Trans in Practice, Transition in Sequence: Providing Medical Assistance for Gender Transitions in Trans and Gender Non-Conforming Youth

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Each clinical visit at the pediatric gender clinic begins with three knocks. After a sharp rap on the closed door, the pediatric endocrinologist pushes the handle and enters the consultation room without hesitation. From there, a world of possibilities opens. This paper explores the possibilities these clinic-room doors open.

Biomedicine has been 'treating' trans adults in the United States with hormones since Harry Benjamin championed endocrine therapy in the 1950s (Benjamin 1954). Children and adolescents, on the other hand, have only recently become eligible for transition related medical intervention. It was not until 2009 that the "Endocrine Society" first recommended puberty blockers as part of "treatment of transsexual" children (Hembree et al. 2009; Gill-Peterson 2018).[1] This medical care has been impactful for trans young people, who experience disproportionate levels of mental health issues (Becerra-Culqui et al. 2018) and homelessness (Whitbeck et al. 2014) compared with cis-gender youth. In 2019, the state of Minnesota in the US found that "transgender students in the 11th grade… are more than four times more likely to attempt suicide than their cisgender 11th-grade peers" (Minnesota Department of Health 2019). In aggregate, trans youth face a 41 percent lifetime suicide attempt risk (Haas, Rodgers and Herman 2014), as compared to a 3.0-5.1 per-

1 The "Endocrine Society" is the leading professional medical organization for endocrinology in the United States. It publishes standards and recommendations for care of endocrine conditions, as well as hormone management for trans individuals.

cent lifetime suicide attempt rate in the general US population (Nock et al. 2008).

It is under this shadow of transphobia and trans youth suicide that I conducted ethnographic fieldwork within a pediatric gender clinic in the United States for 5 months in 2017 through 2018. Drawing on this ethnographic data, I will first briefly explore the ontology of gender and transness within a pediatric gender clinic, and then employ this understanding to examine the temporal sequence of transition within the gender clinic. I draw on Annemarie Mol's work, *The Body Multiple* (2002), to explore how gender is enacted in practice and how multiple enactments of gender interact to bring realities of trans people into being (see Latham 2017 for a trans autoethnographic engagement with Mol's work). I employ Mol's term, "enacted," because in the gender clinic actions are occurring that bring gender and transness to the forefront and into being. Gender and transness are not simply known; they are *done*. Per Mol's application, enactment implies that "objects [genders] come into being—and disappear—with the practices in which they are manipulated" (Mol 2002:5). Enactment "suggests that activities take place… [and] that in the act, and only then and there, something *is*—being enacted" (ibid.:33). In the practices of the gender clinic an ontology of gender and transness arises.[2]

After establishing this ontological claim, I expand the focus of this essay to unpack how enactments of gender are temporally structured in the creation of a transition. Specifically, I name three relationships of enactments—predication, obstruction, and justification—which sequence realities of gender and transness. These relationships, respectively, form, disrupt, or accelerate the normative sequence of transition enforced by biomedicine within the gender clinic.

I conclude the paper by acknowledging the utilitarian value of the gender clinic's normative sequence, while exploring the ways an understanding of gender and trans ontologies and their sequencing can improve and expand the care of trans youth beyond biomedicine's enforced normative sequence of transition.

2 This is true for cis- as well as trans people. A separate ethnography could explore the how gender is enacted throughout clinics not specifically designed for trans patients. The practices of medicine bring gender – and its many ontologies – into being in these spaces.

Trans in Practice

In *The Body Multiple* (2002), Annemarie Mol traces atherosclerosis and its many ontologies through a Dutch hospital. She argues that atherosclerosis is "enacted" differently by patients, surgeons, doctors, nurses, and varying medical technologies. Accordingly, the ontological reality of what atherosclerosis *is* multiplies.

Transness is likewise *done* in multiple ways by and with numerous actors in the gender clinic. Yet gender and transness as ontology are also unruly. Their multiple realities – the multiple ways of enacting gender and transness – sometimes align, but often conflict or take precedence over one another. And for a child in transition, the socio-material practices of the clinic, as well as the ways the child moves through the gendered world outside of the clinic, offer many modes in which gender and transness can be done and undone.

To understand the multiple ontologies of transness, one must consider the diverse realities of gender and the practices that realize their being. This is essential, of course, because gender is what is being 'trans-d' in the pediatric gender clinic. While I argue transness is brought into being in the conflict of gender enactments, the object brought into being, transness, is not a botched gender or a failure to fit into the order of things. Rather, transness appears in the conflict of gender enactments as something greater than the dissonant gender enactments. Put differently, 'trans-ing' gender creates an object that is more than just normative gender. To understand this, lets return to those three knocks:

Three short knocks and the doctor strides into the last consult of her day. Khalif, a young child dressed in baggy jeans and an orange t-shirt, is just climbing off the exam table.

> *"How are we doing today?" the doctor asks, both as a pleasantry and a coded way to ask 'what brings you in?'*
> *"We're doing well," Khalif's mom replies, "Khalif came into his kindergarten socially transitioned. He wears boy clothes and likes his hair cut as a Mohawk."*
> *The doctor turns from her computer to Khalif and asks, "And Khalif, what pronouns do you use?"*
> *"He," Khalif answers quietly, lowering his gaze sheepishly to his swinging feet.*
> *"Well, I use she, her, hers, [myself]," the doctor says kindly. "How has school been?"*
> *"Good," Khalif again says quietly.*

> *"Good," Khalif's mom echoes, "All of the teachers know Khalif is trans and are supportive. They use his correct name and his pronouns. We haven't had any problems with any of the other kids." As the endocrinologist gets up and starts washing her hands, the mom goes on: "I'm in an online support group for parents with trans kids and I wanted to come in today because I want to know a timeline of when we should start Khalif on [puberty] blockers and T[estosterone]."*
> *The doctor begins her normal check-up routine: moving her stethoscope along the Khalif's chest and back as he breathes, shining a light into his eyes, ears, and mouth. She explains that she starts her patients on blockers when the child begins puberty. Hormone replacement therapy [HRT] normally starts at 16 years old at the earliest, but if "we know the child is trans, we can start hormones earlier."*
> *Khalif's mom and I both sit silently as the doctor continues with her exam. She checks Khalif's armpits for hair, his chest for any breast tissue growth, and completes a genital exam.*
> *To end the consult, the endocrinologist explains the different ways blockers can be administered – injections, pill, or patch – and tells Khalif and his mom to return in a year or if they start to see any signs of puberty. "Look for breast tissue development first. That could start around age nine."* [3]

Gender is done in many different ways in this consultation. Khalif's male identity is enacted as wearing clothes associated with boys, his Mohawk haircut, and the pronouns he uses. The doctor might describe Khalif's maleness as a lack of breast development. In Khalif's case, we see his gender is done through multiple registers: style, language, the body, and by various people: his mom and teachers, Khalif himself, the doctor in the clinic. I argue Khalif's male gender is multiple because pronouns are not a lack of breast tissue, which are also not haircuts. Yet gender is all of these things. This is what it means to hold Khalif's male gender as multiple.

However, 'boy' is not the only gender identity brought into being in Khalif's clinical visit. When the endocrinologist turns to Khalif's medical file, she sees Khalif's legal, female name and an 'F' standing under the category of sex, imported from Khalif's state-issued birth certificate. Likewise, female is enacted in the doctor's visual assessment of Khalif's vagina, and her palpation

3 I was able to observe clinical visits at the pediatric gender clinic after receiving IRB approval from the clinic's hospital and informed consent from the providers. Informed consent was obtained from patients if they were over 18 years old and from patients' parents/guardians with the patient's assent if the patient was under 18 years old for all interviews.

of his breast tissue. In fact, temporal ruptures bring many of these female enactments into the present. The 'F' on Khalif's birth certificate (a state and institutional enactment of gender) is dragged from the past into the medical record while a future referential of breast development is brought across Khalif's body and into the exam room through the doctor's breast exam.[4]

Transness is brought into being when these enactments of 'female' are held against the realities of stereotypical masculinity also present in the consultation room. Trans materializes when Khalif's legal name stands next to 'he' and when the doctor discusses chemicals that will foreclose a particular form of bodily development. Trans is enacted when the 'F' on Khalif's birth certificate ruptures into the present and stands next to his male enactments of hair and clothing styles. Without this encounter between male and female enactments, trans would not come into being in the gender clinic. Khalif enacts 'boyness' until the doctor examines his chest and genitals or looks through his medical file. It is only then that trans is brought into being. Trans is enacted by practices over and over again in the gender clinic. Gender enactments such as the speech act, "I am a boy," haircuts, blood tests for hormone levels, teste size, deepening voices, 'peach fuzz' above the lip, and menses are held against one another as well as past and future enactments to bring transness into being.

Transition in Sequence

Foregrounding the practices of the gender clinic reveals that gender comes into being in socio-material practices. Trans ontology, in turn, is enacted as these practices are held against one another. I now wish to explore how relationships between enactments of gender and trans bring about a transition within the pediatric gender clinic.

4 Many of the practices of the gender clinic queer time. For instance, in Khalif's case, both past and present appear in the present. Similarly, abstracting the term "chrononormativity" from Elizabeth Freeman's *Time Binds* (2010), we can see how the gender clinic's interventions queer the chrononormative timeline of development put forward by western medicine. Many of the gender clinic's patients go through a second puberty, or blockers will cause a "temporal drag," in which prepubescence is maintained for years beyond it's 'normal' expected conclusion (Freeman 2010). This is what Lauren Berlant would describe as an "impasse" (Berlant 2011), and Kathryn Bond Stockton would argue is "growing sideways" (Stockton 2009).

The pediatric gender clinic's intervention orients itself around transition; the endocrinologist tells me, "As the endocrinologist what I'm trying to do is to help their bodies align more with their gender identity." Consequently, the gender clinic is as much about gender identity as it is about development, about change over and through time. The relationship between enactments of gender and transness reveals sequences that define development and transition. Certain forms of development will stall while others will proceed. And, critically, when one analyzes the temporal relationships between gender and trans enactments in the clinic, certain epistemological assumptions about transitions and development arise. Succinctly, the gender clinic imagines and enacts a normative time(line) of transition. Certain enactments of gender are necessary for the sequence of transition to proceed, others block the sequence from advancing, and still others move the sequence along at a faster rate than the 'normal' trans subject or the 'normal' sequence. I will call these relationships predication, obstruction, and justification, respectively.

Predication is that relationship in which an enactment must be done, must be present, for a sequence to proceed. For instance, a letter of support from a psychotherapist is required to predicate a medical intervention. The enactment of gender as a letter of support must precede enactments such as hormone levels, breast development, or voice deepening. Predication is the foundation of the sequence. It can be thought of as a check point, a necessary step.

Obstruction is the relationship of enactments that foreclose other enactments from coming into being or completely shields them from view. It occurs when enactments inhibit the sequence of transition from proceeding and thus occlude certain enactments of gender and transness from coming into being. This reveals contesting sequences of transition (some of which are the absence of a transition) and how certain enactments can produce violence against trans subjects.

Lastly, justification is an accelerant. In contrast to obstructions, which hamper or terminate a transition, these enactments bring others into being, pull them into the sequence, before they would normally occur. As revealed by Khalif's visit, the endocrinologist 'normally' begins HRT at sixteen years old. However, if the gender clinic "knows the child is trans" hormones can be administered starting at fifteen. As I will discuss, the enactment of the gender clinic 'knowing' a patient is trans accelerates the normative sequence and allows the patient to enact gender as hormones (and changing body fat distribution, etc.) earlier than sixteen.

These relationships – predication, obstruction, and justification – are an organizing schema, but they are not meant to imply there is no grey area or overlap between them. It is possible that enactments of gender and transness may fall into multiple categories or somewhere in between. For instance, a letter of support predicates other (medical) enactments; however, withholding a letter is a form of obstruction. Likewise, the opposite of many obstructions may sometimes (often when massively combined) act as accelerants to a transition. Finally, a second way to think about these terms is what these relationships mean for sequence. Thus, one can also read this schema: normative sequence, dissonance within the sequence, and accelerants of the sequence.

Many enactments of gender within the gender clinic can be temporally unregimented and diverse. A patient does not need to legally change their name, or go by a chosen name at all, before the patient injects a hormone into their body. While hairstyles, chest binders, and makeup all bring gender into being, none must precede or follow another. There is no strict temporal linearity or sequence to these events in the gender clinic. However, a letter of support from a mental health provider must always predicate any medical intervention from the clinic (Hembree et al. 2017). In requiring this predicative relationship between a letter of support and levels of hormones within one's blood, a sequence emerges.

> *Logan is in his mid-teens when I meet him. His hair is colored a mélange of blue, grey and purple. When the social worker tells Logan he's now ready for testosterone, a smile arches across his face that will stay with him for the rest of the visit. "We do need a letter of support, though," the social worker says. "How is therapy going?" she then asks.*
>
> *"It's good. I don't like the group sessions much, but I can go to more of the group therapy if that means I can get a letter of support," Logan replies, not letting this roadblock temper his excitement.*
>
> *"Who's your mental health provider, again?" the clinical social worker asks rhetorically as she looks down at her notes. "Ah! Well, I can also give you a referral to one of the gender friendly mental health providers we recommend. I do want you to keep going to group therapy, but we need that letter before we can start you on T. I'll tell you what, though, let me go talk to the doctor and we can probably send you the prescription for T once we get that letter, so you don't have to wait until your next visit."*

As the first checkpoint in the standard timeline of transition, scenes of acquiring a letter of support in order to begin medical treatment at the gender

clinic happen often. One mother tries to get her son's psychologist on the phone while she and her son are still in the clinical consult. Another patient had completed a round of therapy before they came to the gender clinic, but learned they need to return to a psychotherapist in order to obtain a letter of support.

Logan's consultation and many others reveal the predicative role of the psychotherapist's letter of support to gender enacted as hormones or puberty blockers. Moreover, one observes a normative sequence unfolding. First a letter, then hormones. To bring gender as hormones or blockers (the lack of hormones) into being, transness enacted as a diagnosis of gender dysphoria must be present.

The gender clinic premises its medical intervention on the letter of support in order to meet the medical standards of care set by *the World Professional Association for Transgender Health (WPATH)* and the "Endocrine Society" (Coleman et al. 2012; Hembree et al. 2017). One of the criteria for a "physical intervention" in these standards of care is that adolescents must demonstrate gender non-conformity and gender dysphoria. This standard is in place to make sure the medical apparatus does not complete a "physical intervention" when in fact a patient does not desire a "physical intervention." However, this same safety, or check, is not applied to the endocrinologist's other pediatric endocrinology patients. For instance, the doctor describes a cis gender patient in her general pediatric endocrinology clinic, who is frustrated that he has not begun puberty. It turns out that he has a hormonal disorder in which he is not producing (enough) sex hormones. Consequently, the endocrinologist prescribes him testosterone. What is important to note here is that the patient does not need a letter of support from a mental health professional verifying his distress in order to receive medical care.

This cis male patient had to give informed consent with his parents, a standard of ethics in western medicine. So, too, do the patients in the gender clinic. However, the requirement of trans patients to acquire a letter of support in addition to their consent before a medical intervention reveals a sociomedical doubt of their transness. Trans patients are required to obtain a letter of support in order to *prove* their identity. Cis patients visiting the pediatric endocrinology clinic do not need to prove their distress with a psychological acknowledgement that a lack of medical care will maintain their suffering. They are taken at face value.

The necessary predication of a letter of support to the clinic's intervention forces the pediatric trans patient to fall into an enforced normative sequence.

Put differently, these predicative relationships, such as the letter before the intervention, ground and construct the normative sequence. In the gender clinic, many enactments of gender are unimportant to medicine's sequence – legal name change, how one cuts one's hair, wearing a binder – but the predicative relationship of enactments bring a sequence into being.

Holding cis and trans patients against one another, it is clear that the letter of support enacts transness because there is doubt. Yet the letter also enacts transness in the face of doubt. These two readings of the letter's enactment are not mutually exclusive. Transness is enacted in the letter by a patient, a psychotherapist, and the clinician who requires the letter. This is done because of the high epistemological stakes of gender in societal systems such as biomedicine, the law, the household, etc. (Butler 1990; Kessler 1990; Spade 2006). Transness is held as an epistemological challenge to the gender binary, and thus is doubted and regulated (Plemons 2010; Spade 2006). However, the gender clinic also requires a letter of support in the face of this doubt. The endocrinologist and clinical social worker are invested in and committed to the trans community. In interviewing the clinical social worker, she stresses that she knows "that medicine has not always been kind to that entire population, not just trans, but to LGBT+ together… [W]ith such a marginalized population, I could understand how hard it would be to gain their trust. And trust was really important to us, because once you gain their trust you don't want to fail them… especially with minors, which is a very new, very controversial concept and treatment." Thus, by requiring a letter of support and following the international standards of care, the clinic is ensuring that medical care can be provided to these trans children, despite societal doubts about their existence. Doubt engenders predication, but an insistence on predication keeps the clinic open.

Other relations of predication beyond the letter of support construct a normative sequence within the gender clinic. For example, a patient must begin puberty before they can receive blockers.

> *It's immediately clear that Eric is shy when I follow the endocrinologist into her first consult of her afternoon clinic. Eric slouches in his chair, answering questions with a deep shrug so that his shoulders nearly reach the pink tips to his short brown hair. Eric's mother reports to the doctor that Eric started feeling pain in one of his nipples, so they went to their family doctor who confirmed breast development was beginning.*

> *"After the pediatrician said it was the beginning of puberty, we made the appointment with you." Eric's mom says. "You told us to come if we saw signs of puberty."*
> *"How long ago did this start, Eric?" the endocrinologist asks. Eric shrugs, but his mom answers, "Two months."*
> *"Do you want to stop breast development?" the doctor asks. Again, Eric shrugs.*
> *"Honey, you have to voice up and let us know what you want," Eric's mom tells him.*
> *"I don't want to do anything you don't want to do," the doctor says, scrubbing in for the physical exam. "Do you want to have your breasts continue to grow?" the doctor finally asks pointe blanc.*
> *"No, I don't want my breasts to continue growing," Eric says.*
> *After the physical exam in which the endocrinologist confirms that breast development – female puberty – has begun, she tells Eric and his mom, "Well if we don't want the breast development to proceed, with blockers we have a plan. We can do injections, patch, or we can do the implant."*
> *"Remember that implant we saw at our last visit?" Eric's Mom asks him. He nods a yes, and says he'd rather do the implant than the shots.*
> *After our goodbyes, the doctor and I return to the workroom where she orders labs for Eric and a referral for the implant to be put in. She begins dictating her notes with, "Patient is tanner 2, so we can begin puberty suppression."* [5]

For Eric breast development, a bodily enactment of female, must predicate a medical intervention to stop such bodily enactments. The gender clinic requires that all patients who receive blockers begin mis-gendered puberty. This is why they inform patients (and their caregivers) to look for the first sign of puberty and then schedule an appointment.

Like the letter of support from the psychotherapist, the gender clinic establishes this predicative relationship to dispel doubt. The common challenge to pediatric gender clinics by critics is that children and adolescents are not mature enough to make informed decisions about procedures and interventions that have permanent consequences, which hormone treatment does. Consequently, the endocrinologist references 'cognition' as the basis for requiring patients to begin a mis-gendered puberty before they can begin blockers. This 'cognition' signifies a patient is mature enough to offer 'assent' to

5 Tanner stages are stages of puberty on a scale of one to five, with one being pre-pubertal, and five being full pubertal maturity (Marshall and Tanner 1969; 1970). Of note, puberty blockers must be administered before tanner stage three, and early bodily changes in puberty can recede if blockers are administered early in puberty.

blockers (the parent must still offer 'consent') and has rejected their natal sexed puberty. The doctor explains that there is no physiological necessity to wait for puberty to begin; rather, the mis-gendered puberty is a tool that confirms the patient's rejection of a past gender and desire for a gender transition. In short, puberty becomes a litmus test. Thus, though Eric may have wanted to begin blockers at previous visits, he was told that he had to wait until he (or his mom) saw the first signs of female puberty.

Transness comes into being in this predicative relation between mis-gendered puberty and blockers. The bodily enactment of female gender as breast tissue, and the enactment of blockers as the absence of gender are practices that cross Eric's body. As I argued previously, a reality of transness is enacted as these practices are held in conflict. Moreover, we see a 'transition' in their sequencing. Eric transitions *from* female *to* male when these enactments – past, mis-gendered enactments; his current enactments of gender; and future, ideal enactments – are done in sequence. Predicative relationships establish this normative sequence: a letter of support always predicates medical intervention; a mis-gendered puberty always predicates blockers.

Khalif, the youngest trans- patient I meet in the clinic, is not considered for blockers during his visit because he has not started puberty. Logan must obtain a letter of support before the endocrinologist will prescribe him hormones. Eric begins blockers only now that he has had some breast tissue growth. All of these patients will have to wait until they are sixteen years old to begin HRT, and, per standards of care, will need a second letter of support to undergo any surgical procedures when they are eighteen or older. To participate in the gender clinic's intervention, Khalif, Logan, and Eric must fall into the normative sequence established by predicative relationships between ontologies of gender.

While predication can be thought of as a coordination of multiple realities of gender, sometimes various enactments conflict. One enactment may obstruct one specific reality of gender or transness from being enacted, or one reality may take preference in certain spaces, obstructing another from view.

An example of one of the simplest instances of obstruction in the clinic occurs, when a patient has their blood drawn to test hormone levels—testosterone and estrogen, most importantly. Vials of blood are taken to a lab, a space outside of the consultation and work rooms of the clinic, where they are analyzed. The vials of blood do not return to the clinic; instead, concentrations of hormones are sent back as test results. When looking at these hormone levels on her computer screen (all of the tests are reported digitally in

the electronic medical health record), the doctor does not see a patient's social transition. Haircuts and clothing, pronouns and binders do not appear in the blood test. Blood test results – gender as hormone concentrations – obstruct many other enactments of gender from view.

Now, of course, this can be done in reverse and across many other gender-enactments. The clinical social worker's intake packet tells nothing of a patient's chromosomes. Gender enacted as hormone levels are obscured from a psychotherapist's letter. There are also times in which certain enactments of gender don't simply obstruct another enactment from view, but rather preclude other enactments of gender from coming into being. Such obstruction can be leveraged for clinical purposes – for example, blockers occlude an unwanted pubertal path – but it can also cause violence. Lily offers an example of this:

> *I meet Lily, a cheery middle schooler, at their first appointment at the gender clinic. They have a soft-spoken nature and cross their legs tightly when sitting on the exam table. Lily identifies as gender fluid and uses they/them/theirs pronouns; however, they tell the doctor they would like to "transition to female" and use she/her/hers pronouns in the future. This desire is why they are at the clinic, now.*
> *The doctor is the first to see Lily. The consult begins with the doctor asking Lily about her gender identity and why she has come to the clinic. She then asks questions that are couched both as ways to build rapport and gain an understanding of the Lily's life and gender expression outside the clinic. "How is school?" the doctor asks Lily.*
> *"Um… Alright, I guess. I've got some friends, but I get teased," Lily says sitting on top of the exam table.*
> *"The school isn't great," Lily's mom adds from her spot sitting on a chair in the corner. "They're not very supportive. Lily can't use the bathroom she would like, and the teachers and administration don't do enough to stop the bullying. The teachers still call Lily by their male name and don't use the right pronouns."*
> *"And are you out at school?" the doctor asks.*
> *"No. We talked to the school about using my name and pronouns, but they weren't supportive," Lily responds.*
> *"Lily and I have talked about this and we decided it will be best for them to wait to transition and come-out at school until they go to high school," Lily's mom says.*
> *"And how do you feel about that, Lily?" the doctor asks, "Is that ok for you?"*
> *"Mmm-yeah," Lily answers.*
> *The doctor turns from Lily for a moment to write this in her notes on the computer. The doctor then asks, "And how are things at home?"*

Lily and their mom explain that Lily's father is "not on board". That he thinks Lily's trans identity will "turn Lily's younger sister trans, too." That he won't use Lily's chosen name, or the gender-neutral nickname the family came up with. Lily's mother is supportive: she's brought Lily to the clinic and always uses Lily's pronouns and chosen name, but she feels torn between her husband and her child.
When we leave the consultation room and return to the workroom, the doctor briefs the clinical social worker on the consult. She reports Lily's name and pronouns, goes over some of their medical history and the medical exam – that they have started puberty, but are still in the early stages, so blockers will still be effective – and recounts Lily's experience at home and at school. The doctor ends by saying, "They're a good candidate [for treatment], except for their dad."

Here, Lily's father linguistically enacts maleness onto Lily by continuing to use a male name and male pronouns when speaking about them. By not recognizing Lily's chosen name and pronouns, Lily's father is blocking, obstructing, a relational linguistic enactment of Lily's gender fluidity (and femininity) from coming into being. Furthermore, because of Lily's father's legal power over them, his use of male pronouns and rejection of Lily's gender identity can obstruct other realities of gender. This is why we hear the doctor say, "They're a good candidate except for their dad". Lily's father's linguistic enactments of maleness could cross Lily's body and obstruct the sequence of gender affirming enactments the gender clinic provides for its patients. In fact, it is possible that if Lily cannot access gender-affirming care, Lily may miss the window to begin puberty blockers (before tanner stage 2) and their body will further corporally enact maleness in permanent ways – bone development, voice deepening, facial hair – as puberty progresses. Thus, Lily's father's use of former pronouns and names upholds its own sequence, one antithetical to Lily's gender identity, but one that, because it is imbued with power, has the ability to obstruct the realities of their gender Lily would like to enact.

Luckily for Lily, only one parent is required to provide consent for blockers. In turn, Lily is given a prescription for blockers and told to return in four months to monitor their hormone levels. Yet if Lily had been older and seeking HRT, the gender clinic would be more hesitant to prescribe HRT. In Lily's case, the benefit of blockers is that they have no positive effects: they will only stop puberty from beginning, rather than provide the 'feminizing effects' estrogen does. However, because of Lily's father's rejection of their gender identity, because of his enacting male with "he", Lily could be put in danger – harassed or kicked out of their house by their father – by taking estrogen and beginning

a positive, medical transition. The gender clinic would not start Lily on HRT until they had Lily's father's consent and it was safe for Lily to begin a medical transition.[6] In this case, we see a masculine enactment, "he", obstructing enactments of femininity and gender fluidity – such as estrogen concentrations in Lily's blood, breast development, and fat redistribution – from coming into being.

Lily also experiences mis-gendering at school. Enacting gender as names and pronouns requires at least two actors: in this case, Lily and a teacher or the school administration. In refusing to participate in the linguistic enactments of Lily's gender as gender fluid or female, the school forecloses relational and social realities of gender fluid or female from being enacted, instead perpetuating Lily's enactment as male. "He" again obstructs gender fluidity and femininity enacted as "Lily" from coming into being.

Yet a medical transition would not necessarily be obstructed by the school's mis-gendering enactments. The school does not have the same power over Lily as their father does. In fact, while the gender clinic would never begin a medical transition if it thought doing so would put the patient in harm's way, the gender clinic applies its normative sequence so as to alleviate the violence a patient receives from society. The clinical social worker explains to me that the gender clinic is treating an incongruence between the patient's "body not matching their inside," but also "society saying that you're not normal." That is, the clinic understands that in some social spaces – such as schools – a dissonance between gender enactments, for instance a female name and pronouns and male skeletal shape and hair distribution, can place a child or adolescent at risk of violence.[7] Consequently, the gender clinic provides care that allows patients to bring bodily enactments of gender into reality under a logic that aligning the body with one's gender identity and expression decreases one's risk of violence.

The comparison of the possible violence of Lily's family and Lily's school leads to a critical point. The normative sequence of the gender clinic imagines a normative trans- subject, but it also expresses an assumption about where violence occurs: in society; that is, schools, extra-curricular activities,

6 In such cases, the clinic, especially the clinical social worker, would work with the family until it was safe for Lily to begin hormones.

7 While there are numerous high-profile cases of such violence, the recent work of Gayle Salamon, *The Life and Death of Latisha King: A Critical Phenomenology of Transphobia* (2018), offers in-depth scholarly coverage of one such case.

public spaces. However, Lily demonstrates that while violence can be societal, it is also intimate. That is, violence can come from one's own family. This is a violence that the normative sequence of the gender clinic cannot account for. It is an intimate violence of obstruction that causes a break, a pause, a block, a rupture in a child or adolescent's transition. The irony of the gender clinic's sequence is that a parent's support is necessary for a patient to enter the space of the clinic and for the sequence to even begin. Though the gender clinic aims to alleviate violence against trans youth, its normative sequence precludes those most at risk of violence – trans children with unaccepting parents – from accessing its services. In the context of trans youth suicide, this irony of the gender clinic's intervention assumes a morbid nature.

Lily's story is accordingly unlike that of the majority of patients in the clinic. Most have two supportive parents: an (at least mostly) accepting relationship between parent and child is what brings the patient to the gender clinic in the first place. Minors cannot make doctor's appointments without their parent's support, nor can they give consent.[8] Put plainly, children with unaccepting parents are rarely seen in the gender clinic. Thus, Lily's case reveals the original predicative relation of the gender clinic: the cooperation of parent and child must predicate the initiation of the gender clinic's sequence. Lily allows us to see the genesis and the morbid irony of the gender clinic's sequence.

While the relationship of obstruction exhibits how enactments can (permanently) forestall both sequences and other enactments from coming into existence or being seen, the relationship of justification has a converse effect. Justifying relationships accelerate the normative sequence of the clinic.

Beginning HRT is the point where justification most prominently comes into play because HRT is a point of predication (16 and having a letter of support) that has some 'wiggle room'. Most of the predicative relationships within the gender clinic follow strict rules: a patient *must* have a letter of support to begin hormone therapy or blockers; patients *must* have a second letter of support, have had twelve months of hormone therapy, and have lived twelve months openly as their gender identity before they can have gender affirmative surgeries (Coleman et al. 2012). However, the requirement that patients be at least sixteen years old before they are allowed to begin a hormone therapy

8 A court order can supersede a parent's lack of consent. This happens in the clinic when the care team believes the patient is at risk of suicide if the patient does not receive medical assistance with their transition.

has variability. New 2017 Endocrine Society practice guidelines state, "there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD [Gender Dysphoria]/gender incongruence" (Hembree et al. 2017). While the standards offer thirteen and a half to fourteen years old as an earliest age to begin "sex hormone treatment," the pediatric gender clinic I study takes a more conservative approach, allowing some patients to begin receiving HRT at fifteen years of age.

In these cases, some outside factor, some other enactment of gender, allows the patient to enact gender as hormone levels and all of its consequent corporeal enactments sooner. Hormones produce some permanent changes. Consequently, the gender clinic follows the *Endocrine Society* guidelines, which state patients should only receive hormone treatment before they are sixteen years old if they have "sufficient mental capacity to give informed consent" (Hembree et al. 2017:3870). The logic of accelerating care, though, does not track in the gender clinic solely as a "mental capacity to give informed consent." Rather, the doctor might prescribe hormones when a patient is fifteen if she and the clinical social worker also "know" the patient is trans. This relation is labeled justification because the patient or an outside event must validate this "knowing" against any potential doubt in the patient's trans identity. That is, the patient must prove that they will not, as the social worker tells me, "desist from their cross-gender identification," in order to justify beginning hormone therapy early. In the current political climate[9] that surrounds trans children, desisting could lead to negative publicity for the gender clinic, causing it to limit its activity or even shut down. As such, "knowing" becomes a necessary justification for acceleration, in order that the clinic may continue to provide care for trans children and adolescents into the future.

Most of the clinical encounters that I observe in which "knowing" cumulates in beginning hormone therapy at age 15 rather than 16 are characterized by joy from the patients. They beam, ecstatic that a dream of theirs is

9 Political attacks on trans youth have taken on a chimeric form in the United States. Many of these laws, either proposed or ratified, have challenged trans children and adolescents' existence within public spaces. For instance, multiple states have challenged trans young people's use of bathrooms that align with their gender identity (Kralik 2019) and stopped trans youth from competing on school sports teams (GLSEN 2019). In 2020, a wave of states proposed laws against gender affirmative care for trans children and adolescents (Lam 2020). Being denied access to bathrooms associated with their gender identity and gender-appropriate college housing has been associated with increased suicidality (Seelman 2016).

coming true, and that a year of waiting has disappeared. Yet the calculus of "knowing" is never outright described. It appears often in the clinic, but its logic is left amorphous. The doctor tells Kalif's mother that hormone replacement therapy normally starts at 16 years old at the earliest, but if "we *know* the child is trans, we can start hormones earlier" (emphasis mine). She tells another patient and her mother, "We begin patients on gender affirming therapy [HRT] at 16, but it's possible to begin estrogen before 16 when we really *know*" (emphasis mine). There is no rubric or scale by which the clinic attempts to measure the transness of its patients. In fact, numerous times, the doctor and the clinical social worker stress to me—and also demonstrate with their actions—that they do not have an agenda for what a transition should look like, where it should end, or how a patient should identify and express themselves. Instead, it appears "knowing" is grounded in a trust between the patient and the gender clinic. Though not explicitly stated, this trust is founded upon compliance and consensus. Compliance insofar as the patient must be a 'good patient', one who makes their appointments, has their letter of recommendation, goes to therapy, etc.[10] And consensus between actors – therapists, parents, the social worker, the doctor – that the patient understands the risks and benefits of hormone therapy and does not doubt their gender identity. When all of the parties agree, when the gender clinic "knows" the patient is trans, the sequence can be accelerated so HRT can begin.

One patient, June, is told she can begin HRT when her father informs the doctor that June competes in trampoline gymnastics, and she may be qualify-

10 Racial and ethnic differences in compliance have been shown for various treatments, but it is unclear "whether they are due to differences in the way patients are treated or advised, in the cultural background of each patient, or in other factors" (Bulatao and Anderson 2004). While I did not observe any racial bias in the gender clinic, people of color are known to experience bias within medical settings that often leads to worse "patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes" (Hall et al. 2015). We also know that racial bias leads to less treatment and acknowledgement of people of color's pain as compared to white patients (Meghani, Byun and Gallagher 2012; Hoffman et al. 2016). Knowing that people of color may need to 'prove' their needs in medical spaces, it is possible people of color felt they had to especially prove their transness in order to receive medical care at the pediatric gender clinic. While I did not observe patients of color attempt to 'prove' their transness more than white patients, in my interviews and clinical interactions, many patients did express an (later admittedly unrealized) expectation to prove their gender identity and/or their worthiness for trans healthcare before entering the pediatric gender clinic.

ing for the national championships this year. She needs to meet the Olympic standards for testosterone levels to be able to compete in the women's category. This enactment of June's gender, competing in the women's category, justifies beginning estrogen therapy before June is 16 years old. "Knowing" is present in June's clinical visit, though the word is never said. She is one of the care team's favorite patients (they tell me so), and the care team views her as a compliant patient. If the consensus of June's gender from this outside actor is founded on certain hormone levels, and the gender clinic 'knows' June as trans, then extending this 'knowledge' justifies beginning estrogen therapy early.

Further evidence of "knowing" as justification for beginning HRT therapy early can be found in the contrapositive cases: when the doctor and social worker feel a patient should not begin hormone therapy early. There are not many patients the care team feels, who must wait until they are 16 to begin HRT, but Aaron offers an example of one:

> *I meet Aaron when I observed his clinical visit; however, I am not able to observe his time with the clinical social worker. When the care team reconvenes in the workroom, the clinical social worker asks in regard to Aaron, "Taking testosterone increases your risk of stroke, right? Both his father and his grandfather died young because of stroke. So, I asked him, 'How are you going to deal with that risk?' Aaron said he would eat healthy and exercise, but then I asked him, 'Didn't your dad also eat healthy and exercise?'"*
>
> *By the end of their discussion, both the doctor and the clinical social worker agree that Aaron "is a patient we should really wait until 16 with. He may not have the maturity to understand the risk of taking these hormones and we need to wait until he understands the risks more."*
>
> *A training clinical social worker then asks the clinical social worker, "Is the patient immature?"*
>
> *The clinical social worker replies, "Aaron isn't immature for a natal male, but he is immature for a natal female."*

All of the staff of the gender clinic address Aaron by his male name and use he/him/his pronouns – the ones he told them he uses. They accept Aaron as trans and don't visibly doubt his identity. At the same time, the doctor and the clinical social worker are not convinced Aaron "gets the risk of" and can provide informed consent for the medical intervention he wishes the undergo. 'Maturity' is obstructing an acceleration of the clinic's normative sequence.

The clinical social worker also states that at Aaron's age, natal females should be mature, whereas natal males are immature. In a sense, Aaron's immaturity should enact male, then. He is meeting medicine's epistemological understanding of maturity and development for the male sex. However, the conclusion the gender clinic reaches is because Aaron's assigned sex at birth is female, and because he is not mature when a female should be mature, he is developmentally behind and cannot give consent. While the care team would never explicitly doubt Aaron's gender identity, in employing Aaron's natal sex to establish his maturity, the clinical social worker and doctor continue to enact femaleness in Aaron. This enactment of female breaks a potential consensus of actors enacting maleness with Aaron. There is still some doubt with female still being done, still present. Therefore, through the language of maturity and informed consent, the gender clinic does not fully 'know' Aaron is trans, and he cannot accelerate his transition.

In sum, Aaron's and June's stories demonstrate that the relationship of justification accelerates the normative sequence of the clinic. This acceleration is unobtainable to Aaron and other patients, for whom a consensus of 'knowing' cannot be reached, or for those who are considered non-compliant patients. Acceleration takes advantage of the changing recommendations of when to begin hormone therapy, but it must be justified because the clinic is betting against patients "desisting from their cross-gender identification." In short, gender enacted as the clinic 'knowing' a patient's gender identity justifies accelerating the normative sequence and prescribing HRT before the age of sixteen.

Conclusion

In this chapter, I have explored the ontology of gender and transness within a United States pediatric care clinic and employed this exploration to examine the temporal sequence of gender transitions. While engaging ethnographic data, I outlined the ways in which Mol's theory of "ontology as practice" can be applied to a pediatric gender clinic. Realities of gender come into being through practices, and trans ontologies appear in the conflict of gender ontologies, often through temporal rupture. Building on this, I explored through vignettes how predicative relationships between enactments construct the normative sequence of transition within the gender clinic, and how obstruc-

tive and justifying relationships slow, halt or accelerate this normative sequence.

Within the framework of relationships between enactments I elucidate the original predicate of the pediatric gender clinic: that the patients of the gender clinic must have their parents' support to access its resources—an assumption of the location of violence, and in turn, a morbid irony. The gender clinic aims to mitigate violence against trans youth by providing affirming medical care; however, this original predicate forecloses access to the gender clinic's resources to those trans children experiencing the most intimate of violence. Said differently, the normative sequence cannot account for the intimate violence that trans youth without supportive parents experience by being precluded from accessing the gender clinic's resources.

Mol closes her book, *The Body Multiple* (2002), by asking "What reality should we live with?" (Mol 2002:165). While not directly taking this question on, this chapter allows us to see that the gender clinic's normative timeline has a utilitarian value, but also strands in relation to structural and intimate violence as a predicate to entering the clinic's doors. Thinking about the open-ended relationship of the term 'trans', how might the gender clinic build coalitions of care with actors beyond the hospital walls to reach and support those trans youth precluded from its care (Stryker, Currah and Moore 2008)? And how might the clinic make space for trans youth enacting realities not accounted for within its normative sequence? Trans youth both within and outside the normative timeline of care are navigating shifting landscapes of predication, obstruction, and acceleration. With its seat within biomedicine, the pediatric gender clinic has the power to shape what realities they and we should live with.

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