al. (2019). "Fertility Preservation Outcomes in Adolescent and Young Adult Feminizing Transgender Patients". In: *Pediatrics* 144.3, e20183943. DOI: `10.1542/peds.2018-3943`.

Beck, Ulrich (2006). "Living in the World Risk Society: A Hobhouse Memorial Public Lecture given on Wednesday 15 February 2006 at the London School of Economics". In: *Economy and Society* 35.3, pp. 329–345. DOI: `10.1080/03085140600844902`.

Benedict, Ruth (1934a). "Anthropology and the Abnormal". In: *The Anthropologist at Work: Writing of Ruth Benedict*, pp. 262–283.

— (1934b). *Patterns of Culture*. Vol. 8. New York, NY: Houghton Mifflin Harcourt.

Benjamin 1885, Harry (1966). *The Transsexual Phenomenon*. New York: Julian Press. 286 pp.

Berlant, Lauren (1997). *The Queen of America Goes to Washington City: Essays on Sex and Citizenship*. Duke University Press.

— (2011). *Cruel Optimism*. Durham, NC: Duke University Press. URL: `http://stage.dukeupress.edu/Cruel-Optimism/?viewby=author&lastname=Berlant&firstname=Lauren&middlename=&sort=newest`.

— (2019). "The Hundreds, Observation, Encounter, Atmosphere, and World-Making". In: *Journal of Visual Culture* 18.3, pp. 289–304. DOI: `10.1177/1470412919875404`.

Bloch, Ernst (1995). *The Principle of Hope*. Red. by Stephen Plaice and Paul Knight. Trans. by Neville Plaice. Vol. 1. MIT Press Cambridge, MA.

Boellstorff, Tom (2004). "Playing Back the Nation: Waria, Indonesian Transvestites". In: *Cultural Anthropology* 19.2, pp. 159–195.

Bosk, Charles L. and Raymond G. De Vries (2004). "Bureaucracies of Mass Deception: Institutional Review Boards and the Ethics of Ethnographic Research". In: *The Annals of the American Academy of Political and Social Science* 595.1, pp. 249–263. DOI: `10.1177/0002716204266913`.

Bouman, Walter Pierre et al. (2010). "World Professional Association for Transgender Health Consensus Statement on Considerations of the Role of Distress (Criterion D) in the DSM Diagnosis of Gender Identity Disorder". In: *International Journal of Transgenderism* 12.2, pp. 100–106. DOI: `10.1080/15532739.2010.513927`.

Brown, Adrienne M. (2017). *Emergent Strategy : Shaping Change, Changing Worlds /*. AK Press,

Buchbinder, Mara (2015). *All in Your Head : Making Sense of Pediatric Pain /*. University of California Press,

Butler, Judith (1988). "Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory". In: *Theatre Journal* 40.4, pp. 519–531.

— (2006). *Gender Trouble: Feminism and the Subversion of Identity*. Routledge Classics. New York: Routledge. 236 pp.

Butler, Octavia E. (2000). *Parable of the Sower /*. Warner Books,

Béhague, Dominique P. (2015). “Taking Pills for Developmental Ails in Southern Brazil: The Biologization of Adolescence?” In: *Social Science & Medicine* 143, pp. 320–328.

Canguilhem, Georges (1978). *On the Normal and the Pathological.* Dordrecht, Holland; Boston: D. Reidel Pub. Co. 208 pp.

Carr, E. Summerson (2011). “Qualifying the Qualitative Social Work Interview: A Linguistic Anthropological Approach”. In: *Qualitative Social Work* 10.1, pp. 123–143.

Castañeda, Claudia (2015). “Developing Gender: The Medical Treatment of Transgender Young People”. In: *Social Science & Medicine* 143, pp. 262–270. DOI: `10.1016/j.socscimed.2014.11.031`.

Cavell, Stanley (1969). “Knowing and Acknowledging”. In: *Must We Mean What We Say? : A Book of Essays /*. Cambridge University Press, pp. 238–266.

Chu, Andrea Long (2018). “My New Vagina Won’t Make Me Happy”. In: *The New York Times* 24.

Chu, Andrea Long and Emmett Harsin Drager (2019). “After Trans Studies”. In: *TSQ: Transgender Studies Quarterly* 6.1, pp. 103–116. DOI: `10.1215/23289252-7253524`.

Cohen, Stanley (2002). *Folk Devils and Moral Panics : The Creation of the Mods and Rockers /*. Routledge,

Cohen-Kettenis, Peggy T. and Stephanie H.M. Van Goozen (1997). “Sex Reassignment of Adolescent Transsexuals: A Follow-up Study”. In: *Journal of the American Academy of Child & Adolescent Psychiatry* 36.2, pp. 263–271. DOI: `10.1097/00004583-199702000-00017`.

Coleman, Eli et al. (2012). “Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7”. In: *International journal of transgenderism* 13.4, pp. 165–232.

Coleman, Lester and John Coleman (2002). “The Measurement of Puberty: A Review”. In: *Journal of adolescence* 25.5, pp. 535–550.

Commission, Care Quality (2021). *GP Mythbuster 8: Gillick Competency and Fraser Guidelines — Care Quality Commission*. URL: `https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-8-gillick-competency-fraser-guidelines`.

Coursolle, Abigail (2018). *California Pride: Medi-Cal Coverage of Gender-Affirming Care Has Come a Long Way*. National Health Law Program. URL: `https://healthlaw.org/california-pride-medi-cal-coverage-of-gender-affirming-care-has-come-a-long-way/`.

Cox, Aimee Meredith (2015). *Shapeshifters: Black Girls and the Choreography of Citizenship*. Duke University Press.

Cretaz, Britni De la (2021). "Hate Groups Are Making It Easier Than Ever to Introduce Anti-Trans Bills". In: *them*. URL: `https://www.them.us/story/hate-groups-easily-introducing-anti-trans-bills`.

Cutway, Adrienne (2015). *One man's 'Jeopardy' answer leaves viewers scratching their heads*. orlandosentinel.com. URL: `https://www.orlandosentinel.com/features/gone-viral/os-jeopardy-fail-20150406-post.html`.

Das, Veena (1996). "Language and Body: Transactions in the Construction of Pain". In: *Daedalus* 125.1, pp. 67–91.

— (2007). *Life and Words: Violence and the Descent into the Ordinary*. Berkeley, CA: University of California Press.

Davis, Elizabeth Anne (2012). *Bad Souls: Madness and Responsibility in Modern Greece*. Duke University Press.

Davis, Georgiann, Jodie M. Dewey, and Erin L. Murphy (2016). "Giving Sex: Deconstructing Intersex and Trans Medicalization Practices". In: *Gender & Society* 30.3, pp. 490–514. DOI: `10.1177/0891243215602102`.

De Vries, Annelou L. C. and Peggy T. Cohen-Kettenis (2012). "Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach". In: *Journal of Homosexuality* 59.3, pp. 301–320. DOI: `10.1080/00918369.2012.653300`.

De Vries, Annelou L. C., Peggy T. Cohen-Kettenis, and Henriette Delemarre-van de Waal (2006). “Clinical Management of Gender Dysphoria in Adolescents”. In: *International Journal of Transgenderism* 9.3-4, pp. 83–94. DOI: `10.1300/J485v09n03_04`.

Dhejne, Cecilia et al. (2011). “Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden”. In: *PLOS ONE* 6.2, e16885. DOI: `10.1371/journal.pone.0016885`.

Disease Control, Center for. *Health Insurance Portability and Accountability Act of 1996*. URL: `https://www.cdc.gov/phlp/publications/topic/hipaa.html`.

Douglas, Mary and Aaron Wildavsky (1983). *Risk and Culture: An Essay on the Selection of Technological and Environmental Dangers*. University of California Press. DOI: `10.1525/9780520907393`.

Drummond, Kelley D. et al. (2008). “A Follow-up Study of Girls with Gender Identity Disorder”. In: *Developmental Psychology* 44.1, pp. 34–45. DOI: `10.1037/0012-1649.44.1.34`. pmid: `18194003`.

Dumit, Joseph (2012). *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Duke University Press.

Edelman, Lee (1996). “The Future Is Kid Stuff: Queer Theory, Disidentification, and the Death Drive”. In: *Narrative* 6.1, pp. 18–30. URL: `http://www.jstor.org/stable/20107133`.

Ehrensaft, Diane (2016). *The Gender Creative Child: Pathways for Nurturing and Supporting Children Who Live Outside Gender Boxes*. The Experiment.

Ehrensaft, Diane et al. (2018). “Prepubertal Social Gender Transitions: What We Know; What We Can Learn—A View from a Gender Affirmative Lens”. In: *International Journal of Transgenderism* 19.2, pp. 251–268. DOI: `10.1080/15532739.2017.1414649`.

Episode 1 (2018).

Erikson, Erik (1994). *Identity: Youth and Crisis*. 7. New York, NY: WW Norton & Company.

Espinoza, J.Jennifer (2016). *There Should Be Flowers*. Civil Coping Mechanisms.

Everhart, Avery R. et al. (2022). "'I'm Not Interested in Research; i'm Interested in Services': How to Better Health and Social Services for Transgender Women Living with and Affected by HIV". In: *Social Science & Medicine* 292, p. 114610. DOI: `10.1016/j.socscimed.2021.114610`.

Ewing, Eve L. (2020). *I'm a Black Scholar Who Studies Race. Here's Why I Capitalize 'White.'* Medium. URL: `https://zora.medium.com/im-a-black-scholar-who-studies-race-here-s-why-i-capitalize-white-f94883aa2dd3`.

F. Beek, Titia, Peggy T. Cohen-Kettenis, and Baudewijntje P.C. Kreukels (2016). "Gender Incongruence/Gender Dysphoria and Its Classification History". In: *International Review of Psychiatry* 28.1, pp. 5–12. DOI: `10.3109/09540261.2015.1091293`.

Fabbre, Vanessa D. (2014). "Gender Transitions in Later Life: The Significance of Time in Queer Aging". In: *Journal of Gerontological Social Work* 57.2-4, pp. 161–175.

Fanon, Frantz (1968). *The Wretched of the Earth*. Penguin Twentieth-Century Classics. New York: Grove Press. 316 p. URL: `http://pi.lib.uchicago.edu/1001/cat/bib/426346`.

Farrow, Ronan and Jane Mayer (2018). "Senate Democrats Investigate a New Allegation of Sexual Misconduct, from the Supreme Court Nominee Brett Kavanaugh's College Years". In: *The New Yorker*. URL: `https://www.newyorker.com/news/news-desk/senate-democrats-investigate-a-new-allegation-of-sexual-misconduct-from-the-supreme-court-nominee-brett-kavanaughs-college-years-deborah-ramirez`.

Fausto-Sterling, Anne (2012). "The Dynamic Development of Gender Variability". In: *Journal of Homosexuality* 59.3, pp. 398–421. DOI: `10.1080/00918369.2012.653310`. pmid: `22455327`.

Fitzsimons, Tim (2019). "A Viral Fake News Story Linked Trans Health Care to 'thousands' of Deaths". In: *NBC News*. URL: `https://www.nbcnews.com/feature/nbc-out/viral-fake-news-story-linked-trans-healthcare-thousands-deaths-n1059831`.

Ford, Zack (2017). *The Pernicious Junk Science Stalking Trans Kids*. Think Progress. URL: `https://archive.thinkprogress.org/transgender-children-desistance-a5caf61fc5c6/`.

Foucault, Michel (1973). *The Birth of the Clinic*. Vintage Books Edition.

— (1977). *The History of Sexuality*. Vol. I. Pantheon Books. New York, NY: Pantheon Books. URL: `http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:The+History+of+Sexuality#0http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:The+history+of+sexuality,+Vol.+1#0`.

Freeman, Elizabeth (2005). “Time Binds, or, Erotohistoriography”. In: *Social Text* 23 (3-4 (84-85)), pp. 57–68.

Fritz, Melanie and Mulkey Nat (2021). “The Rise and Fall of Gender Identity Clinics in the 1960s and 1970s”. In: *The Bulletin of the American College of Surgeons*. URL: `https://bulletin.facs.org/2021/04/the-rise-and-fall-of-gender-identity-clinics-in-the-1960s-and-1970s/`.

Garcia, Angela (2010). *The Pastoral Clinic*. University of California Press.

Geertz, Clifford (1973). *The Interpretation of Cultures : Selected Essays /*. Basic Books,

Giddens, Anthony (1991). *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Stanford university press.

Gill-Peterson, J. (2014). “The Technical Capacities of the Body: Assembling Race, Technology, and Transgender”. In: *TSQ: Transgender Studies Quarterly* 1.3, pp. 402–418. DOI: `10.1215/23289252-2685660`.

Gill-Peterson, Jules (2018). *Histories of the Transgender Child*. U of Minnesota Press.

— (2021a). *The Bad Faith Artist*. Sad Brown Girl. URL: `https://sadbrowngirl.substack.com/p/the-bad-faith-artist`.

— (2021b). *The Cis State*. Sad Brown Girl. URL: `https://sadbrowngirl.substack.com/p/the-cis-state`.

Gillick -v- West Norfolk And Wisbech Area Health Authority and Department of Health and Social Security (1985). URL: `https://www.swarb.co.uk/c/hl/1985gillick.shtml`.

Giordano, S (2008). “Lives in a Chiaroscuro. Should We Suspend the Puberty of Children with Gender Identity Disorder?” In: *Journal of Medical Ethics* 34.8, pp. 580–584. DOI: `10.1136/jme.2007.021097`.

Glissant, Édouard (1997). *Poetics of Relation.* University of Michigan Press.

Goldenring, John M. and David S. Rosen (2004). “Getting into Adolescent Heads: An Essential Update”. In: *CONTEMPORARY PEDIATRICS-MONTVALE-* 21.1, pp. 64–92.

Green, Richard (1987). *The Sissy Boy Syndrome: The Development of Homosexuality.* Yale University Press. DOI: `10.2307/j.ctt1ww3v4c`.

Guss, Carly E. et al. (2021). “Family Building Desires among a Sample of Transgender and Nonbinary Students”. In: *Journal of GLBT Family Studies* 17.5, pp. 470–481. DOI: `10.1080/1550428X.2021.1911013`.

Gusterson, Hugh (1997). “Studying up Revisited Methodology”. In: *PoLAR: Political and Legal Anthropology Review* 20.1, pp. 114–119. URL: `https://heinonline.org/HOL/P?h=hein.journals/polar20&i=124`.

Hacking, Ian (2007). “Kinds of People: Moving Targets”. In: *Proceedings-British Academy.* Vol. 151. Oxford University Press Inc., p. 285.

Halberstam, Jack (2005). *In a Queer Time and Place: Transgender Bodies, Subcultural Lives.* New York, NY: NYU Press.

— (2011). *The Queer Art of Failure /.* Duke University Press,

Hall, G Stanley (1904). “Adolescence (Vols. 1 & 2)”. In: *New York: Appleton.*

Haraway, Donna (1988). “Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective”. In: *Feminist Studies* 14.3, pp. 575–599.

Haraway, Donna J. (2013). *SF: Science Fiction, Speculative Fabulation, String Figures, So Far.* Ada New Media. URL: `https://adanewmedia.org/2013/11/issue3-haraway/`.

Harding, Sandra (1992). “Rethinking Standpoint Epistemology: What Is” Strong Objectivity?””. In: *The Centennial Review* 36.3, pp. 437–470.

Harding, Sandra G (1986). “From the Woman Question to the Science Question”. In: *The Science Question in Feminism*. Ithaca, NY: Cornell University Press, pp. 15–19.

Haslanger, Sally (2000). “Gender and Race: (What) Are They? (What) Do We Want Them To Be?” In: *Noûs* 34.1, pp. 31–55. DOI: `10.1111/0029-4624.00201`.

Hausman, Bernice L. (1995). *Changing Sex*. Duke University Press.

Helen Webberly (2020). *Being a Trans Man in the World Today*. In collab. with Aydin Olson-Kennedy. URL: `https://www.gendergp.com/being-a-trans-man-in-the-world/`.

Holt, Alison (2020). “Puberty Blockers: Under-16s ’Unlikely to Be Able to Give Informed Consent’”. In: *BBC News*. URL: `https://www.bbc.com/news/uk-england-cambridgeshire-55144148`.

Holt, Lauren (2021). “Transgender Rights in the Spotlight as Arkansas and Tennessee Become Latest States to Pass Anti-Trans Legislation”. In: *CNN*. URL: `https://www.cnn.com/2021/03/28/us/transgender-rights-arkansas-tennessee-anti-trans-laws/index.html`.

Hunsley, John and Gina Giulio (2006). “Norms, Norming, and Clinical Assessment”. In: *Clinical Psychology: Science and Practice* 8, pp. 378–382. DOI: `10.1093/clipsy.8.3.378`.

Hurst, Greg (2019). “Mother Sues Tavistock Child Gender Clinic over Treatments”. In: *news*. URL: `https://www.thetimes.co.uk/article/mother-sues-tavistock-child-gender-clinic-over-treatments-r9df8m987`.

Imarisha, Walidah et al., eds. (2015). *Octavia’s Brood: Science Fiction Stories from Social Justice Movements*. Oakland, CA Edinburgh: AK Press. 296 pp.

Irni, Sari (2017). “On the Materialization of Hormone Treatment Risks: A Trans/Feminist Approach”. In: *Body & Society* 23.2, pp. 106–131. DOI: `10.1177/1357034X17697365`.

Jackson, John L. (2013). *Thin Description : Ethnography and the African Hebrew Israelites of Jerusalem /*. Harvard University Press, Jain, Sarah Lochlann (2007). “Living in Prognosis: Toward an Elegiac Politics”. In: *Representations* 98.1, pp. 77–92. DOI: `10.1525/rep.2007.98.1.77`.

Johns, Michelle M. et al. (2019). “Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students — 19 States and Large Urban School Districts, 2017”. In: *MMWR. Morbidity and Mortality Weekly Report* 68.3, pp. 67–71. DOI: `10.15585/mmwr.mm6803a3`.

Kann, Laura et al. (2018). “Youth Risk Behavior Surveillance —United States, 2017”. In: 67.8, p. 479.

Katzenellenbogen, Rachel (2005). “HEADSS: The ”Review of Systems” for Adolescents”. In: *AMA Journal of Ethics* 7.3, pp. 231–233. DOI: `10.1001/virtualmentor.2005.7.3.cprl1-0503`.

Kessler, Suzanne J. and Wendy McKenna (1985). *Gender: An Ethnomethodological Approach.* Chicago, IL: University of Chicago Press. 252 pp. URL: `https://press.uchicago.edu/ucp/books/book/chicago/G/bo3629888.html`.

Kirk, Sheila (1993). “It’s Time For Your Medicine”. In: *The TV-TS Tapestry Journal* 66. URL: `https://www.digitaltransgenderarchive.net/files/dv13zt26k`.

Kleinman, Arthur (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition.* Basic books.

Knudson, Gail, Griet De Cuypere, and Walter Bockting (2010). “Recommendations for Revision of the DSM Diagnoses of Gender Identity Disorders: Consensus Statement of the World Professional Association for Transgender Health”. In: *International Journal of Transgenderism* 12.2, pp. 115–118. DOI: `10.1080/15532739.2010.509215`.

Koch, Erin (2013). *Free Market Tuberculosis: Managing Epidemics in Post-Soviet Georgia.* Nashville: Vanderbilt University Press. URL: `http://muse.jhu.edu/book/21108`.

Kosciw, Joseph G and Lesbian Gay and Straight Education Network (2014). *The 2013 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgen-*

der Youth in Our Nation's Schools. URL: `http://arks.princeton.edu/ark:/88435/dsp01wd375z94x`.

Kranendonk, Elcke J, Raoul C Hennekam, and Martine Corrette Ploem (2017). "The Dutch Legal Approach Regarding Health Care Decisions Involving Minors in the NGS Days". In: *European Journal of Human Genetics* 25.2, pp. 166–166. DOI: `10.1038/ejhg.2016.159`.

Kroenke, Kurt, Robert L. Spitzer, and Janet B. W. Williams (2003). "The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener". In: *Medical Care* 41.11, pp. 1284–1292. DOI: `10.1097/01.MLR.0000093487.78664.3C`. pmid: `14583691`.

Kulick, Don (1998). *Travesti: Sex, Gender, and Culture Among Brazilian Transgendered Prostitutes.* Chicago, IL: University of Chicago Press.

Kyweluk, Moira A., Afiya Sajwani, and Diane Chen (2018). "Freezing for the Future: Transgender Youth Respond to Medical Fertility Preservation". In: *International Journal of Transgenderism* 19.4, pp. 401–416. DOI: `10.1080/15532739.2018.1505575`.

Latour, Bruno (1999). *Pandora's Hope: Essays on the Reality of Science Studies.* Harvard university press.

— (2004). "Why Has Critique Run out of Steam? From Matters of Fact to Matters of Concern". In: *Critical Inquiry* 30.2, pp. 225–248. DOI: `10.1086/421123`.

Lavery, Grace (2020). "Egg Theory's Early Style". In: *Transgender Studies Quarterly* 7.3, pp. 383–398.

Lavietes, Matt (2022). "At Least 7 States Proposed Anti-Trans Bills in First Week of 2022". In: *NBC News.* URL: `https://www.nbcnews.com/nbc-out/out-politics-and-policy/least-7-states-proposed-anti-trans-bills-first-week-2022-rcna11205`.

Le Guin, Ursula K. (2012). *Finding My Elegy: New and Selected Poems.* Houghton Mifflin Harcourt.

Lehmann, Peter, Ted Chiricos, and William Bales (2018). "Juveniles on Trial: Mode of Conviction and the Adult Court Sentencing of Transferred Juveniles". In: *Crime & Delinquency* 64, pp. 563–586. DOI: `10.1177/0011128717714203`.

Lepselter, Susan (2016). *The Resonance of Unseen Things: Poetics, Power, Captivity, and UFOs in the American Uncanny.* University of Michigan Press.

Lesbian Rights, National Center for (2016). *Family Sues Rady Children's Hospital-San Diego for Discriminatory Treatment of Transgender Teenager [Press Release].* URL: `https://www.nclrights.org/about-us/press-release/family-sues-rady-childrens-hospital-san-diego-for-discriminatory-treatment-of-transgender-teenager/`.

LeVay, Simon (1991). "A Difference in Hypothalamic Structure between Heterosexual and Homosexual Men". In: *Science* 253.5023, pp. 1034–1037. URL: `https://www.jstor.org/stable/2878803`.

— (1994). *The Sexual Brain.* MIT press.

LeVine, Robert A. (2007). "Ethnographic Studies of Childhood: A Historical Overview". In: *American anthropologist* 109.2, pp. 247–260.

Lipsky, Michael (1980). *Street-Level Bureaucracy: Dilemmas of the Individual in Public Service.* Russell Sage Foundation.

Littman, Lisa (2018). "Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports." In: *PloS one* 13.8.

Livingston, Julie (2012). *Improvising Medicine.* Duke University Press.

Love, Heather (2013). "Close Reading and Thin Description". In: *Public Culture* 25.3, pp. 401–434. DOI: `10.1215/08992363-2144688`.

Luhmann, Niklas (1993). *Risk: A Sociological Theory.* Trans. by Rhodes Barrett. Aldine Transaction.

Lupkin, Sydney (2021). "Drugmaker Drops Cheaper Version of Drug, Leaving Patients Stuck with Pricier One". In: *NPR. Shots: Health News from NPR.* URL: `https://www.npr.org/sections/health-shots/2021/11/06/1051878026/drugmaker-drops-cheaper-version-of-drug-leaving-patients-stuck-with-pricier-one`.

MacKinnon, K. R. et al. (2021). "Preventing Transition "Regret": An Institutional Ethnography of Gender-Affirming Medical Care Assessment Practices in Canada". In: *Social Science & Medicine* 291, p. 114477. DOI: `10.1016/j.socscimed.2021.114477`.

Malatino, Hil (2022). *Side Affects: On Being Trans and Feeling Bad*. U of Minnesota Press.

Martin, Caitlin E., Christopher Lewis, and Kenan Omurtag (2021). "Successful Oocyte Cryopreservation Using Letrozole as an Adjunct to Stimulation in a Transgender Adolescent after GnRH Agonist Suppression". In: *Fertility and Sterility*.

Martin, Paula (2020). "Cubical Ethnography: Another Kind of Fieldwork". In: *Medicine Anthropology Theory* 7.2 (2), pp. 290–295. DOI: `10.17157/mat.7.2.793`.

Masco, Joseph (2013). *The Nuclear Borderlands*. Princeton University Press.

— (2014). *The Theater of Operations*. Duke University Press.

McGuire, Jenifer K. et al. (2016). *The Utrecht Gender Dysphoria Scale-gender Spectrum [Adapted from: Cohen- Kettenis, P.T. and van Goozen, S.H. The Utrecht Gender Dysphoria Scale . J Am Acad Child Adolesc Psychiatry. 1997; 36: 263–271]*. URL: `https://www.sexualhealth.umn.edu/ncgsh/measures`.

McHugh, Paul R. (1992). "Psychiatric Misadventures". In: *The American Scholar* 61.4, pp. 497–510. URL: `http://www.jstor.org/stable/41213388`.

Mead, Margaret (1928). *Coming of Age in Samoa : A Psychological Study of Primitive Youth for Western Civilisation.* Blue Ribbon Books,

Meadow, Tey (2018a). "The Loaded Language Shaping the Trans Conversation". In: *The Atlantic*. URL: `https://www.theatlantic.com/family/archive/2018/07/desistance/564560/`.

— (2018b). *Trans Kids: Being Gendered in the Twenty-First Century*. Univ of California Press. 346 pp. Google Books: `ZrNcDwAAQBAJ`.

Mendoza-Denton, Norma and Aomar Boum (2015). "Breached Initiations: Sociopolitical Resources and Conflicts in Emergent Adulthood". In: *Annual Review of Anthropology* 44, pp. 295–310.

Meyerowitz, Joanne J. (2009). *How Sex Changed*. Harvard University Press.

Meyers, Todd (2013). *The Clinic and Elsewhere: Addiction, Adolescents, and the Afterlife of Therapy*. University of Washington Press.

Mol, Annemarie (2002). *The Body Multiple: Ontology in Medical Practice*. Duke University Press.

Mullins, Jenna (2015). *This Might Be the Most Uncomfortable Jeopardy Response You'Ll Ever See—Watch If You Dare!* E! Online. URL: `https://www.eonline.com/news/643275/this-might-be-the-most-uncomfortable-jeopardy-response-you-ll-ever-see-watch-if-you-dare`.

Muñoz, José Esteban (2009). *Cruising Utopia : The Then and There of Queer Futurity /*. Sexual Cultures. New York University Press,

Nahata, Leena et al. (2019). “Understudied and Under-Reported: Fertility Issues in Transgender Youth—A Narrative Review”. In: *The Journal of Pediatrics* 205, pp. 265–271. DOI: `10.1016/j.jpeds.2018.09.009`. pmid: `30293639`.

Namaste, Viviane (2008). “Undoing Theory: The “Transgender Question” and the Epistemic Violence of Anglo-American Feminist Theory”. In: *Hypatia* 24.3, pp. 11–32. DOI: `10.1111/j.1527-2001.2009.01043.x`.

News, AP. “California Law Affirms Gender-Related Care for Foster Youth”. In: *AP NEWS. Health* (). URL: `https://apnews.com/article/8a72cf5be3f5488a922d06e1ad86e9b3`.

Newton, Esther (1972). *Mother Camp: Female Impersonators in America*. Chicago: University of Chicago Press.

Nichter, Mark (1981). “Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India”. In: *Culture, Medicine and Psychiatry* 5.4, pp. 379–408. DOI: `10.1007/BF00054782`.

Niewöhner, Jörg and Margaret Lock (2018). “Situating Local Biologies: Anthropological Perspectives on Environment/Human Entanglements”. In: *BioSocieties* 13.4, pp. 681–697.

Nimmons, David (1994). “Sex and the Brain”. In: *Discover Magazine*. URL: `https://www.discovermagazine.com/mind/sex-and-the-brain`.

Obeyesekere, Gananath (1985). “Depression, Buddhism, And”. In: *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* 16, p. 134.

Olson, Johanna et al. (2015). “Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria”. In: *Journal of Adolescent Health* 57.4, pp. 374–380. DOI: `10.1016/j.jadohealth.2015.04.027`.

Olson, Kristina and Lily Durwood (2016). “Are Parents Rushing to Turn Their Boys Into Girls?” In: *Slate*. URL: `https://slate.com/human-interest/2016/01/what-alarmist-articles-about-transgender-children-get-wrong.html`.

Olson, Kristina R. et al. (2016). “Mental Health of Transgender Children Who Are Supported in Their Identities”. In: *Pediatrics* 137.3, e20153223. DOI: `10.1542/peds.2015-3223`.

Organization, World Health (n.d.). *WHO/Europe Brief – Transgender Health in the Context of ICD-11*. URL: `https://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions/whoeurope-brief-transgender-health-in-the-context-of-icd-11`.

Ortner, Sherry B (1996). *Making Gender: The Politics and Erotics of Culture*. Boston, MA: Beacon Press.

Owen, Gabrielle (2014). “Adolescence”. In: *TSQ: Transgender Studies Quarterly* 1.1-2, pp. 22–24. DOI: `10.1215/23289252-2399479`.

Parikh, Shanti (2016). *Regulating Romance: Youth Love Letters, Moral Anxiety, and Intervention in Uganda’s Time of AIDS*. Vanderbilt University Press.

Petryna, Adriana (2013). *Life Exposed*. Princeton University Press.

Pickstone-Taylor, Simon D. (2003). “Children with Gender Nonconformity”. In: *Journal of the American Academy of Child & Adolescent Psychiatry* 42.3, p. 266. DOI: `10.1097/00004583-200303000-00005`.

Pitts-Taylor, Victoria (2020). "The Untimeliness of Trans Youth: The Temporal Construction of a Gender 'Disorder'". In: *Sexualities*, p. 1363460720973895. DOI: `10.1177/1363460720973895`.

Plemons, Eric (2017). *The Look of a Woman: Facial Feminization Surgery and the Aims of Trans-Medicine*. Duke University Press.

Prentice, Rachel (2012). *Bodies in Formation*. Duke University Press.

Prescott v. Rady Children's Hospital-San Diego (2017). URL: `https://casetext.com/case/prescott-v-rady-childrens-hosp-san-diego`.

Prosser, Jay (1998). *Second Skins: The Body Narratives of Transsexuality*. New York, NY: Columbia University Press.

Raikhel, Eugene (2009). "Institutional Encounters". In: *Being There: The Fieldwork Encounter and the Making of Truth*. Ed. by John Borneman and Abdellah Hammoudi. University of California Press Berkeley, CA.

Raikhel, Eugene and William Garriott (2013). *Addiction Trajectories*. Duke University Press.

RAND. *Delphi Method*. URL: `https://www.rand.org/topics/delphi-method.html`.

Rapp, Rayna (2004). *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. Routledge.

Restar, Arjee Javellana (2020). "Methodological Critique of Littman's (2018) Parental-Respondents Accounts of "Rapid-Onset Gender Dysphoria"". In: *Archives of Sexual Behavior* 49.1, pp. 61–66.

Richardson, S. Sarah (2013). *Sex Itself: The Search for Male and Female in the Human Genome*. Chicago, IL: University of Chicago Press. URL: `http://bibliovault.org/BV.landing.epl?ISBN=9780226084688`.

Roberts, Celia (2015). *Puberty in Crisis: The Sociology of Early Sexual Development*. Cambridge: Cambridge University Press. URL: `http://dx.doi.org/10.1017/cbo9781316221853`.

Rose, Nikolas (2003). "Neurochemical Selves". In: *Society* 41.1, pp. 46–59.

Rose, Nikolas (2007). “Beyond Medicalisation”. In: *The Lancet* 369.9562, pp. 700–702. DOI: `10.1016/S0140-6736(07)60319-5`. pmid: `17321317`.

Rosenberg, Charles E. (2007). *Our Present Complaint: American Medicine, Then and Now.* JHU Press.

Rubin, Gayle (1975). “The Traffic in Women”. In:

Rubin, Henry S. (1998). “Phenomenology as Method in Trans Studies”. In: *GLQ: A Journal of Lesbian and Gay Studies* 4.2, pp. 263–281. DOI: `10.1215/10642684-4-2-263`.

Russ, Joanna (1986). *The Female Man /.* Beacon Paperback ; Beacon Press,

Sadjadi, Sahar (2013). “The Endocrinologist’s Office—Puberty Suppression: Saving Children from a Natural Disaster?” In: *Journal of Medical Humanities* 34.2, pp. 255–260.

— (2019). “Deep in the Brain: Identity and Authenticity in Pediatric Gender Transition”. In: *Cultural Anthropology* 34.1, pp. 103–129.

— (2020). “The Vulnerable Child Protection Act and Transgender Children’s Health”. In: *TSQ: Transgender Studies Quarterly* 7.3, pp. 508–516. DOI: `10.1215/23289252-8553202`.

Save Adolescents From Experimentation Act (2021). In collab. with Lundstrum. URL: `https://www.arkleg.state.ar.us/Bills/Detail?id=HB1570&ddBienniumSession=2021%2F2021R`.

Schilt, Kristen (2015). “Born This Way: Thinking Sociologically about Essentialism”. In: *Emerging Trends in the Social and Behavioral Sciences: An Interdisciplinary, Searchable, and Linkable Resource*, pp. 1–14.

Schneider, Catharina et al. (2016). “Measuring Gender Dysphoria: A Multicenter Examination and Comparison of the Utrecht Gender Dysphoria Scale and the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults”. In: *Archives of Sexual Behavior* 45.3, pp. 551–558. DOI: `10.1007/s10508-016-0702-x`.

Schreier, Herbert and Diane Ehrensaft (2016). “Want to Know a Child’s Gender? Ask”. In: *SFGate*. URL: `https://www.sfgate.com/opinion/article/Want-to-know-a-child-s-gender-Ask-6843665.php`.

Schwartzapfel, Beth (2013). “Born This Way?” In: *The American Prospect*. URL: `https://prospect.org/api/content/a89ffb3d-1651-5fc5-90ed-ea3e7298f275/`.

Sedgwick, Eve Kosofsky (1991). “How to Bring Your Kids up Gay”. In: *Social Text* 29, p. 18. DOI: `10.2307/466296`.

Serano, Julia (2016). *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*. Hachette UK.

— (2018). “Reframing “Transgender Desistance” Debates”. In: *Medium*. URL: `https://juliaserano.medium.com/reframing-transgender-desistance-debates-68648a4fd01a`.

— (2019). “Detransition, Desistance, and Disinformation: A Guide for Understanding Transgender Children. . . ” In: *Medium*. URL: `https://juliaserano.medium.com/detransition-desistance-and-disinformation-a-guide-for-understanding-transgender-children-993b7342946e`.

Shange, Savannah (2019). *Progressive Dystopia*. Duke University Press.

Shrage, Laurie J. (2009). “Sex and Miscibility”. In: *You’ve Changed: Sex Reassignment and Personal Identity*. Oxford University Press, p. 175.

Shrier, Abigail (2020). *Irreversible Damage: The Transgender Craze Seducing Our Daughters*. Simon and Schuster.

shuster, stef m. (2016). “Uncertain Expertise and the Limitations of Clinical Guidelines in Transgender Healthcare”. In: *Journal of Health and Social Behavior* 57.3, pp. 319–332.

— (2019). “Performing Informed Consent in Transgender Medicine”. In: *Social Science & Medicine* 226, pp. 190–197. DOI: `10.1016/j.socscimed.2019.02.053`.

— (2021). *Trans Medicine: The Emergence and Practice of Treating Gender*. New York: New York University Press. 1 online resource (xi, 223 pages.) URL: `http://pi.lib.uchicago.edu/1001/cat/bib/12620983`.

Siddique, Haroon (2021). “Appeal Court Overturns UK Puberty Blockers Ruling for Under-16s”. In: *The Guardian.* URL: `https://www.theguardian.com/society/2021/sep/17/appeal-court-overturns-uk-puberty-blockers-ruling-for-under-16s-tavistock-keira-bell`.

Singal, Jesse (2018). “When Children Say They’re Trans”. In: *The Atlantic. Health.* URL: `https://www.theatlantic.com/magazine/archive/2018/07/when-a-child-says-shes-trans/561749/`.

Skinner, Debra (1989). “The Socialization of Gender Identity: Observations from Nepal”. In: *Child development in cultural context*, pp. 181–192.

Snorton, C. Riley (2008). ““A New Hope”: The Psychic Life of Passing”. In: *Hypatia* 24.3, pp. 77–92. DOI: `10.1111/j.1527-2001.2009.01046.x`.

— (2017). *Black on Both Sides: A Racial History of Trans Identity.* U of Minnesota Press.

Social Workers, National Association of (2017). “The Color of Juvenile Transfer: Policy and Practice Reccomendations”. In: *Social Justice Brief.* In collab. with Mel Wilson and Jeree Michele Thomas, p. 27. URL: `https://www.socialworkers.org/LinkClick.aspx?fileticket=30n7g-nwam8%3D&portalid=0`.

Spack, Norman P. et al. (2012). “Children and Adolescents with Gender Identity Disorder Referred to a Pediatric Medical Center”. In: *Pediatrics* 129.3, pp. 418–425.

Spear, Linda Patia (2013). “Adolescent Neurodevelopment”. In: *The Journal of adolescent health : official publication of the Society for Adolescent Medicine* 52 (2 0 2), S7–13. DOI: `10.1016/j.jadohealth.2012.05.006`. pmid: `23332574`.

Spiegel, Alix (2008). *Two Families Grapple with Sons’ Gender Identity.* URL: `https://www.npr.org/2008/05/07/90247842/two-families-grapple-with-sons-gender-preferences`.

Spitzer, Robert L. et al. (2006). “A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7”. In: *Archives of Internal Medicine* 166.10, pp. 1092–1097. DOI: `10.1001/archinte.166.10.1092`.

Spivak, Gayatri Chakravorty (1988). “Subaltern Studies: Deconstructing Historiography”. In: *In Other Worlds : Essays in Cultural Politics*. Routledge,

Stark, Brett et al. (2021). “Family Building Desires among Transgender and Gender Expansive Adolescents: A Longitudinal Family-Level Analysis”. In: *International Journal of Transgender Health* 22.4, pp. 425–439. DOI: `10.1080/26895269.2021.1896410`.

Steensma, Thomas D and Peggy T Cohen-Kettenis (2018). “A Critical Commentary on ’A Critical Commentary on Follow-up Studies and “Desistence” Theories about Transgender and Gender Non-Conforming Children’”. In: *International Journal of Transgenderism*, pp. 1–6.

Steensma, Thomas D et al. (2011). “Desisting and Persisting Gender Dysphoria after Childhood: A Qualitative Follow-up Study”. In: *Clinical child psychology and psychiatry* 16.4, pp. 499–516.

Steensma, Thomas D. et al. (2013). “Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study”. In: *Journal of the American Academy of Child & Adolescent Psychiatry* 52.6, pp. 582–590. DOI: `10.1016/j.jaac.2013.03.016`.

Steinmetz, Kathy (2014). “The Transgender Tipping Point”. In: *Time*. URL: `https://time.com/135480/transgender-tipping-point/`.

Stevenson, Elizabeth Margaret (2013). *Life Beside Itself: Imagining Care in the Canadian Arctic*. Berkely, CA: University of California Press. URL: `https://books.google.com/books?hl=en&lr=&id=TQYWBAAAQBAJ&oi=fnd&pg=PP1&dq=stevensonlifebesideitself&ots=tVEKAmkbEo&sig=ViGQKEdOpCK1Ev4YaSdOiLPUyHO`.

Stewart, Kathleen (1996). *A Space on the Side of the Road: Cultural Poetics in an” Other” America*. Princeton University Press.

— (2007). *Ordinary Affects*. North Carolina, UNITED STATES: Duke University Press. URL: `http://ebookcentral.proquest.com/lib/uchicago/detail.action?docID=1170511`.

Stone, Sandy (1992). "The Empire Strikes Back: A Posttranssexual Manifesto". In: *Camera Obscura: Feminism, Culture, and Media Studies* 10.2, pp. 150–176. DOI: `10.1215/02705346-10-2_29-150`.

Strathern, Marilyn (1988). *The Gender of the Gift: Problems with Women and Problems with Society in Melanesia*. Berkeley, CA: University of California Press.

Stryker, Susan (2017). *Transgender History: The Roots of Today's Revolution*. Hachette UK.

TallBear, Kim (2014). "Standing with and Speaking as Faith: A Feminist-Indigenous Approach to Inquiry". In: *Journal of Research Practice* 10.2, N17–N17.

Tanner, James Mourilyan and James M. Tanner (1990). *Foetus into Man: Physical Growth from Conception to Maturity*. Harvard University Press.

Taussig, Karen-Sue, Klaus Hoeyer, and Stefan Helmreich (2013). "The Anthropology of Potentiality in Biomedicine: An Introduction to Supplement 7". In: *Current Anthropology* 54.S7, S3–S14. DOI: `10.1086/671401`.

Temple Newhook, Julia et al. (2018). "A Critical Commentary on Follow-up Studies and "Desistance" Theories about Transgender and Gender-Nonconforming Children". In: *International Journal of Transgenderism*, pp. 1–13.

Thoma, Brian C. et al. (2019). "Suicidality Disparities Between Transgender and Cisgender Adolescents". In: *Pediatrics* 144.5, e20191183. DOI: `10.1542/peds.2019-1183`.

Tishelman, Amy C. et al. (2015). "Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples." In: *Professional Psychology: Research and Practice* 46.1, pp. 37–45. DOI: `10.1037/a0037490`.

Travers, Ann (2019). *The Trans Generation: How Trans Kids (and Their Parents) Are Creating a Gender Revolution*. NYU Press.

Táíwò, Olúfémi (2020). "Being In the Room Priviledge: Elite Capture and Epistemic Deference". In: *The Philosopher* 108.4. URL: `https://www.thephilosopher1923.org/essay-taiwo`.

Valentine, David (2007). *Imagining Transgender: An Ethnography of a Category*. Durham, NC: Duke University Press. xiv, 302 p.

— (2012). "Sue E. Generous: Toward a Theory of Non-Transexuality". In: *Feminist Studies* 38.1, pp. 185–211. URL: `http://www.jstor.org/stable/23269176`.

Van Anders, Sari M. (2015). "Beyond Sexual Orientation: Integrating Gender/Sex and Diverse Sexualities via Sexual Configurations Theory". In: *Archives of Sexual Behavior* 44.5, pp. 1177–1213. DOI: `10.1007/s10508-015-0490-8`.

Van Anders, Sari M (2013). "Beyond Masculinity: Testosterone, Gender/Sex, and Human Social Behavior in a Comparative Context". In: *Frontiers in Neuroendocrinology* 34.3, pp. 198–210.

Velocci, Beans (2021). "Standards of Care: Uncertainty and Risk in Harry Benjamin's Transsexual Classifications". In: *TSQ: Transgender Studies Quarterly* 8.4, pp. 462–480. DOI: `10.1215/23289252-9311060`.

Von Doussa, Henry, Jennifer Power, and Damien Riggs (2015). "Imagining Parenthood: The Possibilities and Experiences of Parenthood among Transgender People". In: *Culture, health & sexuality* 17.9, pp. 1119–1131.

Wang, Thelma (2022). "Trans as Brain Intersex: The Trans-Intersex Nexua Is Neurobiological Resaerch". In: *Trans Studies Quarterly* 9.2, pp. 172–183.

Webb, A, J.E. Holmes, and J.L Peta (2016). "Assessment Norms for Gender and Implications for Transgender, Nonbinary Populations". In: *Division 44 Newsletter*. URL: `https://www.apadivisions.org/division-44/publications/newsletters/division/2016/04/nonbinary-populations`.

Webberly, Helen (2020). "Bell V Tavistock Judgment: What Went Wrong?" In: *GenderGP Transgender Services*. URL: `https://www.gendergp.com/analysis-bell-v-tavistock-judgment/`.

Weisleder, Pedro (2007). "Inconsistency Among American States on the Age at Which Minors Can Consent to Substance Abuse Treatment". In: *Journal of the American Academy of*

Psychiatry and the Law Online 35.3, pp. 317–322. pmid: `17872552`. URL: `http://jaapl.org/content/35/3/317`.

West, Candace and Don H. Zimmerman (1987). “Doing Gender”. In: *Gender & society* 1.2, pp. 125–151.

Williams, Raymond (1977). *Marxism and Literature*. Vol. 392. Oxford Paperbacks.

WPATH. *History - WPATH World Professional Association for Transgender Health*. URL: `https://www.wpath.org/about/history`.

— (1985). “Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons”. In: *Archives of Sexual Behavior* 14.1, pp. 79–90. DOI: `10.1007/BF01541354`.

Ye, Shenghe (2021). “Talking Science to Schools: Organizing the Research-Practice Nexus in Early 21st Century American Education”. United States – Illinois: The University of Chicago. 230 pp. URL: `http://www.proquest.com/pqdtglobal/docview/2585854285/abstract/23EA9839C2394B4BPQ/1`.

Young, Allan (1982). “The Anthropologies of Illness and Sickness”. In: *Annual review of anthropology* 11.1, pp. 257–285.

Zucker, Kenneth J. (2010). “The DSM Diagnostic Criteria for Gender Identity Disorder in Children”. In: *Archives of Sexual Behavior* 39.2, pp. 477–498. DOI: `10.1007/s10508-009-9540-4`.

— (2018). “The Myth of Persistence: Response to “A Critical Commentary on Follow-up Studies and ‘Desistance’ Theories about Transgender and Gender Non-Conforming Children” by Temple Newhook et al. (2018)”. In: *International Journal of Transgenderism* 19.2, pp. 231–245. DOI: `10.1080/15532739.2018.1468293`.