Transidentity and Puberty[1]

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Summary

An early medical support of children's and teenagers' gender identity variances gives them opportunities for a more harmonious development. Delaying puberty developments can mean gaining valuable time and the effects resemble premature puberty. If the antigonadotropines are discontinued, the development of puberty resumes again, provided there is no hormone cross-sex therapy. In this case the desired result is achieved faster, thereby avoiding numerous treatments for the correction of an undesirable sex development. The psychological support of the children and their families during this phase can prove really useful.

On the Terminology

We speak of 'transidentity',[2] since it is an identity and not a form of sexuality or sexual desire. 'Transidentity' refers to the identity of trans persons, whether they be 'transsex' (in the French original version: transsexe) or transgender (in the French original version: 'transgenre'). We have replaced the term 'transsexual' with 'transsex', since it is not supposed to point to possible forms of sexual desire or sexual practices, i.e. to sexuality, and since the term 'transsexual', owing to its terminological proximity to the terms 'homosexual' and 'heterosexual', is therefore inappropriate. The term 'transsex' builds on the concept of the term 'transgender'. With the term 'trans persons', we refer equally to 'trans or transidentitarian persons' and to 'transgender persons'. As should be common knowledge, trans persons can be heterosexual, homosexual, bisexual, asexual etc. We choose not to use the terms 'transsexuality' and, if possible, 'transsexualism' and will in the following speak of 'transidentity'.

1 | Original version in French.

2 | The term 'transidentité' used in the French original is derived from the German term 'Transidentität', which was translated by Support Transgenre Strasbourg into French.

We understand transidentity as an atypical development or variance of gender identity. Just because only a minority displays this variance of an identitary development, it is not necessarily pathological – left-handed persons are not diagnosed with an ability disorder either just because they belong to a minority.

Benefit of an early medical support

The following section discusses puberty, hormone therapy at the beginning of puberty, hormonal treatment of 16-year-old Polynesian girls as well as its physiological and psychological effects. A brief overview presents the advantages of early medical support.

A conference held in 1998 in Oxford by 'Press For Change' in the course of which a Scottish team of doctors presented their results of hormone therapy in children and adolescents between 14 and 16, as well as the testimonies presented on Lynn Conway's homepage, in addition to my personal development and the statements of numerous trans persons whom I have met in the past 20 years have reinforced my long-standing conviction, which is: the early support of children and adolescents is a model for the future.

Gender-variant persons must be given particular attention from childhood onwards. This refers in particular to the support of youngsters and their families as well as the medicinal delay of puberty development from its inception until the age of 14 to 16. The ideal time for prescribing a cross-sex hormone therapy would be at the average entry age into puberty of the respective target sex/gender, i.e. for MtF[3] between 12 and 13 years of age, and for FtM[4] between 14 and 15 years of age. This would enable the young people to undergo developments concurrently with their peers. In the French context, this could constitute a great step forward as French endocrinologists rarely have the will to support young people they would agree then to a delay of puberty as timely as possible, before secondary sexual characteristics have fully developed. It would therefore be desirable to already support the children before the age of eight to ten years. If puberty development is already in full swing, an active cross-sex hormone therapy is necessary (as with adults) in order to reverse the already completed development and enable in the gender corresponding to the adolescent's identity a satisfactory passing.

Since the 2000s, I have met around 15 Polynesian girls in the course of my work who had begun a hormone therapy in Tahiti between the age of 14 and 16. It seemed simply inconceivable to think that these women had not been born in the feminine sex. Those who had not undergone hormone therapy before their 18th year of life had to resort to plastic surgery. In their region of origin,

3 | MtF: transition from male to female.
4 | FtM: transition from female to male.

transidentity is a culturally accepted possibility of development beside the other two majority gender identities (woman or man). In Polynesia there is at least one trans person in each family's extended family environment (siblings, cousins). Transidentity is thus a rather common phenomenon. Due to this particular context, the personal development is more harmonious, the trans persons have not to confront of feelings of shame. Potential psychological problems are no different to those of the rest of the population.

If puberty has been prevented to set and if a hormone cross sex therapy has begun between 14 and 16 of age it leads to results comparable to those presented by the Scottish team mentioned above. Since the male puberty of the MtF cannot assert itself, female development is ideal: the skeleton (in particular of the hands and feet) remains more delicate and the height is lower. The distribution of the fatty tissue leads to the development of female curves (e.g. at the hips) corresponding by favorable proportions with uscle tissue in the shoulder region. The vocal range, the Adam's apple and body hair are only developed in a feminine way. The epilation of facial hair, voice training as well as the operative feminization of face and neck are no longer necessary. The physical appearance changes rapidly towards a definitively feminine aspect. The puberty of FtM, which begins comparatively early, has to be delayed right from the start. Subsequently, a hormone therapy beginning at the age between 14 and 16 will also show positive results: the skeleton becomes more robust, the length of the body (particularly the length of hands and feet) increases by a few centimeters, the development of muscle tissue and the distribution of fatty tissue produces favorable proportions between shoulders and hip. The voice, the hairs and the beard are developed in a masculine way. The mastectomy is no longer necessary.

If entry into male puberty is not delayed, the muscle tissue that has developed as a result cannot always be reduced with the same effect by a later feminizing hormone therapy. Similarly, the development of muscle tissue by means of a virilizing hormone therapy is less pronounced if it is administered only after female puberty is concluded.

Some doctors reserve treatmentat the age of majority. They want to maintain an alleged neutrality and let matters take their natural course. However, this non-action is not neutral. The consequences are just as significant as those of a cross-sex hormone therapy. Instead, something approaching a neutral stance would consist in agreeing to block the development of puberty, since this not only buys valuable time, but the young trans person can also be spared the often difficult reversal of undesirable puberty development at the cost of significantly more massive treatment.

An early medical support of trans children can help to prevent despair, suffering, teasing, stigmatization, collateral damage in the family, failure at school, anxiety, depression, suicidal thoughts and their execution. The psychological development and the socialization of the adolescents would have the chance to proceed as transition in the right gender, are more positive, the relationships with their peers turn batter.

In the case of intersex persons, by contrast, medical surgery that is aimed at their 'atypical nature' and does not serve the preservation of life or health should not be carried out. Hormone therapy administered during childhood constituted a source of great emotional distress for all intersex persons I know. They described how this treatment destroyed their lives and wished the hormones had never been administered. For them, these treatments have meant a painful abuse.

It is essential not to push intersex or trans children into one or the other direction, but rather to listen to them and to support them, as well as their families. Slowing the children down in their development is not a solution. Instead, all possible options existing should be discussed with them so that they can make the choice that is best for them. It is more effective to involve them as equal partners in the decision-making processes.

Maturity

Trans persons cannot be expected to be psychologically more balanced than the rest of the population. Such an expectation cannot be demanded as a mandatory requirement for the application of the desired treatments. Feeling better with a hormone therapy and wanting to continue the treatment seems to me more telling than any psychological assessment. As long as the barrier of 'psych'[5] approval' continues to be demanded by endocrinologists and surgeons, the relations between trans persons and 'psych'' will remain distorted. Psychotherapy with trans persons is difficult, even though sometimes there is indeed a need for it. Persons desiring hormone therapy should be able to carry the responsibility for their choice by themselves, and health professionals should not be prosecuted for this decision but only held responsible for the professional application of adequate medical measures. Those unsure of their gender identity should be able to ask for help to reach a better understanding of their situation to then make a clarified decision. If the persons concerned do not wish to make the choice alone, then no one else should be allowed to do so in their place. If they choose the path of transition then this bears witness to their maturity. I have experienced several times that only those who are actually ready for it will take this path.

5 | Psych': (adjective) psychiatric or/and psychological or (noun) psychiatrist or/and psychologist.

Maturity is a complex psychological phenomenon that includes various (intellectual and emotional) characteristics as well as several levels that depend on various stages of development (oral, anal…), some of which the majority of people fail to reach. There are elements that develop only if transidentity gets the adequate medical support, others may develop in a later period of life and contingent on specific events. This depends primarily on the individuals and their personal history. A certain degree of intellectual maturity is certainly necessary for a free and informed agreement to a treatment. However, not all levels of emotional maturity need to be completely developed to take a decision of this magnitude, even if some of them are helpful in the course of life.

Possible particularities besides transidentity

A not insignificant number of trans persons have an IQ of over 125, which in general implies particular cognitive and emotional faculties, these however must not be confused with psychological disorders. Examples: a highly developed awareness with regard to depression or a heightened emotionality regarding unsolved emotional problems.

Not rarely, trans persons have been the victims of sexual harassment or rape, those occurring within the family or outside. These persons often suffer being unwell in their body which makes them easier to notice by sexual predators. Others have experienced physical or psychological violence. Here, too, the various elements have to be regarded in a differentiated way, and possible symptoms of a post-traumatic stress disorder have to be recognized as such. However, these have no link with the atypical identity development, particularly if this latter one was already present before the attacks or the experience of violence.

I have noticed that a further number of trans persons which has not to be underestimated (40% to 50%) suffers from anxiety or depression, about 10% of my trans clients (adult as well as juvenile) display signs of autism (Asperger syndrome, non intellectual deficient autism). These phenomena are not incompatible with transidentity. The 'World Professional Association for Transgender Health' reachs the same conclusion in the 7th version of its 'Standards of Care for the health of transsexual, transgender, and gender non conforming people' and states on page 12:

"It is relatively common for gender-dysphoric children to have coexisting internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autism spectrum disorders seems to be higher in clinically referred, gender-dysphoric children than in the general population" (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010) (WPATH, 2012).

From my experiences with transitioning I can say that for some persons, a hormone therapy can have an unbalancing effect on their psychological condition. In my opinion, the risk of a development of a bipolar ('manic-depressive') disorder should not be underestimated. In this sense, a psychological support, particularly at the beginning of hormone therapy, is often useful. The depression-promoting side-effects of the anti-androgene drugs on the market in France are also known, in particular, those of cyprotrone acetate. These drugs should therefore not be administered to people who have already suffered from depressive moods. Even if they have frequently been rejected due to their relatively high cost, anti-gonadotropines constitute an effective alternative, providing they are well tolerated.

Forms of therapeutical relationship

It is important to use the grammatically appropriate gender trans persons identify themselves with, especially if they explicitly request it, and this regardless of their outward appearance. Here the therapists should be flexible. This is not about sharing the fantasies of trans persons or encouraging them, but above all about not humiliating them. They have agreed to therapeutical treatment because they have already embraced the issue or believe having identified a particular problem and are looking for professional confirmation. For young people, when there is no doubt, they assert their gender identity, speak about it to their parents if these ones are sufficiently open-minded and listening for that problematic option and then ask for a proper transition. If they are in doubt, they usually do not agree to therapy and do not address this issue.

The goal of therapy is, first of all, to establish whether trans persons are able to give their free and informed agreement, to convey clear information that is appropriate to their level of comprehension, and to check whether they have sought counsel elsewhere and are aware of the consequences of the desired treatment. Here, therapists have to adjust to the trans persons' paces, i.e. must not proceed too fast, but also not too slowly, and take their needs into account regarding the frequency of sessions, the issues to be addressed as well as the kind of hormonal-surgical treatment that is expected

Meeting and knowing trans persons has given me the opportunity to understand that love and sexual attraction can change over time. They are social constructions which have to be localized in the context of heteronormativity (the political system that produces heterosexuals). The people concerned must allow themselves to question gender and sexual stereotypes in order to achieve greater freedom. Children and adolescents usually have no major problems with the deconstruction of sexuality transmitted through gender, sex and sexuality norms.

At this point one should note that the division into 'primary' and 'secondary' transsexuality still common in France is obsolete and was abandoned internationally years ago. The criteria have also become more flexible. In psychotherapy, elements continuously come to the surface that were suppressed in infancy and childhood because they were inconceivable at the time. This phenomenon also occurs in the work with intersex persons who have undergone treatment as children or adolescents. Just because persons come out as themselves relatively late in life, are married and have children, must not be a reason for segregationist classification.

Hormones and puberty

Administering the pregnancy hormone progesterone for FtM seems counterproductive to me. Even though the activity of the ovaries is suppressed, at the same time the negative effects of this hormone are encouraged: (in part considerable) increase of weight and unfavorable distribution of fatty tissue (contrary to the desired distribution). As important as the suppression of menstruation may be, it should not be achieved at any cost, since there are more beneficial solutions for this.

There are two good ways for a suppression of gonads' function: the first consists in long-term, continuous administration of natural hormones produced by the gonads (this corresponds to the principle of contraception by continuous administration of the pill, which in women causes amenorrhea, the absence of menstrual period), but this method is not an option for trans persons of any age. The second option suppresses hormone production of the gonads by influencing the feedback mechanism. This method can possibly delay puberty in juveniles so that they gain a few years in order to address their issue in depth. Such a way is more costly than the commonly used cross-sex hormones, the latter are however not neutral and through their hormonal effect induce a puberty of sorts.

A third possibility for adult trans persons is the direct administration of an active hormone therapy with hormones of the desired sex/gender (testosterone for FtM, estrogen and progesterone for MtF), or, where it presents itself, in combination with the second option. After a treatment period of six months, this method is equally effective for the majority of those treated. Nevertheless, every hormone treatment has to be tailored to personal needs and discussed with every person individually after providing clear information. The decision has to be taken jointly by doctor and patient. If a MtF is suggested a treatment with anti-androgenes, then these should never be prescribed as the sole medication,

but always in combination with estrogens. The daily doses should here not exceed 100 mg and ingestion has to be ended after a gonadectomy or substituted by progesterone. Potential side-effects need to be monitored in particular for the liver and the state of mind. Infertility possibly ensuing after two years is the only irreversible effect of the treatment. All further changes are reversible and ultimately correspond to the changes of the sex-related appearance of adult trans persons through hormonal treatment. Furthermore, the administration of all three hormones has to be monitored to ensure that the respective level corresponds to the desired result.

Some health experts claim they do not give adolescents a hormone therapy and neither want to delay their puberty, for they do not know the long-term effects on their health. At the same time, neurochemical treatment of restless children[6] seems to cause no particular concern regarding the long-term effects on the brain. The basic problem, however, is the same. Certainly, anti-gonadotropines have not insignificant side-effects, but nevertheless, they are used in children whose premature puberty is to be delayed and there is no evidence of a negative effect on the neurological development. What is possible for these children should also be possible for trans children after they have been candidly informed about the current state of knowledge about this form of treatment, thus creating the possibility for an informed decision. Since the 1990s this procedure is permitted in several countries: USA, Canada, Great Britain, The Netherlands, Germany, Australia etc. Since 2014/15, this became also possible in France.

Hormone therapy as a psychological testing procedure

The changes brought about by hormone therapy in the first three months are not noticeable by people living in contact with the persons who want to test if they feel better with hormones of the other majority sex. These effects are wholly reversible once the hormones are discontinued. Generally, the person becomes aware within the first three months whether this is really the right way for them. This hormonal test is much more effective than any 'psych'' assessment. Anyone who does not feel better after a three-month treatment should question the pertinence of continuing the treatment. Potentially irreversible and relatively undramatic changes when terminating a virilizing hormone therapy after three months would be an enlarged clitoris and a deeper voice (equal to that of a 40 year old woman who smokes more than 20 cigarettes a day). Abandoning a feminizing hormone therapy as it is administered in France since 2000, would have as only effect an enlarged areola and nipple zone (but without an actual development of the gland function).

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6 | Children suffering from an attention deficit disorder with or without hyperactivity (ADHS) or a serious development disorder; the latter is the new term for the autism spectrum as a whole.

Conclusion

The professional support of trans children can begin as soon as they express the desire to receive it, or as soon as they demonstrate a gender identity variance, even if they do not move in the direction of a transition. Should they opt for a transition during or after professional support, appropriate solutions can be offered quickly. If the support begins when the person enters puberty or shortly before, it is possible to prevent, through a delay of puberty, a development in the wrong direction from the point of view of the juvenile person and gain valuable time. Hormone therapy is more effective when preceded by a delay of the development of puberty. In case of a termination of treatment, the latter can still resume where it was interrupted. Since not everyone enters puberty at the same age, it can be delayed for one or two years without any problems. In case of a transition, genital surgery is only necessary for those who expressly desire it.

A change of first name can be effected from the beginning, permitting an adaptation of the obtained diplomas. A change of civil status could be given from 18 months of hormonal therapy or from the age of 18. A professional carreer could thus be approached in the desired gender from the beginning.

The ideal solution would evidently be to omit the mention of sex in the civil status for everyone. This would mean abandoning such a criteria on all kinds of documents, like it was done before with the colour of skin, denomination, etc. The sex and gender distinction fills the bed of sexism as the racial notion does for the one of racism.