

THINKABLE FUTURES, PERMISSIBLE FORMS OF LIFE: LISTENING TO TALK
ABOUT TRANS YOUTH AND EARLY GENDER TRANSITION

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By

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LAY ABSTRACT

We are in a time of expanding futures for transgender youth who are able to “buy time” by blocking puberty and transitioning to a new gender while young. Clinical research and literature suggest this as a lifesaving option for trans youth, allowing them to avoid distress and harm. Yet there remain troubling disparities with this treatment. Many clinics report they are primarily serving white middle class trans youth and there are some indications that autistic trans youth may be stalled or delayed in the process. I report on a discourse analysis of 18 interviews with health and mental health clinicians across six countries, in addition to 10 interviews with community level experts. I draw on a range of theory and an “interpretive repertoire” analysis to theorize how these futures become thinkable and possible for trans youth, while considering the political implications and unforeseen consequences for those youth unable to benefit.

ABSTRACT

This is a time of expanding futures for transgender youth who are able to “buy time” by blocking puberty and transitioning young. Twenty years of clinical literature indicates that suppressing puberty can be lifesaving for trans youth, allowing them to avoid the distress and harm associated with transgender lives writ large. A growing number of “gender affirming” clinics now offer young trans people greater autonomy over their bodies, their futures, and their future bodies. Yet there remain troubling disparities, with indications that clinics are primarily serving white middle class trans youth and that autistic trans youth face delays. This thesis is a discourse analysis of 18 interviews with international health and mental health clinicians and 10 interviews with key stakeholders. Drawing from the literature of queer temporalities, sociological work on time and social power, queer and trans of colour critique, critical disability studies, critical autism studies, and transgender studies, I use an “interpretive repertoire” analysis to ask: How have puberty suppression and early gender transition become thinkable futures for trans youth? This thesis finds that the conditions of possibility that make early transition possible for some, are the same that foreclose it for others. The discourses of maturity and cognitive age, the expected “chrononormative” narrative, and the discourses of crisis and the “race against time”, each work to make outsiders of autistic and racialized trans youth in particular. While there is much to celebrate in the new futures available to trans youth, I argue that puberty blockers currently function as a “switchpoint” moving privileged trans youth onto a track toward even greater privilege, and widening the gap in life opportunities. This thesis introduces the concept of “the

temporality of privilege” and calls for greater attention to the political implications augured by the contemporary scene of gender-affirming care for trans youth.

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LISTS OF ABBREVIATIONS

APA	American Psychiatric Association
CAS	Critical Autism Studies
CDS	Critical Disability Studies
CPATH	Canadian Professional Association for Transgender Health
DSM	Diagnostic and Statistical Manual
EPATH	European Professional Association for Transgender Health
QTCC	Queer and Trans of Colour Critique
WPATH	World Professional Association for Transgender Health

CHAPTER ONE: INTRODUCTION

“Time passes. That’s for sure.”
– Eileen Myles

Background

In the 1960s, gender variant children (primarily those identified by adults as “feminine boys”) began to be seen in US clinical settings in the hopes of preventing them from coming to embody the “devalued adult outcomes” of transsexuality or homosexuality (Bryant, 2011, p. 37). Psychiatrist Richard Green hopefully remarked: “My focus will be on what we might call the prevention of transsexualism” (1971, p. 167). When a rationale for “reparative” treatment was required, it came by way of associating transsexuals and homosexuals with the bad futures of unemployment, exclusion, violence and suicide, essentially social and literal death (Rekers et al., 1977). Yet in 2017, vis-à-vis puberty suppression techniques and other medical interventions, the youth gender clinic now facilitates rather than forecloses trans life. The same grim futures are used to argue for, rather than against, transition. Once deferring trans identity, the gender clinic now confers it, though importantly, not for all. This study is an exploration of the discourses that make these futures and forms of life thinkable and possible for trans youth, an inquiry into *which* trans youth gain access to these futures, and a meditation on the political implications, the unforeseen and unseen consequences.

In 2012, I wrote that trans children were unintelligible (Pyne, 2012). Six years later, this is clearly not the case. In the growing media coverage on trans youth, one can witness a shift toward the depiction of trans in hopeful terms, as promising, life-affirming,

future-oriented. Trans children in particular are described in the media as “inspirational” (Diblasi, 2015). Yet this occurs alongside the steep rise in the criminalization and murder of young trans women of colour (Democracy Now, 2014). For their part, parents once participated in large numbers in therapies intending to extinguish their child’s non-conformity (Rekers, 1972). While there remain many parents who struggle and even reject a trans child, an attitudinal shift is evident. In 2002, clinician Bernadette Wren wrote of her efforts to encourage parents to accept their child’s transition in the face of comments like: “Oh, so I’ve given birth to a monster, have I?” (Wren, 2002, p. 383). Yet 13 years later, Wren (2015) describes being threatened by parents who feel she is not facilitating these procedures fast enough for their child. A shift toward greater autonomy for trans youth can be seen, epitomized in the phrases “the child-taught parent” (Hill & Menvielle, 2009) and “letting them lead” (Jess, 2014). Yet this too occurs alongside clinical controls on autistic youth who seek transition (Parkinson, 2014), and the public depiction of autism as an anti-inspirational stand-in for social death.¹ It is necessary to theorize the paradoxical opening of some trans futures against the closing of others (Gossett, Stanley & Burton, 2017).

Since the early 1990s, a technology available within pediatric endocrinology (gonadotropin-releasing hormone analogues GnRHa or “puberty blockers”), has been used to halt the pubertal development of trans youth for up to several years at a time (Kreukels & Cohen-Kettenis, 2011). Addressing the immediate distress of a body felt to

¹ A 2007 awareness campaign featured a “ransom note” written by autism: “We have your son. We will make sure he will no longer be able to care for himself or interact socially as long as he lives” (Kras, 2010).

be developing in the “wrong” direction, puberty suppression is also said to facilitate a future transition by preventing bodily growth that is difficult or impossible to later undo (Spack et al., 2012). The reduced visibility this affords is said to lessen the difficulties faced as a trans adult, and thus enhance future wellbeing (Kreukels & Cohen-Kettenis, 2011). Vis-à-vis newly forming youth gender clinics, as Roen (2011) notes, the use of puberty suppression to facilitate trans futures has gone from a rare occurrence to an institutionalized best practice. Despite ongoing controversy, within the past ten years, the number of families who present at youth gender clinics has increased ten-fold, though predominantly white and middle-class families.² The opening of these new futures, for some, necessitates returning to the still recent time when this was unthinkable, to understand the progression of trans youth to, as one media headline put it: “Finally Normal” (Shapiro, 2015).

The research questions I aim to pursue in this study include: How have puberty suppression and early gender transition become thinkable futures for trans youth? What are the conditions of possibility (on the socio-cultural level and in the clinical moment) through which this “form of life” becomes permissible? (Sekuler, 2014). For whom are these futures thinkable and permissible and for whom are they not? While puberty suppression and cross-sex hormones are not the same intervention, I focus on both as each raises unique anxieties. Talk of puberty suppression and early transition occurs in multiple realms, however, this project focuses on youth gender clinics and the accounts of clinicians working in these clinics, as sites where meanings around gender are currently

² Personal communication, Dr. Greta Bauer, March 2015

being “worked out” (Valentine, 2007). Theories of time and temporality (queer and otherwise) provide the foundation of this inquiry.

Review of Clinical Literature

While media critics have both celebrated and denounced the practice of puberty suppression and early transition for trans youth, the primary literature referencing the phenomenon is European and American clinical literature, the subject of this review.

The earliest clinical literature referencing those who failed to comply with gender norms emerged from 19th and early 20th century European sexology, organizing these individuals into amusing taxonomies of aberration (Krafft-Ebing, 1877/2006). At a time when deviating from gender norms was against the law in Europe, sexology as a discipline formed partly in response to the gender non-conforming figure, rescuing “inverts”³ from the courts and placing them under the control of those to whom they rightly belonged: the clinician. Through an analysis of popular literature that spanned this era, Grant (2004) traces shifts in the politics of gender and child rearing, as well as the emergence of the new science of human development, all of which worked to transform the “sissy” from a 19th century moral failure into a 20th century clinical problem.

The study of gender non-conforming children in North America was institutionalized in the 1960s (Bryant, 2006) and the clinical literature grew from the 1970s onward. Clinicians published reports from psychotherapy (Stoller, 1970), group therapy (Green & Fuller, 1973), behaviour modification (Rekers, 1972), as well as short-

³ Inversion was a term of sexology from the late nineteenth and early twentieth century, referring to homosexuality, thought to be an in-born inversion of male and female traits.

term outcomes (Green, Newman & Stoller, 1972), long-term outcomes (Green, 1987) and rationales for treatment (Rekers et al., 1977). Much of this writing stated or assumed that homosexuality and transsexuality ought to be prevented and that childhood was a time when this intervention might be possible. Richard Green (1971) wrote: “I believe an effort should be made to make a psychiatric intervention during a life period in which gender misidentification may be reversible...” (p. 167). Clinicians also produced scholarship suggesting that both gender non conforming young people and their parents were psychologically compromised (Stoller, 1968).

Some of the clinical writing of this time spurred protest (see Winkler, 1977), as did the 1980 entry of the *Gender Identity Disorder of Childhood* (GIDC) diagnosis into the Diagnostic and Statistical Manual (APA, 1980; see Bryant, 2011). The alternative sense-making of this protest literature was often feminist and gay-positive, yet importantly not trans positive, with authors defending children against pathologization on the grounds that they were likely “proto-gay” and thus not truly disordered [for example, not proto-trans] (Bryant, 2008). Thus, some of the first public defenders of gender non-conforming children seemed to agree with the very clinicians they critiqued on at least two matters: that a transsexual outcome would be problematic; and that the matter of chief concern was who these children would become in the future. Where protest literature did in fact protest, was over the issue of whether gender non-conformity was a problem. While pathologizing clinicians assumed yes, their critics argued no in order to fend off diagnoses and unwanted interventions on proto-gay children (Corbett, 1999; Pickstone-Taylor, 2003). This pattern of refusing problematization later reversed itself

with the advent of early transition technologies – a development that required advocates to articulate a problem to justify this *wanted* intervention.

The practice of administering puberty blocking hormones for trans youth got its start with clinician Henriette Delmarre-van de Waal in the Netherlands in the early 1990s. The first youth to whom she offered blockers at age 13, then presented to a gender identity clinic for assessment to transition at age 16 (Cohen-Kettenis & van Goozen, 1998). The first publication reporting on the practice of puberty suppression retained the focus on future outcomes from previous pathologizing literature, yet also marked new ground by expressing concern for the stated “small” number who would grow up to be trans (Gooren & Delemarre-van de Waal, 1996). Indeed, the concerns of trans youth are somewhat present in this writing, including the now obvious assertion that it is “distressing” to develop bodies at odds with their identities. Likewise, the use of “transgendered” is notable, as this was relatively new in the 1990s, and clinical literature had thus far described trans women as “homosexual male transsexuals.”

With the seminal publication of this clinical field, Gooren and Delemarre-van de Waal (1996) laid out a quasi-blueprint for the discursive terrain that would unfold. They described blockers as “fully reversible” and able to “buy time” (p. 72). They made discursive gestures to trans suffering, including the goal of sparing transsexuals from their “plight” and the “torture” of the “wrong body.” Gooren and Delemarre-van de Waal (1996) also laid the groundwork for the professional project of managing trans children and youth, a project now in full swing: “It goes without saying that eligibility for

hormone treatment by transgendered juvenile persons can only be the outcome of long-term observation by experts in the field” (p. 70).

Dutch literature regarding puberty suppression emerged steadily from the late 1990s onward. Dutch clinicians and researchers quickly published a follow-up study on the first case of puberty suppression (Cohen-Kettenis & Van Goozen, 1998), and many more publications regarding their protocol which required youth to have “lifelong consistent and extreme GID” (Cohen-Kettenis et al., 2011, p. 843), appearing at a young age and worsening with puberty. In addition, this literature stated that youth required parental support and psychological stability. This “stability” often meant no other mental health diagnoses to “complicate” matters (Cohen-Kettenis, Delemarre Van de Waal & Gooren, 2008), but sometimes meant achievements as specific as “doing well in school” (Cohen Kettenis & van Goozen, 1998, p. 265). Dutch clinical literature also contained the rationales for treating early, which included the low risk of blockers due to their “reversibility”, the prevention of distress at the onset of puberty, the facilitating of a post-transition body to avoid harassment and violence (Cohen-Kettenis, Delmarre Van de Waal & Gooren, 2008, p. 1894), and the prevention of need for future surgeries. While the phrase “buying time” is frequently used to describe the benefit of blockers, it is clear in Dutch writing that the time being bought belonged to the clinician for more evaluation.

The Dutch literature indicates adjustments in their protocol over time, but the discourses used to depict this treatment and the youth who receive it, have remained relatively constant. Phrases such as “strict conditions” (De Vries & Cohen-Kettenis 2012, p. 315), “strict criteria” (Smith et al. 2001, p. 479), “carefully selected” (Cohen Kettenis

& van Goozen, 1997), “careful diagnostic work” (Cohen-Kettenis et al., 2011) and “rigorous study” (Cohen Kettenis & van Goozen, 1997), make clear a number of professional priorities and affects. Youth who are not approved for surgery are described in one study with terms such as “confusion”, “unstable”, “psychopathology”, and “problematic” (Smith et al., 2001). In a follow-up report about one youth who was approved, the word “normal” appears 17 times in four pages (Cohen-Kettenis et al., 2011). In another, the term “functioning” appears 30 times in eight pages (De Vries et al., 2014). Indeed, Dutch follow-up studies reporting on “psycho-sexual outcomes” (Wallien & Cohen Kettenis, 2008), outcomes from youth sex-reassignment surgery (Smith et al., 2001), the choice to pursue transition or not (Steensma et al., 2010), gender dysphoria after puberty suppression (De Vries et al., 2011), and psychological outcomes (De Vries et al., 2014), reveal much beyond the stated goals. In a contested area, follow-up studies helpfully justify controversial treatment, yet precisely because of that, also have much to teach about what precisely serves as justification.

Literature and practice developed in other regions in relation to the Netherlands, yet often on an altered timeline. In the UK, the Royal College of Psychiatrists issued a report in 1998 that made recommendations regarding treatment for gender non conforming children, leaning heavily toward caution and delaying any medical treatment “as long as it is clinically necessary” (p. 5). The report itself is so brief and devoid of research or literature that it is somewhat unclear how it came to be. In another report that would seem to be a reply, Whittle and Downs (1999) imply that the College’s document may have emerged in response to the 1996 airing of a BBC Channel 4 film entitled “The

Decision” (Morse, 1996) which followed several trans adults and one 13 year-old trans boy to the Netherlands to seek care, and in the case of the youth, to seek puberty blockers not available in the UK. Whittle and Downs (1999) note that the film presented the Dutch practices as superior and portrayed happy and more conventionally masculine trans men who had transitioned early in the Netherlands. Whittle and Downs (1999) argued that clinicians in the UK had a legal obligation to provide blockers and issued a recommendation that still has not been implemented 20 years later: that clinicians provide access to blockers unless there is a positive reason not to, and that delay is defensible only if in the best interests of youth. Rather than the conventional approach of advocating caution when providing blockers, Whittle and Downs (1999) instead suggest exercising caution when considering *denying* blockers. Subtly, in their rationale, Whittle and Downs (1999) refer to the time that blockers provide as time for the youth and not for the clinician. They offer similar reasons for blockers as Dutch clinical literature, yet with the added reason of clinician’s avoiding litigation.

Though treatment in the UK seemed to progress and expand like many other regions, the worrying and somber tone of the Royal College report continued in UK literature on this issue, with Viner et al. (2005) issuing challenges to the Dutch protocol suggesting that blockers and early transition were a worry, for many reasons, including uncertain medical effects and the potential inability of young people to make such decisions. Clinical literature from the UK continued to issue these protests against early treatment (Wren, 2000), leaning much more toward the cautious 1998 Royal College report than to Whittle and Down’s (1999) reply.

American clinical literature addressed puberty blockers and early transition much later than European literature. While treatment was already underway in Europe, US clinicians and advocates seemed to be focused on debating the DSM diagnosis of *Gender Identity Disorder in Childhood* (Isay, 1997; Langer & Martin, 2004; Lev, 2005; Winters, 2005) and debating opposing philosophical treatment models, between “reparative therapy” and what came to be known as the “affirming model” which aimed to support youth in authentic expression, whether transition or another path (Menvielle & Tuerk, 2002; Wingerson, 2009). After US clinical literature began to explore the possibility of blockers (Spack, 2005), and after the first American clinic to offer blockers was established in 2007, debate still continued regarding reparative versus affirming treatment (Minter, 2012). After the publication of the international Endocrine Society Guidelines which enthusiastically endorsed puberty blockers (Hembree et al., 2009), and the seventh revision of the international Standards of Care which moderately endorsed them (WPATH, 2011), American literature began to emerge from new clinics opening in Boston, Los Angeles, Chicago, New York, Seattle and the Bay Area.⁴ While featuring the now common discourses of “buying time”, etc., these publications also offered new rationales for allowing access to blockers, such as “gender authenticity” (Ehrensaft, 2011) and approving youth who are “insistent, persistent and consistent” in their desire for transition (Hidalgo et al. 2013, p. 286). The affirming approach now functions as the model in use for many youth gender clinics in North America, with some question as to

⁴ Canadian clinicians, though practicing for decades, have rarely prioritized publishing. This may be because those who practiced early with trans youth, lacked dedicated funds or clinic time and often added this to other clinics with other populations. New Canadian research teams will likely publish going forward.

whether all mean the same thing by this now ubiquitous term. The literature in the field is now extensive, along with trainings and conferences, books and websites. While supportive of transition in general, increasingly literature addresses specific populations described as complex and challenging, often autistic trans youth (Tishelman et al., 2015), whose pathways to transition are a focus of this current study.

Finally, there is the beginning of a critical social science literature regarding puberty suppression, posing queries beyond the concepts of health and mental health, including a critique of “normalization.” For example, although Dutch clinician Cohen-Kettenis is reported to have regularly reassured her students that “... doing research is basically only about counting and summarizing!” (Kreukels, Steensma & De Vries 2013, p. xii), social scientist Katrina Roen (2011) does not agree and critiques the clinical and discursive “production” of trans youth in the Dutch clinic vis-à-vis their research and clinical practice agendas. Roen (2011) proposes that the production of successful trans youth seems to rely on the selection of youth who are already “successful” and criticizes the focus on normalizing post-transition youth as well as the lack of legitimacy for gender uncertainty and instability. In her reply, Cohen-Kettenis (2011) argues that as the first clinicians to attempt this practice, they were wise to be careful in their selection of youth, lest there be a problem that threatens the whole program.

Like Roen (2011), Claudia Castaneda (2015) and Sahar Sadjadi (2013) also critique the normative discourses of puberty suppression and early transition treatment. Though additional literature exists, Castaneda’s (2015) and Sadjadi’s (2013) work is somewhat paradigmatic of a small body of work which, while asking questions similar to

the ones I ask, come to radically different conclusions. Castaneda (2015) analyzes protocol documents such as the WPATH Standards of Care (2011) through the lens of human development questions the value of youth transitioning because development is a “disappointing fiction” (p. 8) and because “the capacity to function effectively and even happily in a social system is not the measure of freedom...” (p. 8). For her part, medical anthropologist Sadjadi (2013) criticizes the liberal use of blockers, charging that the discourses of urgency and disaster inspire fear of puberty itself and sway parents to hastily support treatments with the potential to end youth fertility, which she regards as the truly serious matter. Like the authors, I also decline to view trans youth treatment as the simple march of scientific progress and I also think the social rationales for puberty suppression are of much interest. Yet I disagree with the answers Castaneda (2015) and Sadjadi (2013) offer, essentially that we ought to pause or discourage this practice.

Regarding Sadjadi (2013), I do not share her fears about blockers, and in fact, would note that she creates her own version of the crisis temporality she criticizes when she presents the loss of fertility as a (heteronormative and cisnormative) catastrophe. Trans youth are currently asked what their priorities are regarding fertility, whether to start treatment immediately at puberty and possibly forego future fertility, or to wait for the development of sperm or egg, extract and freeze that tissue, and then begin treatment. There are class issues at play in access to such procedures. However, in suggesting that the priorities of trans youth themselves (stopping puberty), are less important than their fertility, Sadjadi (2013) takes a position that runs counter to the stated wishes of the youth in question. It is unclear how Sadjadi imagines this proposal as a new approach, rather

than a repetition of the patronizing past of trans health care in which clinicians decided what was best for trans individuals, against or oblivious to their stated wishes. In essence, trans youth themselves, as subjects, are missing from Sadjadi's analysis about them.

Regarding Castaneda (2015), when she analyzes the WPATH Standards of Care, she reads a diagnostic description of trans youth and the clinician's procedural recommendation for how their bodies and lives ought to progress. Yet Castaneda (2015) reads this document as if it is a transcript of what actually occurs in the lives of trans youth, rather than an artifact reflecting its authors. While I agree that some clinicians do indeed practice with the goal of creating normal heterosexual binary upright humans on the other end of transition, I trust that regardless, clinicians will likely be thwarted in this goal much of the time. From my vantage point within the community, while some trans lives are ordinary, others are rebellious, and never cease thumbing their noses at societal expectations. Further, there is much evidence that some become more non-conforming after transition, for example, trans men who transition into feminine men, precisely because transition allows for such a possibility. In the end, as Prosser (1998) said of queer theory and post structural feminism, these critics view trans youth as *constructed* subjects rather than *constructing* subjects, and fail to perceive what might be positive about construction (p.8).

Theoretical Framing

This study brings together theoretical threads from transgender studies, critical disability studies, critical autism studies, queer and trans of colour critique, and the literature of queer and trans temporalities. Below I discuss each briefly.

Transgender Studies

While the study of transgender people occurred throughout the twentieth century, these texts tend to explain trans existence through a psychopathology lens (Meyerowitz, 2002; Stryker, 2018). Transgender studies departs from this history by taking as its object of study, not trans people per se, but the conditions through which their lives come to require explanation (Stryker, 2006). Far from the study of a rare minority, trans studies offers a “trans optic” on a range of topics (Salah & Plett, 2014), a way of seeing that demands attention to the insights of those who are askew in the world. Transgender studies traces a trajectory through vexing debates in feminist theory, queer theory, disability studies and queer of colour critique, and reckons increasingly with non-normative and decolonial embodiments outside a white settler context (Bhanji, 2013; Dutta & Roy, 2014).

Critical Disability Studies

As a field devoted to re-thinking the norm (Titchkosky & Michalcko, 2009), critical disability studies (CDS) is in many ways simpatico with the study of trans ways of being. CDS points to non-normative embodiment as an opportunity to “see the world otherwise” (Ignagni, 2013) and a lens through which to consider the edges of human life (Goodley & Runswick-Cole, 2014). CDS has a thorny engagement with medical science,

taking a critical stance on its rhetorics and epistemologies (Dolmage, 2014; Linton, 2006) and also making use of its interventions (Kafer, 2013). With a complex relationship to cure, shame, and passing, CDS offers resistance to pity, tragedy and the failures of the dominant imagination (Clare, 2017). CDS refuses normalization (Titchkosky & Michalko, 2009) and plays host to debates over body and mind differences, theorizing why those differences comes to matter and why they come to count as “trouble” (Clare, 2017). Debates in CDS over the social and medical interpretation of difference dovetail with longstanding debates in trans studies, and in both fields, the middle-ground between the body’s phenomenology and its social habitat, turns out to be a generative space for theory (Baril, 2015; Bettcher, 2014; Crawford, 2013; Halberstam, 1998; Prosser, 1998; Rubin, 2003; Salamon, 2010; Shakespeare, 2006; Siebers, 2008; Wendell, 2001).

Critical Autism Studies

As an off-shoot of CDS, critical autism studies (CAS) also returns the gaze, recasting the mainstream story of autism, rather than autism itself, as rigid, repetitive and indicative of a limited imagination (McGuire, 2016). CAS challenges the “whatness” of autism, proposing it as “neuroqueerness” (Yergeau, 2018, p.9), as an “interpretive category” (McGuire, 2016, p.21), and a “genre of stories” about personhood (Narby, 2016) that reveal the profound anxieties of the non-autistic (Hacking, 2009a). Careful not to disappear autism as merely a social construction (Davidson & Orsini, 2013), theorists insist we explore “autistic presence” (Murray, 2008). Engaging with non-speaking authors (Savarese & Savarese, 2010), the study of narrative and its absence, holds a central place in CAS as one of the key metrics through which humanity is conferred or

withheld (Dolmage, 2014; Duffy & Dorner 2011, Hacking, 2009b; McGeer, 2009; Murray, 2008; Osteen, 2013; Yergeau, 2018). I draw significantly on these authors in Chapter three entitled “Narrative Malady, Normative Temporality.”

Queer and Trans of Colour Critique

Queer and trans of colour critique (QTCC), has pushed the study of gender and sexuality to contend with “analyses of racial capitalism and the racial state” (Ferguson, 2018). QTCC got its start through the re-remembering of “home” from the perspective of queers of colour, both excluded from the protections of a national home due to racism and from the protections of their familial homes due to homophobia (Reddy, 1997). With an analytic lens attuned to silence, QTCC points to gaps between the theories of white queer publics and the incommensurate knowledges of queers of colour (Johnson & Henderson, 2005). Cathy Cohen (1999) writes that the AIDS epidemic was experienced differently in Black communities where the abbreviation of life and abandonment by health authorities was already a long-standing tradition.

A sense of “debilitating ongoingness” (Puar, 2011, p. 149) permeates queer of colour theory. Rinaldo Walcott (2017) writes of the “unfinished business” of modernity and the “longue durée” of Black unfreedom. Troubling the idea of the past as *passed*, Sharpe (2016) and Walcott (2017) insist on theorizing the “afterlife” of atrocity. However, as Syrus Ware (2017) notes, it is also vital to resist viewing Black queers as merely the conquered victims of time. Thus, movements like Black Lives Matter and Afrofuturism become important foci as direct action projects and bodies of speculative critique responding to the need to imagine a livable future (see Walcott, 2017; Womack,

2013). As Rod Ferguson writes, we must see the possibility of “pleasure and alrightness” that persists in the Black queer present (Ferguson, 2004, p. 1).

A more recent body of trans of colour critique looks critically at the failures of mainstream trans progress agendas, both the failure to comprehend the centrality of race to anti-trans violence (Juang, 2006; Lamble, 2008) as well as to question racist and carceral logics in the uncritical quest for state recognition (Snorton & Haritaworn, 2013; Stanley & Smith, 2015). Aizura (2013), Amin (2016) and Dutta and Roy (2014) note the colonial agenda visible in the “new frontier” of trans rights, and Ellison, Green, Richardson and Snorton (2017) critique the academic field of trans studies as a locale where Black trans experiences of precarious life can be used as a springboard to other things, “presumably white things” (p. 162). Scholars question mainstream trans temporalities, including: the idea that trans people of colour are new and following in white trans footsteps (Snorton, 2017), and the false universality of transition as a temporary disruption to an otherwise assumed stable citizenship (Bhanji, 2013). Summing up the temporal problems associated with race and trans status, Syrus Ware (2017) writes: “Trans lives of colour follow a different temporality” (p. 172). I draw on this literature in Chapter four entitled “The Temporality of Privilege.”

Queer and Trans Temporalities

McCallum and Tuhkanen (2011) remark that “living on the margins of social intelligibility alters one’s pace” (p.1). Halberstam (2005) proposed that queer thinking on time dovetailed most obviously during the AIDS crisis at the end of the twentieth century. With gay life foreshortened, queer cultural production took up themes of death and dying

and community formed around the absence of a future. Side-stepping a deficit model, queer scholars theorized those lives that departed from the normative trajectory of growing up, coupling and reproducing, the style of temporality dubbed “reproductive futurity” (Edelman, 2004), “reproductive time” (Halberstam, 2005) or “straight time” (Muñoz, 2009). At this point, we are well past the “temporal turn” in queer studies (Salamon, 2012), however, with recent contributions to trans temporality, C. Riley Snorton’s (2017) *Black on Both Sides*, and the first special journal issue on trans temporality (Fischer, Phillips & Katri, 2017), work on trans time has its own momentum.

Scholarship on trans temporality got its start with proposals to consider “trans” as a term that situates bodies in time and space (Stryker, Currah & Moore, 2008), and to consider trans bodies as symbols of time, specifically the postmodern age (Felski, 2006; Halberstam, 2005). Cadwallader (2014) and Amin (2014) use Freeman’s (2010) concept of *chrononormativity* to explore the operation of the gender clinic. In Carter’s (2013) meditation on trans time and dance and Sunden’s (2015) work on performance and transition, each calls for a non-chrononormative trajectory – for transition as a movement in multiple directions at once. Carter (2013) notes that queer temporalities literature has thus far not been sensitive to trans experience with the romanticized stasis of “arrested development” failing to square with the “purposive movement toward an embodied future” demanded by many trans bodies (p.142). Carter (2013) suggests “transition time” may do something new by incorporating queer and straight time.

Three concepts from queer temporalities literature inform this study: Arrested Development; Chrononormativity; and Futurity. In chapter two (Pyne, 2017), the concept

of arrested development, used in psychoanalysis, eugenics, and scientific racism to describe a stall in development for racial, sexual, and disabled others, has been reclaimed as potentially liberating by queer temporality scholars (Halberstam, 2005). Yet for a young disabled girl named Ashley X, the arrest of her development was imposed against or oblivious to her will. Given the pubertal arrest that trans youth urgently seek, the concept of arrested development is key for exploring the implications of the temporal discourses in the gender clinic, and considering those with the autonomy to arrest time, versus those who are arrested in time.

In chapter three (“Narrative Malady, Normative Temporality”), the concept of chrononormativity guides an analysis of clinician’s talk about their easy and difficult cases. The expected temporality of the authentic-seeming neurotypical trans youth story – the *chrononormative* story – rendered autistic trans youth in comparison as unreliable narrators, suspect, stalled and sometimes stopped in the clinic. Chrononormativity is important for thinking through how the autistic youth comes to be “other” to the authentic narrator of the neurotypical trans youth.

In chapter four (“The Temporality of Privilege”), the concept of futurity informs an exploration into the futures that do and do not become available to trans youth of colour in the gender clinic. Berlant’s (2011) work on crisis time and crisis-ordinary, the event and the situation, frame an inquiry into race and time and social power and the stability that gives the term “crisis” its significance. Below, I expand specifically on futurity with respect to trans kids and youth.

A Note About the Queer and Trans Future

Edelman (2004) launched one of the first explicitly queer investigations of temporality with his polemic text *No Future: Queer Theory and the Death Drive*. Drawing on psychoanalysis, Edelman's central point was that rather than fight to represent the future (by embodying family values for example), queers ought to instead embrace the death drive. Pointing both at the heteronormative mainstream as well as the liberal gay inclusion projects that counter it, Edelman argued that the figure of The Child, to which we are meant to be in service, is always a normative trap and makes possible the queer's continued abjection. Edelman advocated instead that queers divest from the social order and all activist endeavours that seek to improve it. His position came to be known as queer negativity or the anti-relational thesis.

Though Edelman tapped into a deep current of disillusionment with gay respectability, *No Future* nonetheless spurred continuous critique, not the least of which was the charge that what underpins the abandonment of the future, is privilege. Ruti (2008) wrote that women and racially and ethnically marked individuals cannot afford to abandon themselves to death. Halberstam remarked that for certain subjects, Edelman's place of pure critique would amount to "epistemological self-destruction" (Dinshaw, et al, 2007, p.194). Kafer (2013) maintained that since only White non-disabled children are invited into the future, we must invest in, rather than divest from, the futures of those who are said to have none. Hall (2014) argued for a "post-disenchanted" politic that would take responsibility for creating just and livable futures for the planet. Muñoz (2006) shrugged off the anti-relational thesis as "the white gay man's last stand" (p. 825) and a

“romance of the negative” (Muñoz, 2009, p. 1). While a wholesale refusal of the future is not desirable in my view, Edelman’s polemic remains an important warning for the field of trans children and youth, a point I will come back to.

In the public and professional discourse that surrounds transsexuality, the future is treated with much gravitas. Since the inception of the gender clinic (1960s), the professionals who have presided over access to sex change technologies have collectively worried a great deal about what the future holds for the transsexual. These “gatekeepers”, as they are known, have solemnly listened to transsexuals recounting their pasts, gravely contemplated transsexual futures, and wrung their hands over transsexuals’ possible future feelings about their pasts (regret). In the modern-day gender clinic for youth, the role of the gatekeeper as a quasi-guardian of the future would seem to live on, with the spectre of the bad future (suicide) expediting access to treatment and conversely impeding it (fear of regret). In one way or another, sex change (or gender transition) seem to lead to a dangerous, or at least worrisome “form of life” (Sekuler, 2014).

To when, to what time, or to what *kind* of time does sex change lead? Might the transsexual’s voluntary removal of reproductive organs lead to a non-reproductive future that threatens the norm, as Foucault (1996) suggested of homosexuality, more as a “way of life” than a way of having sex? (p. 310). In the 1940s, the loss of reproductive capacity was the chief reason for disallowing sex change by sexology’s heavyweights Alfred Kinsey and David Cauldwell (Stryker & Sullivan, 2009), and continues to animate Ministry of Health debate in the province where I live.⁵ Others have suggested sex change

⁵ Personal communication, Hershel Russell, psychotherapist and trans health consultant.

leads to a future in which stable meaning has dissolved. In this vein, Felski (2006) notes that trans bodies are made to figure postmodernity both by those who are inspired (Haraway's transgender cyborg) and those who are horrified (Baudrillard's transgender as the bellweather of the end of time).

To be inspired or to be horrified, are today's emotional registers for trans children as well, and in the public discourse surrounding early transition, trans children seem to augur both a time that is getting better, and one that is getting worse. Whether those who opine seek to give life to trans childhood, or extinguish it, the future in all cases is anticipated with much anxiety. Early clinicians associated queer and trans futures with various forms of death (Rekers et al., 1977). When puberty suppression became available, the warnings got more specific, including the death of individual children (concern over medical side effects) as well as death on a much grander scale (civilizational decline). When the Dutch media first learned of puberty suppression for trans youth in 1999, they dubbed it "chaos and confusion" and "the world standing on its head" (Schöttelndreier, 1999). More than a decade later, puberty suppression is still at times narrated as "collaborating with madness" (Maza, 2012), the "destruction of children" (Russell, 2013), and society's "rock bottom moment" (Walsh, 2014).⁶ Yet trans children not only appear in the public realm as symbols of death, but also conversely as celebrities of life. A google search using the words "transgender children inspirational story" generated over six million hits.⁷

⁶ For sheer entertainment value, we can consider Pope Francis's comparison of trans people and nuclear bombs, in his view, both with the ability to "annihilate a high number of human beings" (Duffy, 2015).

⁷ Google search December 4, 2015.

Here is where a return to Edelman is useful. Edelman (2004) warned that The Child of the future, said to inspire our present day actions, is a normalizing impulse whose life (figurative life, not the lives of actual children) requires the death of radical queerness. Edelman was suspicious of the feel-good heterosexual family that delimits in advance the terms of debate in American political life. He lighted on the sinister undertone in the injunction that everything be done “for the children” and pointed to the future this secures for some, not others. To understand Edelman, we need only think of the context of the AIDS crisis in which he wrote, which saw the public policy abandonment of gay men to their deaths in the name of protecting “the family”.

Following Edelman (2004) we ought to be suspicious of the relentlessly White, middle class heterosexual family depicted as the welcomer of the trans child. We ought to read with caution, the movement that has risen to speak for trans children, to counsel their parents and usher in a new future – a future described by some as “Finally Normal” (Shapiro, 2015). It behooves us to ask questions about the social class and employment outcomes forecasted for trans youth in the clinic (De Vries et al., 2011). Dr. Norman Spack (2013), the pioneer of trans youth care in the US, should pique our interest when he describes trans kids who block puberty as “beautiful”, “normal” and “like everyone else.” As should the twitter missives of the organization Trans Youth Family and Allies (TYFA), concluding each time with the all-caps message “FOR THE KIDS”. For which kids, and why these kids, are necessary questions.

For this reason, there is a critique of the new normal of trans children from the far left and not only from the far right. Some trans activists can be heard exclaiming that

“trans kids are the new gay marriage”, and this is not meant as a compliment.⁸ Long-time trans activist Riki Wilchins (2012) called puberty suppression “a pill that would stop you from being transgender”, with “blocker babies”, as she called them, no longer trans at all: “Their transgenerness is there, and then – poof! -- it's gone.” In fact, Wilchins’ complaint has something in common with that of the far right, in that she also projects a “civilizational decline” of sorts onto trans youth. Referencing herself as a “transgender dinosaur”, Wilchins uses terms like “extinction” and “vanishing” to cast trans youth as palatable harbingers of the end of the movement. While Wilchins also raised complex issues of intergenerational intelligibility, many trans activists, including myself, still saw fit to critique her (Leftygirl, 2012).

Unlike these critics and Edelman himself, for several reasons I decline to see only a sinister outcome of this public attention to trans kids and their newfound (if unevenly distributed) livable futures. First, there *is* something moving about bearing witness to them barreling forward with a previously unthinkable confidence. There is something moving when parents set aside all that they know and stand behind their child.⁹ Here I am reminded of an older butch friend of mine, stoic in her general approach to life, who nonetheless cries every time she hears a story about parents supporting trans kids. What moves us is important, deeply revealing and ultimately political. Second, as Muñoz (2009) insists, folded into the queer belief in the future is not only a normalizing project but a rejection of the bland and oppressive present and a longing for future worlds. To

⁸ Personal communication, Topside Publishing, Tom Leger & Cat Fitzpatrick, 2015.

⁹ Elsewhere I use moral philosophy to consider parental affirmation as political and justice-based (Pyne, 2016).

exist the ‘not-yet’, we must imagine it, which is a risk. And third, young trans people are not only symbols, but have material lives that may well defy all the ways they are made to mean, by the right and by the left. Heather Love (2007) responds to Edelman: “What one wants more of, though, are things that *No Future* excludes from the start: an account of the relation between the idealization of children and their actual treatment in the world” (p. 131).

In the final chapter of *No Future*, Edelman (2004) references a 1998 *Boston Globe* op-ed about preserving “family values”, noting how the authors refer to children both as souls (“growing those small souls”) and as capital (“essential to the health and wealth of our nation”) (p. 112). In considering how and why early transition becomes thinkable and possible, I consider the way trans children may be both inspiring souls and human capital, inspiring a reflection on life and meaning that can be at once thoroughly genuine and also manipulable and poised for conservative use. To be guided by Edelman, is to be suspicious of those for whom the future is built. To be guided by Kafer (2013), Muñoz (2009), Halberstam (2005), Ruti (2008) and Hall (2014), is to note that we are not free to walk away from those futures.

Research Problem and Questions

“The trans body has been trans longer than the doctor has been a doctor.”
– Cooper Lee Bombardier (*A Trans Body’s Path in Eight Folds*)

In 2000, I received a letter from a gender identity clinic stating that my request for surgery associated with a desired gender transition had been denied. The letter recommended extensive therapy in order that I might come to terms with my strange

motivation for having sought this in the first place. Within an hour, with the help of a photocopier and a glue stick, I had changed the letter to read that I had been enthusiastically approved. This was only one of many curious letters I received about myself from psychiatrists that year, another describing my hairstyle in detail. It became clear that the pronouncements in these letters were a greater indication of the author's state of mind than my own. While the newly doctored letter sufficed for my purposes, I've never stopped being curious about the original, its author, its implications.

In 1978, American attorney Melvin Belli pointed out a conundrum in the way transsexual body modifications had so far been regulated: If those who wanted to change their sex were considered mentally unstable and thus not permitted, then did this mean that those who did *not* want to change their sex *could* be considered mentally healthy, and therefore could go right ahead? The fact that one cannot change one's sex simply because one wants to, is a curiosity. From here the questions radiate: If not because one wants to, then for what reason? If one cannot bear responsibility for this decision oneself, then who can? The field of gender transition for youth is a particularly promising site for research, given that anxieties about young people in general, about the decisions that are made by and about them, tend to be high. Parents, health professionals and the public at large are often "asked to worry" about youth and their imagined precarious futures (Roen, 2011). Yet within the span of 20 years, in many urban centres in the Global North, assisting trans youth to suspend puberty and transition to a new gender has become a widespread and institutionalized practice. It is of interest why some youth can't change their sex, but so too is the question of why some can. Some youth who present to these clinics are

understood to be trans while others are said to “confused” as one clinician explained. Why is that? Hacking (2009a) writes that we can find out what makes something X, by studying what makes something “not X” (p. 45).

My study focuses on this current generation of trans youth, some of whom are blocking puberty and transitioning young; I pose questions about how their futures have become thinkable in this time and place. My central research questions are: How have puberty suppression and early gender transition become thinkable futures for trans youth? What are the conditions of possibility (on the socio-cultural level and in the clinical moment) through which this “form of life” becomes permissible? (Sekuler, 2014). For whom are these futures thinkable and permissible and for whom are they not? In pilot interviews with clinicians, I was struck by the presence of autism and the absence of race, as topics of conversation. Chapters three and four consider my research questions with specific foci on autistic and racialized youth.

Methodology and Methods: Studying Text, Listening to Talk, Thinking with Theory

“This trans body trains the doctor to see it as a patient and its need as deserving of care much in the same way wolves once trained humans to see them as dogs.”
– Cooper Lee Bombardier (*A Trans Body's Path in Eight Folds*)

This study is organized around the discourse analysis concept of “interpretive repertoires”, first proposed by sociologists Nigel Gilbert and Mike Mulkay (1984) in their study of scientific explanations. Gilbert and Mulkay (1984) found that when explaining their activities, scientists drew their discourses from varying and at times inconsistent repertoires (self-contained discursive systems) and that attention to these repertoires

helped to understand the function of the discourse. Gilbert and Mulkey (1984) proposed variation and inconsistency as the norm for all discourse and suggested analysis centre on identifying contradictions, especially in scientific discourse, lest researchers make medicine appear more coherent than it really is (Potter & Mulkey, 1985). I discuss discourse analysis and interpretive repertoires further in chapters three and four, but below I outline background methodological information grouped as studying text, listening to talk (Valentine, 2006) and thinking with theory (Jackson & Mazzei, 2012).

Studying Text

My central research question of “what makes puberty suppression and early transition thinkable and possible” could be answered in many ways. One could explore the technology itself, for example, gonadotropin releasing hormone analogues or cross-sex hormones, which certainly make puberty suppression and transition possible. Why focus on discourse? In 1995, Bernice Hausman investigated the technologies of sex-change and accused physicians of acquiescing to the powerful demands of transsexuals to “engineer themselves” (p. 9). When Jay Prosser (1998) answered Hausman, among his goals was giving a more accurate picture of the power relations between transsexuals and their clinicians, in which transsexuals were obliged to convince their “self-appointed minders” (Stryker, 2006) of the veracity of their claims. Since there exists no objective ‘test’ for transsexuality, clinical assessment relies on narrative - a narrative which must contain the needed story elements to unlock these much sought-after (and according to some trans people and clinicians, life-saving) technologies. Prosser (1998) wrote: “There has probably never been so much at stake in oral autobiography” (p. 108). According to

Prosser (1998), narrative not only makes it possible to access transition care, but to make a workable life from disjointed experience. Narrative is itself a technology.

In the field of trans youth care, the technology of puberty blockers existed long before it was provided to trans youth. The technology exists now in jurisdictions where it is still not offered to trans youth or offered sparingly. Similarly, the technology exists to provide cross-sex hormones directly at the onset of puberty, thus cutting-out the middle stage of puberty suppression and better mimicking the pubertal arc of other youth, and yet this is not done. Perhaps in time it will be, however, in Plummer's (1995) words, we have not yet been "rendered ripe" for this with the stories currently available. I am arguing that the central issue is not the technology, but the discourses that bring it into being, justify it, delay it, speed access to it or shut it down, and attempt to shape the forms of life that will materialize. As T. Garner (2014) wrote: "Medical discourse is not merely representative of the body and the medical technologies applied to it; it is a technology itself through which bodies are materialized in specific forms" (p. 352).

"Listening to Talk"

This project involves a discourse analysis of interviews with clinicians and a small number of community level key stakeholders. In a discussion about approaches to qualitative research, Seale (1998) makes a distinction between viewing talk as a resource (a window into reality), versus viewing talk as itself the topic. Alasuutari (1995) similarly refers to this distinction as a "factist" approach to talk versus a "specimen" approach. To approach talk as a resource, the researcher listens for the content of participant's talk, and organizes analysis around what the participant offers in response to questions about a

phenomenon. Questions of validity centre around whether the participant has indeed had experience with that phenomenon, and whether their remarks are a true reflection. To approach talk as a topic, however, the concepts of true and false do not apply as the object of study is the linguistic expression itself, primarily examined for its effects and how it works to construct different versions of reality (Talja, 1999). Discourse analysis approaches talk in this second way, as a topic.

Qualitative research literature in recent years has expressed a range of perspectives on using discourse analysis to analyze interview data – analyzing speech rather than text. Hammersley (2014) proposed that to do so might be in violation of the ethic of informed consent, since most participants assume you are analyzing content (a resource approach) and have not consented to have their speech analyzed for its own sake. In Taylor and Smith's (2014) response to Hammersley, they contest the notion of an innocent thematic analysis juxtaposed against an allegedly deceitful discourse analysis, noting that researchers are always co-constructing knowledge and always in the scene. Briggs (1986) suggests that performing a discourse analysis on interview data is questionable because the discourse at play in an interview is not of the same field where the construction takes place. Talja (1999) on the other hand argues that the interview is actually the ideal setting to discursively analyze for interpretive repertoires in particular, because the inconsistencies between repertoires will be more apparent than in written text where authors are more likely to notice contradictions and correct for them.

I agree that clinicians may expect me to analyze the content of the interview and not their words, however, because they are not personally identified in the analysis and

because physicians do not constitute a vulnerable group in research¹⁰, I feel my departure from the expected analysis is justified if it serves to support the more vulnerable group (trans youth) who are under clinical authority. With respect to Brigg's (1986) notion of the universes where discourse is made, I agree that interview data should be considered in context, but disagree that there is any one place where the discourse of trans youth care is made. In pilot interviews with clinicians, I learned that they tend not to follow any one protocol and instead bridge together guidance from multiple sources. I also learned that the diagnosis of gender dysphoria is not central to their decision-making, as many feel the diagnosis could fit countless young people who they might not approve for blockers or hormones. In my view, clinical publications and guideline documents, conferences and training sessions, and the mainstream media, are all places where this discourse is made. Finally, I agree with Talja (1999) that the interview setting is ideal for listening to the contradictions in clinical talk, contradictions not always evident in text. David Valentine (2006) suggests that the false tidiness of sexual and gender categories can be illuminated by listening to "talk-about-desire", which often spills out over the edges of identity categories. I pursue the same regarding the false tidiness of clinical categories by listening to clinician talk. Further, as trans people have historically been regarded with suspicion in the gender clinic, my interviews with clinicians reverse what Prosser (1998) called "the hermeneutics of suspicion" in pursuit of new learning about the ongoing power relations between trans youth and their health providers.

¹⁰ Personal communication, Karen Szala-Meneok, McMaster Research Ethics Board, May 2016.

With respect to my project, the concept of “interpretive repertoires” (Gilbert & Mulkay, 1984) holds promise because it allows for, and in fact expects, inconsistencies in the discursive repertoires that actors draw on. At a time when the success of trans activism has unsettled power relations in this field, inconsistencies are very present in the field of trans health. Clinicians are to varying degrees aware that they might be evaluated on how trans-positive they are, and to varying degrees, aware of a trans audience for their remarks both written and spoken. In this context, it would be unwise to use a methodology that might assume rigid or pre-determined power roles, for example, how critical discourse analysis is sometimes used, as this might miss what is potentially the most significant feature of contemporary clinical discourse about trans health. The discourses of power-over are intermingling with those of power-sharing, and the discourses of illness / diagnosis / symptom / treatment are co-existing with those of affirmation / identity / authenticity / self-expression, and less often, rights and autonomy. In a context in which clinical authority is debated, clinicians labour to justify their authority and it is crucial to be able to observe the inconsistencies evident when they do so. Further it remains an ongoing goal of this project to keep in mind both the authority vested in the clinicians who work with trans youth, as well as the great risks some have taken in order to provide care that they could see was needed. Several clinicians told stories of working in other areas of medicine but were so moved by their first trans youth patient, they found a way to open a specialized clinic, often without resources and sometimes without permission from their hospital. Many found ways to get expensive medications covered when needed and continued to visit with prior patients and

sometimes to help with other aspects of their lives. Their genuine care for the youth was evident and is in the scene of trans youth care, along with authority, and sometimes adversarial conflict.

“Thinking with Theory”

In some qualitative research traditions, for example some forms of grounded theory, it is considered ill-advised to approach one’s research with theory already in mind. According to some strict guidelines, even a knowledge of the literature may prove problematic and applying theory to data can be considered an imposition of the researcher’s agenda. Discourse analysis literature does not repeat these instructions, yet descriptions of discourse analysis often use terms such as “excavate” (Fraser & Gordon, 1994), implying that researchers simply dig up what is there. Certainly, researchers tend to avoid reporting that they found what they were looking for.

In their text *Thinking with Theory*, Jackson and Mazzei (2012) issue a challenge to qualitative researchers to avoid the limitations of rote methods – mechanistic coding and summarizing routines that do little, in their eyes, to animate the complexities of social life. Jackson and Mazzei (2012) explain that they had begun to find conventional interpretation lacking, and eventually decided to forego some of the imperatives of qualitative research – for example, giving voice, and letting data speak for itself – feeling that these projects were already failed. Instead they tried “plugging data and theory into one another” (p. vii) by applying concepts from major theorists (Derrida, Spivak, Foucault, Butler, Deleuze and Barad) to their data. In their view, knowledge was “opened up and proliferated” (p. vii) rather than what was feared or warned against, that

knowledge would be limited or less robust. In this project, thinking with theory has been crucial, specifically queer and trans temporalities, critical disability studies, critical autism studies, transgender studies, and queer and trans of colour critique. Some theoretical choices did come from the ground up. My pilot interviews with clinicians in 2015 were saturated with discourses of time, which directed me to queer temporality literature, which sent me back to the data sensitized and alert to new discourses.

In addition, the common qualitative research imperative of “giving voice” to one’s participants and amplifying their perspectives, in this case might risk amplifying voices that are already well heard. Clinicians often write and publish and speak to the media and present at conferences and thus have many mediums at their disposal for communicating their views and experiences. Thus I pursue other methodological goals, driven at times, by theory, and also by the goal of justice-doing (Clark, 2017), hence I focus some of my analysis on race despite this being an area that interviewees most often did not discuss.

Next Steps

In 2017, I sought the participation of trans and non binary youth for interviews about their relationships to transition and youth gender clinics. To my call for 20 participants, over 100 youth responded, and it became clear that this aspect of the research required its own devoted focus. I made the decision to delay youth interviews and will pursue this again during my postdoctoral studies with priority given to interviewing Indigenous trans youth. This present study does not do justice to the ways that Indigenous histories differ from those of other racialized groups, and I expect to focus a new analysis on how concepts of gender understood to be modern (for example,

gender as wholly distinct from sexuality) may render Indigenous trans youth anachronistic in clinician's eyes and create trouble in youth gender clinics.

In addition, this field cries out for a biopolitical analysis, and I am planning a case study focused on one interview in particular in which a clinician considered weight loss a key eligibility criterion for youth to access cross sex hormones. Drawing on biopolitics, I plan to consider how the permitting of some bodies and inhibiting of others, reflects a long history of biopolitical rule over trans bodies. Drawing on fat studies, I plan to explore the nation-making aspects of the “war on obesity” and how fat trans youth can be made to fail and pitched into a precarious future. While discussion of gatekeeping is ubiquitous in trans community, this analysis will consider the gates spatially with respect to who does and does not squeeze through.

Methods and Reflections

This study unfolded between 2015 and 2018, during which time eighteen clinicians were interviewed across six countries. Clinicians were a mixture of child psychologists or child psychiatrists, pediatric or adolescent medicine specialists, pediatric endocrinologists and social workers – all of whom work with trans and gender diverse children and youth to assess and approve (or not approve) access to puberty suppression or cross-sex hormones. As this remains a small and specialized field internationally, to avoid identifying clinicians, I have kept their individual cities, countries and professions anonymous, and I use the gender pronoun “they” for each. Numerous American and Canadian clinicians were interviewed, while others practiced in Western Europe, Oceania, and Southern Africa. Health and mental health care funding models vary across

these countries and span private for-profit systems, socialized healthcare and combinations thereof; however, these distinctions are not the focus of this analysis. Interviewees were asked to describe the cases they find easy or straight-forward, and those they find complex, challenging or conflicted. In interviews, the noteworthy presence of autism as a topic of conversation, paired with the equally noteworthy absence of race in discussions, prompted the focus on autistic trans youth for chapter three and racialized trans youth for chapter four.

Due to this absence of discussion of race with clinicians, I pursued additional interviews with 10 key stakeholders across three countries, primarily social service providers or community level experts working with trans youth of colour and able to offer insights missing from clinician interviews. For these individuals, I use pseudonyms unless interviewees requested to have their real name used, and I describe their work in general terms so as not to identify them. I also sought trans youth participants for this study but rethought and paused that step, which I comment on later. Additionally, prior to and during my three years of interviews, I observed professional discussions about issues of treatment for gender non-conforming children and trans youth at three international conferences (WPATH, Bangkok 2014; EPATH, Ghent, Belgium 2015; WPATH, Amsterdam 2016), three national conferences (Gender Spectrum, Berkeley, CA 2013; Gender Spectrum, Berkeley, CA 2014; CPATH, Halifax 2015), and online through the email listserv and Facebook group for the World Professional Association for Transgender Health (WPATH). While I do not cite these sources directly, they inform my analysis of media and clinical literature and the discourses therein.

Yet my role in this field has also gone far beyond observation. In 2012, I coordinated Canada's first National Workshop on Gender Creative Kids at Concordia University. In 2012-2013, I co-led the Gender Independent Children project at Rainbow Health Ontario - a provincial process to build community support for gender independent children and their families. During that time, I developed brochures for parents, factsheets, trainings and webinars for health and social service providers and co-led a national research meeting to build capacity for research on these issues. I now sit on multiple research teams together with clinicians from Canadian clinics who work with trans youth. In 2015, on behalf of Canadian social workers and social work educators, I led the development of a national joint position statement on affirming gender diverse youth (CASW, 2015). From 2016-2017, I sat on the Board of Directors for the Canadian Professional Association for Transgender Health (CPATH), and from 2013-2014, on the executive committee of a newly forming medical clinic for trans youth. I have written extensively in journals and popular media forums on these issues.

Further to this, I played an active role in the drafting and passage of Ontario's Bill 77 - the Affirming Sexual and Gender Identity Act which banned conversion therapies for queer and trans minors (June 2015). I also played an active role in what some consider a controversial movement to close the Child and Youth Gender Identity Service at the Centre for Addiction and Mental Health (CAMH) in Toronto (2015), a service many felt was inappropriate in its philosophy, goal and methods. In response to that advocacy and my writings about it, I have since been on the receiving end of vastly different public responses. During the course of my PhD studies, I was the recipient of hate mail as well

as a substantial lawsuit (Pyne, 2015). Yet during the same years, I also received an international award for outstanding student contribution to the field of transgender health (WPATH 2015), a nomination for an international advocacy award (WPATH 2016), a nomination for the Order of Ontario by a group of parents of trans youth and clinicians (2016) and was named one of Toronto’s LGBTQ heroes of 2016 (Goldsbie & Cole, 2016). Needless to say, I am very much, and sometimes controversially, *in* this scene, and while it is impossible to fully account for how this fact has shaped my research, it doubtless has. I am aware that as someone who helped to make the case for puberty suppression and early transition care in my region, I have contributed to the very discourses I now analyze. Indeed, doctoral studies have been an opportunity to rethink both the potential and the perils of those discourses. My observations over this time, on the success and limitations of support for trans youth, most especially limitations with respect to race, class and ability, are observations at the centre of this project. Lastly, the fact that I am myself trans, is also a central lens in this study. Being a trans person in a clinical waiting room, waiting to interview clinicians about how trans youth are often left waiting, was an experience that made for unavoidable moments of reflection.

Overview of Chapter Abstracts

“If you are trans, you know how to wait.”
– Darin Issac Blue (*Translations*)

This present chapter (one) is an introduction to this research including background, literature, theory, research problem and questions, methodology, methods and next steps. Additionally, the concluding chapter (five) brings each section together to discuss conclusions that might be drawn from this research with respect to my original

questions, my methods, and the concerns and queries that emerge from this work. The middle chapters between the introduction and conclusion (chapters two, three, four) are each distinct articles that approach my larger questions from various theoretical positions and different problematized trans identities and bodies in mind. Chapter two draws only on clinical and media discourses, where chapters three and four also include data from interviews. The three chapters abstracts are as follows:

2. Arresting Ashley X: Trans Youth, Puberty Blockers and the Question of Whether Time is on Your Side

In 2004, a young Seattle girl with significant disabilities known only by the pseudonym Ashley X, underwent a series of medical procedures without her consent. At the request of her parents, Ashley received a mastectomy, a hysterectomy and hormonal treatment, designed to arrest her development in a child-like state. In the eyes of her doctors, her family, and their lawyers, it was urgent that Ashley's body be aligned with her purported cognitive age. The temporal and ethical arguments used to justify her "Treatment" turned Ashley's body into a site of international debate over disability and human rights, consent and medical science, eugenics and human engineering. Yet the similarities and differences between Ashley's non-consensual pubertal arrest versus that actively sought by trans youth are rarely mentioned. This paper uses the clinical and media discourses at work in both the "Ashley Treatment" and the treatment sought by trans youth to think through this moment in which some bodies are treated to greater forms of autonomy while other bodies have none. I argue that the discourses used to secure transition for some trans youth ought to be weighed against the implications for others, in particular for trans youth with disabilities. While the availability of puberty suppression for trans youth can be narrated as a sign that things are getting better, the literatures of queer temporality and critical disability studies help to consider that it may also augur something else—a widening gap between those invested with the ability to stop time versus those who are stopped in time.

3. Narrative Malady, Normative Temporality: Doing Time with Autistic Trans Youth in the Gender Clinic

Duffy and Dorner (2011) note that despite much searching, there exists no biological marker that distinguishes the autistic from the non-autistic. Autistic identity remains a “narrative condition” that must be storied, a fact shared with transgender identity. This chapter reports on a discourse analysis of qualitative interviews with clinicians who serve trans youth in gender clinics. When asked to describe the cases they find straight-forward or easy, and those they find difficult, 18 clinicians across 6 countries overwhelmingly offered autistic youth as examples of difficult cases. Drawing on the literatures of critical autism studies, transgender studies and queer temporalities, I explore the interpretive repertoires that clinicians draw on in their narrative efforts to account for the youth in their care. With significant changes in the public narrative of how trans youth have been understood over time, disorder to diversity so to speak, the story that now authenticates some trans youth and makes intelligible their narratives, offers no mode of doing the same for autistic trans youth. With stories that seem to fail, both in content and form, autistic youth become unreliable narrators in the clinic and take on a troubling status as “other” in relation to the trans youth subject. In this way, autism, both real and imagined, is curiously taking centre-stage in the field of trans health. While clinicians show great concern for the youth in their care, against a template of an expected story, the narratives of autistic trans youth appear scrambled and out-of-order, strange and disorderly, or simply remnants of another time. The space left by the absence of an intelligible narrative was instead filled with what Yergeau (2018) calls “god theories” about autism as lack (p.11). Yet despite evidence of trouble hearing autistic narratives in the clinic, there remain indicators that in the future, autistic trans stories might yet come into their time.

4. The Temporality of Privilege: Trans Youth of Colour and the Trouble with Triage

In a time of expanding futures for trans youth, some are able to ‘buy time’ by blocking puberty and transitioning young. While controversial, the option of puberty suppression (‘blockers’) for trans youth has been hailed by clinicians as “lifesaving” for halting the crisis of unwanted puberty, and “a lifetime advantage” for reducing visibility and protecting against future victimization. In the media, acquiring blockers before the onset of puberty is often referred to as a “race against time.” A matter in question however, is that gender clinics report they primarily serve white middle class trans youth. The following analysis presents on a discourse analysis of interviews with health and mental health clinicians across six countries as well as interviews with community level experts working with racialized trans youth. Drawing on queer and trans of colour critique,

sociological works on time and social power, and the literature of queer temporalities, I explore the repertoires of time evident in clinical talk about blockers and trans youth futures. I propose that the temporal repertoire of urgency or crisis-time, often meant to characterize the experience of all trans youth, is most likely to reflect white middle class trans youth and to secure their services. Meanwhile, the families of racialized trans youth, beset with multiple struggles of survival, must often triage resources and cannot afford to ‘race against time’ nor ‘buy’ it. Using Berlant’s (2011) juxtaposition of the *event* and the *situation*, I argue that an over-focus on the *event* of pubertal crisis for trans youth in general, can obscure the *situation* of trans youth of colour in specific (i.e.) ordinary long-term structural racism, in the face of which, racialized trans youth lack the stability that gives the term ‘crisis’ its significance. Ultimately, the ability of puberty blockers to act as a “switchpoint” to guide already privileged trans youth into even more privileged futures, threatens to widen the existing racialized opportunity gap in trans communities.

Organization of Sandwich Thesis

As per the McMaster University requirements of a “sandwich thesis”, the first substantial chapter (Chapter 2) has already been published and the full citation is provided prior to the chapter. The reference style in chapter two is Harvard, as per the journal’s requirement. All other sections of the thesis are referenced in APA style. For the substantial chapters (2,3,4) the reference list is within each chapter as each is a distinct article. For chapter one (the introduction) and chapter five (the conclusion), references are listed at the end of the thesis. There are small sections of text overlap between descriptions of methods, theory, and background information. However, this has been kept to a minimum.

CHAPTER TWO

Arresting Ashley X: Trans Youth, Puberty Blockers and the Question of Whether Time is on Your Side

Pyne, J. (2017). Arresting Ashley X: Trans Youth, Puberty Blockers and the Question of Whether Time is on Your Side. *Somatechics*, 7(1), 95-123.

Abstract

In 2004, a young Seattle girl with significant disabilities known only by the pseudonym Ashley X, underwent a series of medical procedures without her consent. At the request of her parents, Ashley received a mastectomy, a hysterectomy and hormonal treatment, designed to arrest her development in a child-like state. In the eyes of her doctors, her family, and their lawyers, it was urgent that Ashley's body be aligned with her purported cognitive age. The temporal and ethical arguments used to justify her 'Treatment' turned Ashley's body into a site of international debate over disability and human rights, consent and medical science, eugenics and human engineering. Yet the similarities and differences between Ashley's non-consensual pubertal arrest versus that actively sought by trans youth are rarely mentioned. This paper uses the clinical and media discourses at work in both the 'Ashley Treatment' and the treatment sought by trans youth to think through this moment in which some bodies are treated to greater forms of autonomy while other bodies have none. I argue that the discourses used to secure transition for some trans youth ought to be weighed against the implications for others, in particular for trans youth with disabilities. While the availability of puberty

suppression for trans youth can be narrated as a sign that things are getting better, the literatures of queer temporality and critical disability studies help to consider that it may also augur something else - a widening gap between those invested with the ability to stop time versus those who are stopped in time.

Introduction

The past two decades have seen the beginnings of the institutionalization of puberty suppression treatment for trans youth – allowing some to arrest their development at the onset of puberty and potentially transition to a new gender while young (Spack, 2013). The ability of puberty blockers to ‘buy time’ and improve mental health and wellbeing, have led clinicians such as De Vries et al (2011) to note that for trans youth, ‘...arresting the development of secondary sex characteristics results in a lifetime advantage...’ (2277). I am in full support of such options. Yet in the current medical milieu, substantial body modification requires a rationale, with the social practice of shaping such rationales carrying much significance. This paper considers the elective developmental arrest of trans youth alongside another example of body-arresting technology – the growth attenuation Treatment¹ imposed on a young American disabled girl known as Ashley X. Reading the clinical and media discourses at work in both treatments, makes visible the similar temporal rationales used to justify them. The discourses of synchrony, the race against time to align body with mind, and the logic of ‘cognitive age’, while expanding the bodily autonomy of some trans youth, further stripped Ashley of hers. Moreover, though these rationales may work to secure what some trans youth seek, their effectiveness would seem to waiver for disabled trans youth. While the availability of puberty suppression for trans youth can be narrated as a sign that things are getting better, the literatures of queer temporality and critical disability studies help to consider that it may also augur something else - a widening gap between those

invested with the ability to stop time versus those who are stopped in time. I begin with the troubled history of the concept of ‘arrested development’.

Arrested Development, Queer Time, Trans Time

During the nineteenth century invention of the category of ‘mental deficiency,’ pseudo-scientific ideas of evolution lent support for the theory that individuals diagnosed as such were suffering from ‘arrested development’ – a purported failure to progress (Bowler 1983; Bowler 1990; Jackson 2000; Tredgold 1908). Featuring later in eugenic programs in the early twentieth century, the temporal diagnosis of ‘arrested development’ helped to justify human sterilization and institutionalization (Dyck 2013; Savell 2004). As Clare (2017) chronicles, those sterilized were often racialized and always poor. While the concept of ‘arrested development’ marked the sexualities of impoverished, racialized and disabled people as dangerous, enabling their incarceration, Freud lifted the term in the 1930s for an (albeit limited) liberation of gay sexuality. Proposing that homosexuals were not dangerous but merely ‘arrested’ en route to a heterosexual destination, Freud declared that homosexual criminalization was unjust, essentially arguing against one kind of arrest but for another (Usher 2009).

According to Rohy (2009), the temporal logic of Freud’s time that cast the queer as immature was borrowed from the rhetoric of scientific racism. In the late nineteenth century, scientists drew on (incorrect) aspects of evolutionary theory to compare the arrested development of the homosexual to the imagined ‘primitivism’ of African American minds (Rohy 2009). The term ‘degeneracy’ stood in for racial inferiority,

signaling decline or deterioration, moving backwards, or failing to move forwards (Stepan 2011). Indeed, across multiple centuries, the entire program of colonialism traded on ideas of modern time and the superior civilization versus that which was stranded in the past. Nanni (2012: 60) writes that colonization was not only a spatial invasion, but a temporal invasion as well, with *terra nullius* (empty land) also regarded as *terra sine tempore* (timeless land). Binding together racism with ableism, the violence in terms such as ‘savage’, ‘primitive’, ‘unevolved’, and ‘backwards’ arguably rests on the ability to cast the Other as a figure of the past and undeserving of a place in the future. What Carter calls the ‘political consequences’ of scientific theories of development can be traced through myriad class, race, ability and gender-based violences, from land theft to institutionalization to sterilization (2013: 143). Osborne proposes all politics involve a struggle over the experience of time (1995: 200).

In the context of queer politics, the past decade has seen a ‘temporal turn’ in queer theory (Salamon 2012)² and a predictable return to Freud’s schema of the queer as ‘developmentally delayed.’ Though the ableism at the heart of the perceived insult of ‘delay’ does not figure in these theorizations, Halberstam (2005) challenges the idea of human development as a heterosexual fantasy, evoking the queer as s/he who refuses to grow up. Imagining the ground that suspended time might offer for revelry and unscripted life, delay has been theorized as a queer temporality - a possible playground rather than prison.³

Much less has been written about trans temporalities, though scholars have begun to explore this through the lens of performance and dance (Carter 2013), autobiography

and digital narrative (Prosser 1998; Prosser 2014), legislative recognition (Grabham 2011), the clinical encounter (Cadwallader 2014), and postmodernity and the new millennium (Felski 2006; Halberstam 2005). Amin (2016) writes of the belated ‘nowness’ of trans, informed as we are by elected officials (Bendery 2012) and media headlines (Steinmetz 2014), that transgender is the issue *of our time*. In Canada, new legal protections for trans people are unfolding rapidly, including recognition for children and youth. Indeed, transgender children would seem to be key celebrities in the ‘nowness’ of trans. A recent Google search using the keywords ‘transgender children, inspiration’ returned over one million hits.⁴ Yet the phenomenon of trans children and youth, and the medical technologies assisting them, have also been narrated in the media as ‘collaborating with madness’ (Maza 2012), ‘chaos and confusion’ and ‘the world standing on its head’ (Schöttelndreier, 1999).⁵ Thus it has been an uphill battle to secure such interventions, a battle in which much progress has been made, with puberty blockers and early transition now recommended as best practice for at least some trans youth by major health organizations (Hembree et al. 2009; Canadian Pediatric Endocrine Group 2012; WPATH 2011). Moreover, it has been proposed by some that parents should follow the lead of trans children (Adriano 2007; Gender Spectrum 2015a), pointing to a temporal reversal in the family order and the emergence of a new familial category: the ‘child-taught parent’ (Hill & Menvielle 2009: 263). Though access to clinical and family support is by no means guaranteed for trans youth,⁶ it has become much more likely. Elsewhere I have argued that this should be the case (Pyne 2013; Pyne 2014a; Pyne 2016).

This article is written in the context of rapid growth in public validation for trans youth and unprecedented access (for some) to the means to block puberty (GnRH analogues or ‘blockers’) and transition young – a time of upsurge in the autonomy of trans youth opting to ‘arrest’ their development. Not all trans youth seek such interventions; however many do and urgently so, and this text concerns itself with this group. In the helping professions there has never been more stated interest in improving the wellbeing of trans youth through professional trainings (for example, WPATH 2016), support groups and conferences (for example, Gender Spectrum 2015b), position statements (for example, AAP 2016) and proposed best practices (for example, Edwards-Leeper, Leibowitz & Sangganjanavanich 2016). Thus it may be a hopeful time. Yet some clinicians also maintain that youth must be ‘carefully selected’ (Khatchdourian 2012) and only eligible for interventions under ‘strict conditions’ (De Vries & Cohen-Kettenis 2012: 315), using ‘strict criteria’ (Smith et al. 2001: 479). Thus the wish will not be granted for all. Further, the current context for trans youth also includes an increase in trans youth of colour being literally ‘arrested’ in urban public spaces and faced with the prospect of ‘doing time’ (Spade 2011), as well as a staggering epidemic of violence against young trans women of colour, the arrest of their lives and their time in a more urgent sense (Democracy Now 2014). Thus whether things are getting better for trans youth, and for *which* trans youth, remains an open question.

I wish to sidestep the matter of whether things are getting better or worse, and consider instead what can be learned from an alternative example of body-arresting technology: the highly publicized arrested development of a young American disabled

girl known as Ashley X. Though queer theory proposes arrested development as liberating for queer subjects, and though the same might be said for trans youth with access to the technologies they seek, these events may also auger something else. In this paper, I aim to read Ashley X's experience alongside that of trans youth in order to reconsider the temporal rationales that underpin both treatments – rationales that contribute to the autonomy of some but remove it from others.

Arresting Ashley

In 2004, the parents of a 6-year old girl met with pediatric endocrinologist Dr. Daniel Gunther at the Children's Hospital and Regional Medical Center in Seattle, Washington. Their daughter, now known by the pseudonym Ashley X, was showing signs of 'precocious puberty' (AM & AD [pseudonyms for Ashley's Mom and Ashley's Dad] 2012), the medical diagnosis for premature development.⁷ At the time, GnRH analogues (gonadotropin-releasing hormone analogues or 'puberty blockers') had been in use for decades to delay puberty if deemed inappropriate for a child's age. This is generally the technology that trans youth seek, albeit temporarily, prior to cross-sex hormones. However, Ashley's parents sought a permanent intervention.

At their meeting with Dr. Gunther, Ashley's parents sought to have her development halted with a high dose of estrogen. Ashley's mother had learned that 'growth attenuation' had been used in the 1950s to prevent teenaged girls from growing tall (AM & AD 2012). Momentarily setting aside the glaring question of *why* Ashley's parents sought this, here is what occurred. After one meeting, Dr. Gunther agreed to

perform this and two additional procedures: a full hysterectomy and a bilateral mastectomy. Ashley's parents and Dr. Gunther appeared before the Seattle Children's Hospital Ethics Board where the procedures were approved,⁸ less a court order for the sterilization as per Washington law (Carlson & Dorfman 2007).⁹ However, Ashley's parents' lawyer succeeded in convincing the hospital that conditions had been met without the legal order (Carlson & Dorfman 2007). Only two months after the ethics committee met, and only six months after the first meeting, six-year-old Ashley was wheeled into surgery for a hysterectomy and mastectomy, followed by two and a half years of hormone treatment (AM & AD 2012). Four years later, in a CNN story, her parents stated: 'Ashley did not grow in height or weight in the last year, she will always be flat-chested, and she will never suffer any menstrual pain, cramps or bleeding' (Burkholder 2008). They declared the three tandem growth attenuation procedures (The Ashley Treatment), 'successful in every expected way' (Burkholder 2008).

Thus far we can note that Ashley herself, her will and her views, do not feature in this story. What circumstance would allow for parents to sterilize a six-year old child? One of the immediately noticeable facts about Ashley is that various actors do not agree on the facts about Ashley. Ashley was diagnosed at birth with 'static encephalopathy of unknown etiology' which her parents describe as 'an insult to the brain,' and 'one that will not improve' (AM & AD 2012).¹⁰ Beyond this diagnosis, we know little of Ashley outside the discourses her parents, physicians, lawyers, and various commentators project onto her. The silence of Ashley's perspective is not a mere footnote or methodological dilemma in attempting to study her situation; it is entirely emblematic of it. Thus I

acknowledge my unease at contributing to the commentary about Ashley, and hope to draw attention to her silencing, rather than reproduce it.

In her incisive analysis of the Ashley X case, Kafer notes that Ashley's Treatment rationales are shot through with 'temporal framings' of the futural disabled mind/body (2013: 48). According to her parents and doctors, Ashley's growth had to be attenuated lest she grow 'too large' to be moved (AM & AD 2012). She was purported to require a mastectomy so that she didn't develop breasts that were 'too large' and thus potentially uncomfortable in her wheelchair straps, develop potential future breast cancer, or become 'inappropriately sexualized toward her caregivers' (AM & AD 2012). She was said to require a hysterectomy to avoid 'the complications of menses' (Gunther & Diekema 2006: 1015) and the possibility of pregnancy if abused (AM & AD 2012).¹¹ Though Ashley's parents stated they would always care for her at home (AM & AD 2012), doctors have since argued that children like Ashley, if not 'treated', will grow to a non-'manageable' size and be institutionalized (Gunther & Diekema 2006: 1013). Disability advocates have argued that each of these bad futures that Ashley was pitched into, could have been addressed in alternate ways (see Kafer 2013).

When Ashley is spoken of in the present tense, she is primarily described in the negative, by what she does not do: hold her head up, roll over, change positions, sit up by herself, walk, talk or make eye contact (AM & AD 2012). It is said that she lacks the awareness to understand the procedures that were done to her (AM & AD, 2012). Yet some of the characterizations of what Ashley *does not* do appear to contradict descriptions of what she *does* do: move her arms and legs, love music and respond by

vocalizing and kicking ‘when she connects with a song’, be ‘alert and aware of her environment’, and smile and ‘[express] delight’ when her parents visit with her (AM & AD 2012). Thus while it is argued that Ashley has no awareness and thus these procedures were non-problematic, it is also argued that the Treatment was intended to prevent her suffering, although the ability to suffer presumably requires some awareness (Kafer 2013). While her parents remark they are not sure she recognizes them, thus they argue she is not aware, they also wish her to be of a light weight so she can be at home with the people she loves, with the ability to love presumably requiring some awareness as well. The observation of these contradictions is not meant to imply that her parents do not care for her. Yet Eli Clare sums up the perspective of many when he writes in his letter to Ashley’s parents: ‘I’m struggling to trust your love’ (2014: 36). These observations are also not meant to imply that Ashley’s parents made choices in isolation. The abysmal lack of support for families with disabled children and the pervasive devaluing of disabled life situate this Treatment in a profoundly ableist context, the blame for which should not rest with Ashley’s parents alone (Brosco, 2006; Mukherjee, 2009).

That Ashley’s doctors describe her surgery as ‘uneventful’ (Gunther & Diekema 2006) is intriguing given that the ‘event’ sparked an international debate. An article penned by Ashley’s doctors in a medical journal (Gunther & Diekema 2006) was met by media fascination (Davies 2007; Verhovek 2007). The National Disability Rights Network called the Treatment ‘shocking and disgusting’ (Not Dead Yet 2012). Disability groups FRIDA (Feminist Response in Disability Activism), ADAPT and Not Dead Yet demanded meetings with the American Medical Association (FRIDA 2007).

Contradictory expert legal and bioethical opinions were commissioned.¹² A blog by Ashley's parents defending the Treatment (pillowangel.org) emerged alongside response blogs with titles such as *No More Ashleys* (2013). The ongoing debate among pediatricians, bioethicists, disability rights advocates and others has seen an ongoing proliferation of arguments for and against the Ashley Treatment.¹³ Despite the controversy, as many as 10 hospitals had begun to offer this Treatment as of 2010 (Koyama 2010). Thus while this paper focuses on one individual, an unknown number of disabled youth have undergone this Treatment as well as other 'newgenic' interventions that exert control over the sexualities of disabled people (EugenicsToNewgenics, n.d.). Because Ashley's Treatment was obtained swiftly and without public discussion, justifications have been produced retrospectively. Most significant for this discussion are the rationales that rest on notions of time and temporality: the argument that Ashley had a true or known 'cognitive age' and that her body needed to be aligned with her mind. I consider the temporal lives of trans youth before returning to Ashley.

Trans Youth and the Demand of Time

Sex change has always been a temporal affair and nowhere is this more true than in the scene of the gender clinic. When the first US adult gender centres opened in the 1960s to respond to sex-change requests, clinicians charged with worrying about transsexual futures took to investigating applicants' claims to their pasts (Garfinkle 1967/2006; Meyerowitz 2002). Among other things, clinicians were concerned that the one percent of applicants they approved had always felt this way and always would

(Green & Money 1969). It remains true in the present-day gender clinic, that much is at stake in the story of the past, intended as it is, to activate the future.

The significance of trans time is even more acute for youth. The first generation of youth gender clinics were devoted to averting a trans or queer future (Rekers 1977). Writing of his pioneering clinical treatments for ‘feminine boys,’ Richard Green hopefully remarked: ‘My focus will be what we might consider the prevention of transsexualism’ (1971: 167). When the need for preventing a transsexual or homosexual future was not self-evident, the rationale came by way of associating these individuals with the bad futures of unemployment, exclusion, violence, suicide and so on (Rekers et al. 1977). Yet with the new option of puberty suppression and early transition, the gender clinic in 2016 now facilitates rather than forecloses trans life.¹⁴ With early transition proposed as a positive mental health strategy (Ehrensaft 2014), grim futures are now used to argue in favour of transitioning, rather than against it. Once deferring trans identity, the youth gender clinic now confers it, though importantly, not for all.

Since the mid 1990s, GnRH analogues or ‘puberty blockers’ have been used to halt the pubertal development of trans youth for up to several years at a time (Kreukels & Cohen-Kettenis 2011). The stated benefits are both of the *now* and of the *later*. In the immediate, blockers hit pause on the potential distress of trans youth who, at puberty, are faced with a body developing in the ‘wrong’ direction. Thus blockers are understood to reduce stress, create time to consider transition and even prevent suicide attempts (Fernandez, 2015).¹⁵ In the long term, puberty suppression can facilitate a future transition by preventing growth that is difficult to later undo, for example breasts on a young trans

boy or facial hair and voice change on a young trans girl (Hembree et al. 2012). After a period of puberty suppression, youth might seek to transition with cross-sex hormones or opt to discontinue and let endogenous puberty take its course. When (if) later transitioning, an early suppressed puberty opens out onto a radically less visible future, which as clinicians themselves note, is: ‘...a lifetime advantage...’ (De Vries et al 2011: 2277). With dozens of gender centres opening in urban children’s hospitals in the US (Hidalgo et al. 2013) and Canada (Pyne, 2014a), puberty suppression for trans youth would seem to be moving from a sporadic occurrence to an institutionalized best practice (Roen 2011).

Returning to Kafer’s (2013) remarks that the Ashley X case is shot through with discourses of time, the same can be said of the discourses surrounding trans youth. In clinical literature and in the media, blockers tend to be described as an emergency, a ‘race against time’ to ‘beat the onset of puberty’ (Hirsch 2016). Dr. Norman Spack (2013), a US forerunner in the use of puberty blockers for trans youth, refers to this work as ‘giving time.’ More often, puberty suppression is described as ‘buying time’, which, given the exorbitant price of the puberty blocker Lupron (\$25,000 USD),¹⁶ is a phrase that aptly captures the convergence of class (and race), time, capital and the pharmaceutical market on the young trans body.

Discourses of time structure the encounters between trans youth and their clinicians. Accused of being cavalier with treatment, some clinicians counter that eligible youth are only those who are ‘insistent, persistent and consistent’ (Hidalgo et al. 2013: 286). The stated need then is not only strong, but stable and repeated over time. The spectre of

regret looms large in the clinic, with much anxiety over the possibility of youth regretting their decision. Thus clinicians listen to the past to anticipate the future, and anticipate future feelings about the past (regret). Suicide is understood to threaten trans youth who cannot access blockers, playing a key role in moving parents and others to action.¹⁷ Further, the image of a future abject trans adult serves as justification for early intervention, lest youth acquire the undesirable ‘psychosocial outcomes’ and physical features imputed to trans adults (Spack 2013).

Judging by clinical and public discourse, that puberty suppression is morally and bioethically thinkable at all, may be because it is deemed ‘reversible’ and thus a safe holding pattern before transsexual hormones and surgeries, ominously coded as ‘irreversible.’ Sekuler (2012) finds that the terms ‘irreversibility’ or ‘reversibility’ appear over fifty times in a French health authority report on transsexualism. Further, that trans youth are seen as anomalous and worthy of public interest is a function of normative notions of time and human development. As Bauer et al. (2009) remark, the belief that those born female will have a girlhood and grow up to be women, and vice versa for those born male, is so pervasive it is rarely spoken. Thus, at times, parents mourn the ‘loss’ of the normatively gendered child (Moss 2015), the child who was anticipated but never arrived, or arrived but drifted off course. Finally, the politics of puberty suppression rely on modern notions of linear progress. The appearance of trans children, and the mobilizing of familial and other supports, is narrated as a sign that ‘it gets better’ and is contrasted with other worse times, in worse places.¹⁸

There are many similarities between the bodily arrest sought by trans youth versus that sought for Ashley. Beginning with the procedure details, Ashley received a bilateral mastectomy, a hysterectomy, and a high dose of estrogen to seal her growth plates – a list that reads like a combination of treatments for trans boys (mastectomy and hysterectomy) and trans girls (estrogen to freeze height). Both scenarios court controversy and the involved endocrinologists are publically narrated, in turn, as either compassionate or monstrous. Bioethicists and experts have weighed in on both interventions, with determination that each procedure may go forward because the benefits outweigh the risks (Hembree et al. 2009; Hastings Centre 2010). Courts have been called on to adjudicate the permissibility of both procedures. And as each is considered quite drastic, extensive justifications have been crafted over time.

There are of course vast dissimilarities as well, including the purpose and the permanence of the treatments, and the fact that while trans youth make their treatment wishes known, Ashley is unable to easily do so.¹⁹ Yet a comparison has already been made. In the only other analysis to my knowledge that brings Ashley's situation together with trans youth, Gillett lifts the rationales that support (some) trans youth to pursue their desires, in order to argue *in favour* of the Ashley Treatment (Gillett 2016). According to Gillett, if it is ethical that trans youth have their bodies and their minds 'aligned' vis-à-vis medical intervention, then it is ethical that this be done to Ashley as well. I will argue the reverse: the similarities between these sets of treatments *do not* serve to authorize unelected body modifications on disabled youth, but instead call into question the ableism that operates directly in Ashley's Treatment and indirectly in the delay or denial of some

trans youths' requests. The following section explores two discursive themes in treatment justification: that of mind/body synchrony or 'alignment' and 'cognitive age'.

Asynchrony and the Alignment of the Mismatched Body/Mind

In the late nineteenth century, Karl Ulrichs wrote that he was a 'female soul in a male body,' and is often credited with the first use of a misalignment metaphor to describe gender variance (1994: 363). Though Ulrich might be categorized as a gay man in today's taxonomy, the phrase 'trapped in the wrong body' came to be used by transsexuals to describe their predicament. In the first clinical text about transsexuality, Harry Benjamin, the highly influential 'father' of modern trans health care, used the musical metaphors of 'dissonance' to describe transsexuals prior to transition and 'harmony' to describe the goal of intervention (1966).

In the present day, after much advocacy and deliberation, the fifth revision of the *Diagnostic and Statistical Manual* (DSM-5) saw the diagnosis of 'Gender Identity Disorder' replaced by 'Gender Dysphoria,' making some headway, though not without critique, toward depathologizing cross-gender identity and facilitating transition (APA 2013a). That one's body might not match one's identity, or that one's gender might not match one's sex, is today's accepted rationale for transition and for emerging rights frameworks established by government bodies and within schools and other institutions (APA 2013b; NASP 2014; OHRC 2014). Though the conception of transness as mismatch does not go uncontested, in the clinical and popular texts that speak to trans health, the 'wrongness' of the imminent pubertal body, juxtaposed against the 'true gender self' within (Ehrensaft 2012), helps to establish the race against time to intervene

and block puberty on a youth's behalf. Thus a finding of misalignment can trigger a release of additional autonomy and form the basis of youth exercising their will.

In Ashley's situation, the rationale of misalignment had a drastically different effect on her will. Ashley's case was also described as a race against time to attenuate her growth before the onset of puberty (Gunther & Diekema 2006). Her impending development was described as an imminent threat and her own 'worst enemy' (AM & AD 2012). What was the threat? In almost all writing about Ashley, she is described as having the cognitive ability of an infant. I will expand below on how discursive age played out for Ashley. In short, however, framing her as an infant established the misalignment for Ashley as a temporal mismatch, with her 'true' or inner age at odds with her chronological age: Kafer (2013) notes that as she aged, Ashley's body was seen to grow apart from her mind, which was thought to not develop at all. Ashley was said to be an infant inside what would become a woman's body: 'Ashley had to be cured of her asynchrony' (Kafer 2013: 57).

As the criticism of Ashley's Treatment grew, bioethicists such as Dvorsky re-articulated the justifications: 'The estrogen treatment is not what is grotesque here. Rather, it is the prospect of having a full-grown and fertile woman endowed with the mind of a baby' (2006). The use of the word 'grotesque' is illuminating and points past the oft-touted concern for Ashley's wellbeing. If we were to accept for a moment that Ashley lacked the cognitive ability to comprehend anything about her own life (though it is crucial we do not accept this), then nothing about her body could be grotesque *to her*, and the term must refer to someone else's experience of her. Kafer (2013) builds on

Davis' (1995) work on disability as a disruption in the 'perceptual field' of others (Kafer 2013: 129), proposing that Ashley was a disruption in the 'temporal field' of others (Kafer 2013: 55). Further, though Ashley's purported mismatch was not a case of 'gender dysphoria,' neither was it outside of gender. As Kafer (2013) notes, the term 'grotesque' adheres particularly well to women's bodies and the eagerness with which interventions were performed on Ashley is difficult to imagine similarly performed on a male body. Williams (2007) asks if a boy would be castrated to better accommodate his wheelchair straps.

Returning to trans youth and their demand for intervention, it is clear that their projected asynchrony might also be a disruption in the 'perceptual field' of others (Davis 1995: 129) and that this could contribute to how and why some are able to receive the procedures they seek. Explaining how he built the first American program of puberty suppression, Dr. Norman Spack recounts showing his hospital administration photos of presumed undesirable trans adults to argue for early intervention (2013). 'You gotta do something for these kids,' the administration responded (Spack 2013). While many trans people certainly do seek to 'pass' with less markedly trans visibility, more than one agenda emerges when youth who block puberty are described as 'beautiful', 'normal' and 'like everybody else' (Spack 2013).

In Gillett's analysis that considers Ashley's case alongside trans youth, he cites the pursuit of 'psychosomatic harmony' (2016: 22) as the thread that ties these interventions together. Gillett argues that Ashley's Treatment can be justified on the same grounds that trans youth are treated in pursuit of the 'classical ideal' of 'harmony between mind and

body’ (2016:35). Lifting the language of ‘reassignment’ (from the phrase ‘gender reassignment’) for use on Ashley, Gillet states: ‘If a gendered psyche is a ground on which a person can be (re)assigned an appropriately gendered and perhaps modified body (*soma*), then perhaps a perpetually infantile psyche should be a ground on which we might consider assigning an infantile body’ (2016: 34). The rationale of alignment can thus be used against Ashley whose parents and physicians are incited to bring about her ‘synchrony,’ oblivious to any indication of her will.²⁰

If, as I have said, the rationale of misalignment can trigger an increase in trans youth’s autonomy regarding their care, then we must ask if it does so for all. To begin, when the end goal is described as ‘beautiful’, ‘normal’ and ‘like everybody else’ (Spack 2013), we should presume that these concepts are more available to some bodies than others, with disabled, poor and racialized youth less likely to be categorized as such. As stated above, in the clinical literature around puberty suppression and early transition, it is not unusual to find reference to approved youth as ‘carefully selected’ (Khatchadorian 2012) according to ‘strict criteria’ (Smith et al. 2001: 473). The criteria for promising candidates tends to centre a strong and longstanding cross-gender identification (De Vries et al. 2011), phrased by other clinicians as ‘insistent, persistent and consistent’ (Hidalgo et al. 2013: 286).²¹ How might some trans youth be disadvantaged?

Recent years have seen an increase in clinical attention to neurodiverse²² trans youth – those diagnosed on the autism spectrum who seek to block puberty or transition young (De Vries et al 2010; Jacobs, Rachlin, Erikson-Schroth & Janssen 2014; Janssen, Huang & Duncan 2016). A range of theories about who these youth are, and why these

youth are, can be found in clinical literature.²³ Some clinicians have helpfully stated that an autism diagnoses should not be used to deny or delay transition indefinitely (Jacobs et al 2014; Strang et al 2016; Tishelman et al 2015). Yet a focus on the rationales that allow access to transition, raises questions about whether neurodiverse youth could be delayed or denied indirectly.

Jay Prosser (1998) notes that since there exists no objective ‘test’ for transsexuality, clinical assessments rely on narrative. The lifelong cross-gender identity – the insistent, persistent and consistent misalignment – must be storied. Prosser writes that ‘there has probably never been so much at stake in oral autobiography’ (1998:108). Yet communication barriers between autistic and non-autistic people are common, and autistic self-advocates like Dawn Prince (2010) point to a “language prejudice” in the way neurodiverse people are evaluated using neurotypical standards. Might the need for a convincing story of misalignment work to set back, rather than secure, transition care for neurodiverse trans youth? Clinicians De Vries et al. report that they are skeptical as to whether autistic youth who present to clinics have a true ‘core cross-gender identity’ or if they might just ‘feel different’ (2011: 2277). Parkinson recounts delaying a request for transition by a young person on the autism spectrum for *six years*, as their status as ‘essentially female’ was unconvincing (2014: 84).²⁴ Returning to Ashley, the purported misalignment between her body and mind worked to speed Treatment against her will. For trans youth, a finding of misalignment might help secure what they seek in a timely fashion, yet this may not be the case for neurodiverse trans youth. Thus the rationales that facilitate care for some, might be precisely what hinder others.

Cognitive Age: The Infant Versus the Mature Minor

As mentioned, Ashley is described as a perpetual infant by her parents, physicians and the vast majority of commentators. Her parents call her a ‘pillow angel’ (AM & DM 2012)²⁵ and her ‘cognitive level’ is said to be that of ‘a baby’ (Dvorsky 2006), ‘a 3 month old’ (AM & AD 2012), or a ‘6 month old’ (Gillett 2016: 28). The effects of this are clear: parents make all decisions for infants, and further, infants don’t menstruate or have breasts, thus the fact that these material realities were imposed on Ashley is lost in what appears to be the normal state of affairs for an infant. Ashley’s parents write: ‘Ashley’s life may be very limited, but like any baby, novelty attracts her attention’ (Pilkington 2012). Yet they write this when she is *nine years old*.²⁶ Of all the critiques of Ashley’s infantilization, perhaps the most devastating indictment comes from Anne McDonald (2007) who penned an op-ed recounting her own institutionalization with the same diagnosis as Ashley - fourteen years during which she was labelled with an IQ of 20. At age sixteen, McDonald was finally given a mode of communication and used it to instruct the lawyers that fought for her release and to complete a degree with majors in the philosophy of science and fine art. While Ashley’s ‘cognitive age’ cannot be verified as a fact, it is most certainly a fact that people with disabilities routinely and vigorously refute infantilizing assessments of their capabilities and the truncated predictions made for them as children (Clare 2017). Further, discourses of race also appear in the infantilization of Ashley, with the language of her parents writing, such as ‘sweet’, ‘pure’, ‘innocent’ and ‘angelic’, deriving significance from racialized notions of whiteness and purity (Berthold

2010). Indeed, Williams (2007) questions whether a Black child would be accepted worldwide as an ‘angel’.

Temporal arguments of age and maturity are also present for trans youth. Those who warn against early transition tend to narrate childhood and adolescence as times of innocence and confusion, and thus not the right ‘time’ for such decisions (Malone 2015). In contrast, those in support often refer to trans children as mature minors - ‘ahead of their time’ (Dibiasi 2015), ‘extraordinarily articulate’ (Olya 2016), ‘mature beyond their years’ (Legge 2015) or ‘wise beyond their years’ (Brown 2008:19). In an anonymous interview, one child psychiatrist described trans children and youth as ‘super advanced’ and ‘years ahead.’²⁷ Moreover, not only can trans youth be narrated as mature minors in the present, but also possessing of adult futures. While Ashley’s purported permanent infancy is produced in part through the rationales that she would ‘never have a job’ (Gunther & Diekema 2006) or be a parent (Gillet 2016: 28), it is evident that having a job and becoming a parent is precisely what is anticipated for (some) trans youth.¹⁹ In a trans youth needs assessment and policy document, it is noted that access to puberty blockers and hormones improves their future employability and ‘earning ability’ (TransActive n.d.).²⁸ Referencing trans youth who are approved for transition, De Vries et al. show concern for their ‘adult professional and personal lives’ (2014: 697). Further, there is concern for future fertility and active strategizing to avoid the loss of reproductive capacity that can occur with early puberty suppression (Berg 2016).²⁹ That participation in reproduction and capitalist labour is conflated with adulthood is important for understanding how and why Ashley can be viewed as a perpetual infant. While

supporting trans youth in their employment and fertility options is positive, this support also signals the future value of their bodies, a value not accorded to all.

How might these discourses work for trans youth on the autism spectrum? As noted, the discursive link between disability and ‘earlier’ states of temporal development was drawn through the nineteenth century concept of ‘mental deficiency’ and remains active today. Temporal terms such as ‘lag’ and ‘delay’ permeate scientific renderings of ‘developmental disability,’ while more colloquial terms such as ‘slow’ mark an imagined stay in progress. A century of scientific theorizing about ‘intelligence’ and ‘cognitive ability’ has secured people labelled with intellectual disabilities as beings of a lesser age, while modern scientific and media discourses infantilize autistic people in particular (Murray 2010; Stevenson, Harp & Gernsbacher 2011). While it is not possible to deconstruct all these discourses in this preliminary reflection, it can be noted that knowledge claims regarding autism, scientific or otherwise, lack consensus.³⁰ Autistic self-advocates and their supporters have contested the science of cognitive age (Series 2014), rejected theories of autistic intelligence and presence (Savarese & Savarese, 2010) denied the presumption of an emotion or empathy deficit (Brewer & Murphy 2016; Kochmeister 2010), spoken back to the ontological categories of ‘high’ and ‘low’ functioning (Murray 2010), and proposed autism as an alternative culture rather than an impaired state of being (Straus 2010). In addition, there is evidence that autistic people return the gaze and engage in the evaluation and classification of neurotypical people as well (Adams, Graham, Brody & Becker 2016).³¹

While clinical literature that addresses neurodiverse trans youth does so from a variety of perspectives, an untroubled acceptance of concepts such as intelligence, deficit, delay, function, impairment and developmental arrest, can be problematic. These are concepts that may preempt some trans youth from accessing the discursive resources that would seem to assist others (for example maturity, wisdom, leadership.) When Smith et al. describe selecting ‘the best functioning transsexuals’ for early transition (2001: 480), it is doubtful they intend disabled youth. As noted, some clinicians have helpfully stated that an autism spectrum diagnoses should not be used to deny or delay transition indefinitely (Jacobs et al 2014; Strang et al 2016; Tishelman et al 2015), yet examples of precisely this outcome can be found. Parkinson (2014) reports intentionally delaying autistic youth from transitioning until they discontinue their attempt. A now deceased young American trans man named Kayden Clark posted an online video in 2016 in which he recounts being denied transition care until he could ‘fix his Aspergers [sic]’ (Clarke 2016).³² Thus, in the gender clinic, it seems as though one might be delayed if one is already deemed delayed. Juxtaposed against an emerging prototype of the trans youth who is older than their years, deserving of autonomy, is the autistic or disabled youth who may be coded as the reverse, as younger than their years. While some trans youth are narrated as ‘ahead of their time’ (Dibiasi 2015), others are more likely to be seen as lagging behind.

To understand what is at stake in these outcomes, one need only return to clinician’s own writings about the benefits of blockers and early transition for trans youth. When puberty is not blocked, this is said to ‘seriously interfere with healthy psychological

functioning and wellbeing’ (Delemarre-van de Waal & Cohen Kettenis 2006:155), and waiting for these interventions is often ‘highly upsetting’ (De Vries et al 2011: 2277). Delemarre-van de Waal and Cohen Kettenis (2006) write that experiencing unwanted puberty causes youth ‘anxiety that limits their capacities...’ (131), while De Vries et al (2011) take note of the reduced visibility afforded by blockers and declare this a ‘lifetime advantage...’ (2277).

Discussion and Conclusion

As stated, the controversial nature of puberty blockers has required the crafting of justifications over time. As noted, these arguments have been increasingly successful in establishing early transition as a best practice within the medical communities most proximal to trans youth. Elsewhere, I have argued vigorously for trans youth to have such options (Pyne 2012a; Pyne 2012b; Pyne 2014a; 2014b). Yet in bringing together the elected developmental arrest for trans youth and the well-known imposed arrest on a young disabled girl (Ashley X), other questions come to the surface. While the temporal discourses of body/mind misalignment and cognitive age may support trans youth in exercising their will, these same rationales worked against or oblivious to the will of Ashley. Moreover, these discourses appear to also have the potential to work against the will of disabled trans youth who seek to transition. What we may consider then is that the mode of argumentation for why some trans youth should have puberty blockers and transition care, may expand the conditions of possibility for some while shrinking those possibilities for others. Trans youth who are able to access the treatments they seek may do so in part because they are deemed able bodied and able minded. Thus the new futures

of (some) trans youth - the ‘lifetime advantage’ of those approved - may also auger something else: a widening gap between youth who are empowered to stop time and those who are stopped in time. At this crucial moment in early transition care for trans youth, I would suggest we must attend to the logics that underpin the provision of these possibilities to ensure that we do not make insiders of some and outsiders of others.³³

Notes

1. Following Hershey (2007) and Kafer (2013) I will capitalize the specific ‘Treatment’ that Ashley received to register that she was neither sick nor in need of this Treatment, and to preempt the conflation of this shocking Treatment with medical treatment in general.
2. In the context of queer politics, Berlant and Freeman (1992) note that activism has often focused on space, for example ‘positive space’ initiatives and slogans such as ‘we’re here, we’re queer, we’re everywhere.’
3. Within queer temporality literature, children and reproduction, real or represented, have feature centrally. See Edelman 2004; Love 2007; Halberstam 2005; Stockton 2009.
4. Google search conducted July 22, 2016. A critique of the idea of ‘inspiration’ is much more developed among disability activists and scholars who have theorized ‘inspiration porn’ (see Stella 2012: <http://www.abc.net.au/news/2012-07-03/young-inspiration-porn/4107006>).
5. This Dutch to English translation of Schöttelndreier (1999) is generalized and may be imprecise.
6. See a recent news story about a mother suing her own transgender child and the health authorities that supported their transition: <http://www.nbcnews.com/feature/nbc-out/minnesota-mom-sues-her-trans-child-over-gender-reassignment-n685266>
7. Some intersex conditions can also lead to ‘precocious puberty’. There are many important parallels and diverging issues with intersex realities that cannot be explored in this paper, but are deserving of scholarly attention. I am indebted to Mauro Cabral and Katrina Roen for their thinking about intersex children and youth and the bodies that are offered protection within medicine, versus those that are discarded.
8. There is some disagreement over how contested this ethics board decision was. No record of the conversation was kept (Clarren 2007).
9. Washington law prohibits parents from consenting to the sterilization of a disabled minor without a due court process in which the child has their own representation (Carlson & Dorfman, 2007).

10. Clare (2017) points out that Ashley's diagnosis is really one of Cerebral Palsy, shared by many, rather than the rare term they use of 'static encephalopathy.' The omitting of this information by her parents raises questions about whether there was an attempt to isolate Ashley from those in the disability rights movement who might identify with her and be moved to action. The parent's labelling of Ashley as 'unable' rather than 'disabled', certainly seems to point to this.
11. It should be noted that there were no indications of breast cancer (Kafer 2013). In addition, critics have pointed out the denial of Ashley's future or present sexuality, reflected in these rationales (Hershey 2007). Further, women with disabilities do face disturbingly high rates of sexual violence, however critics have found it particularly appalling that the removal of a girl's breasts was presented as a strategy for preventing potential violence against her (Hershey 2007).
12. The Washington Protection and Advocacy System launched an investigation concluding that Ashley's rights had been violated, requiring Seattle Children's to apologize and disallow future Treatments. Yet a subsequent expert panel and Hastings Centre Report concluded that these procedures could be ethical and could go forward. An unknown number of children have now undergone these procedures (Liao, Savulescu & Sheehan, 2007).
13. The role and meaning of 'dignity' in Ashley's Treatment was contested, with some arguing that the Treatment was a violation of Ashley's dignity (FRIDA, 2007) while others suggest that her disability made her ineligible for human dignity (Singer, 2012). Various actors have also debated the role of disabled adults as advocates and informants on this issue, with pro-Treatment critics denying that disability activists offer any insight (Singer, 2012; AM & AD, 2012), and others naming the views of disabled adults as crucial to any possibility of ethical understanding (Kittay, 2011). Some argued (unfortunately including the authors of the Hastings Centre expert report) that the Treatment should only be used on those who are 'nonambulatory and have persistent, profound developmental disabilities' (Hastings Centre, 2007; Singer, 2012). As others point out, this would mean the Treatment is effectively used only on those who do not have the social power to contest it (Not Dead Yet, 2012).
14. This shift has not gone uncontested and there have been heated debates within the past year over appropriate treatment for pre-pubertal gender non-conforming children, and a reorganization of which goals for are pursued for these children:
<http://www.sfgate.com/opinion/article/Want-to-know-a-child-s-gender-Ask-6843665.php>
15. Dr. Norman Spack remarks: 'The minute these kids even know they're going to get the puberty suppressants, their suicidal thoughts melt away.' Though not inclusive of young children, a Canadian survey with trans people (ages 16+) found that the time period before medical transition begins is the time of highest suicide risk. In this study, of those trans people who wanted to medically transition, those who had not yet begun were 27 times more likely to have attempted suicide within the past year than those had completed medical transition (Bauer, Pyne, Francino & Hammond 2013).
16. In Canada, the yearly cost of Lupron is closer to \$5,000 CDN, yet still out of reach for many families. Some Canadian clinicians have succeeded in having these costs

covered by drug companies on compassionate grounds. Author's anonymous interview with child psychiatrist, May 2016.

17. I acknowledge that I have also made this argument myself: Pyne 2012a
18. I acknowledge that I have also made this argument myself: Pyne 2014a
19. Some might say that the expressed wish for treatment by trans youth, and the absence of that expressed wish by Ashley, makes these cases too different to compare. Yet the long history of unwanted bodily interventions performed on disabled (Clare 2017) and intersex youth (Holmes 2008), those who could in the physiological sense *speak*, indicates that the question of metaphorical voice with respect to societal power, might be as relevant if not more, than the question of voice in the physiological sense.
20. Gillet does note the lack of an expressed wish for 'harmony' from Ashley to match that of trans youth, but he gets around this by stating that health is 'relational' (Gillett 2016: 29) meaning Ashley's wellbeing is bound up with her family's. We might ask however, if this positions Ashley's wellbeing as subservient to her family's. While promoting family care is an important alternative to the threat of institutionalization, proposals like Gillett's may be why Kafer cautions us to interrogate family care values for whose interests may be served (2013: 62).
21. Clinicians propose differing criteria and there are indications that North American clinics may be more liberal in their use of these treatments, however, it is beyond the scope of this paper to discuss the nuances of existing approaches. The Dutch clinic that developed the use of puberty blockers for trans youth considers candidates eligible for puberty suppression when they have '...suffered from lifelong extreme gender dysphoria, are psychologically stable, and live in a supportive environment.' (Delemarre-van de Waal & Cohen Kettenis 2006:131). Many questions could be asked about the need to be 'psychologically stable and live in a supportive environment', and Roen (2011) suggests that the 'successful outcomes' of some youth gender clinics might be produced by selecting youth who are 'already successful' (64).
22. I am using the term 'neurodiverse' to reflect the language advanced by autism self-advocacy organizations such as ASAN (Autistic Self Advocacy Network), who argue that autism is a reflection of neurological diversity among human beings, rather than an illness in need of cure. Similarly, I use the term neurotypical to describe non-autistic people (Autistic Self Advocacy Network 2016; Autism Network International 1998).
23. De vries et al (2010) note that the clinical literature to date spans various theories to explain the existence of autistic individuals with a cross-gender identity, including the theory that these are 'co-occurring disorders' (Mukaddes 2002), that cross-gender expression is the result of the 'unusual interests' of autistic people (Williams et al 1996) or that both together constitute an 'obsessive compulsive disorder' (Landen & Rasmussen 1997).
24. In addition, Indigenous gender diverse youth might also present a gender narrative that departs from the white European standard (Roen 2006) and thus might trouble the clinical assessment process. Non-binary gender identities also raise issues in the gender clinic process (Richards, Steensma & Nieder 2015). Much of what I note as

disadvantaging neurodiverse youth (the need to story a persistent misalignment) would also disadvantage non-binary youth.

25. Ashley's parents remark: 'We call her our Pillow Angel since she is so sweet and stays right where we place her—usually on a pillow' (AM & AD 2012). Ashley's parents also disturbingly label her 'permanently unable' rather than 'disabled' (AM & AD, 2007). Along with the term 'pillow angel', this not only infantilizes her, but marks her, like an angel, already deceased. While Ashley's parents clearly care for her and aim to preserve her life, for other commentators, death is not out of the question. Bioethicist Dvorsky takes the occasion of Ashley's Treatment to note that this 'undesirable situation' (2006) could perhaps be avoided, citing the UK's Royal College of Obstetricians and Gynecology in their call for health authorities to consider 'active euthanasia' (2006) for 'severely disabled newborns' (2006).
26. Eva and Bill Kittay (2007), also the parents of a daughter with significant disabilities, refuse Ashley's infantilization in their writing about their own daughter: 'We do not believe she is a perpetual child... for she has lived for thirty-seven years in this world and with that has acquired knowledge, sensitivities, and sensibilities that no child of "comparable" capacities could have' (Kittay & Kittay 2007). Kittay has written other work to contest Ashley's Treatment (see Kittay 2011).
27. Author's anonymous interview with child psychiatrist, March 2015.
28. In an earlier clinical era, it was said that youth should be steered away from transsexualism because of (among many threats) the threat of future unemployment (see Rekers & Lovaas 1974). Thus it is a radical departure to argue that transition improves employment outcomes. It is beyond the scope of this article to explore the current relationship between trans youth treatment and the labour market, however Irving's (2016) theorizing about transition as an 'economic event' is instructive.
29. It is beyond the scope of this paper to unravel the links between these treatments that center around reproduction and reproductive futures. Clearly Ashley's perceived lack of a reproductive future functioned to speed up her Treatment – because it was said that she would never be a parent, her hysterectomy was done in violation of Washington state anti-sterilization laws. In fact, Ashley's father argued that those laws were intended to protect women who might choose to have children in the future, and because Ashley could not choose this, he argued she was not due that protection (Pilkington 2012). For trans youth, on the other hand, when they are perceived to have reproductive futures, this can slow down their access to transition care, while clinicians or parents deliberate about the loss of fertility that may occur with these procedures. There is much theorizing to be done about how the discourses of 'reproduction' and 'protection' function in these debates.
30. In an article about trans people with autism diagnoses, Jacobs et al note: 'Both populations also have vocal consumer lobby groups that advocate against pathologizing what they understand to be natural variants of human experience.' (2014: 1)
31. For example, trans health professional Julie Graham reports that her autistic son refers to non-autistic individuals as Highly Interactive Emotionals (HIE) who demonstrate

impaired logic, difficulty tolerating diversity, and a high need for social approval and conformity (Adams, Graham, Brody & Becker 2016).

32. Kayden Clarke was shot dead by police officers in his home in February 2016. Police were called to Clarke's home because of a report that he might be suicidal. The resulting media has since detailed many examples of discrimination Clarke faced based on his disability. See Abeni 2016.
33. I am indebted to Ann Travers for the phrase 'making insiders of some and outsiders of others'.

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CHAPTER THREE

Narrative Malady, Normative Temporality: Doing Time with Autistic Trans Youth in the Gender Clinic

Abstract

Duffy and Dorner (2011) note that despite much searching, there exists no biological marker that distinguishes the autistic from the non-autistic. Autistic identity remains a “narrative condition” that must be storied, a fact shared with transgender identity. This chapter reports on a discourse analysis of qualitative interviews with clinicians who serve trans youth in gender clinics. When asked to describe the cases they find straight-forward or easy, and those they find difficult, 18 clinicians across 6 countries overwhelmingly offered autistic youth as examples of difficult cases. Drawing on the literatures of critical autism studies, transgender studies and queer temporalities, I explore the interpretive repertoires that clinicians draw on in their narrative efforts to account for the youth in their care. With significant changes in the public narrative of how trans youth have been understood over time, disorder to diversity so to speak, the story that now authenticates some trans youth and makes intelligible their narratives, offers no mode of doing the same for autistic trans youth. With stories that seem to fail, both in content and form, autistic youth become unreliable narrators in the clinic and take on a troubling status as “other” in relation to the trans youth subject. In this way, autism, both real and imagined, is curiously taking centre-stage in the field of trans health. While clinicians show great concern for the youth in their care, against a template of an expected story, the narratives of autistic trans youth appear scrambled and out-of-order, strange and

disorderly, or remnants of another time. The space left by the absence of an intelligible narrative was instead filled with what Yergeau (2018) calls “god theories” about autism as lack (p.11). Yet despite evidence of trouble hearing autistic narratives in the clinic, there remain indicators that in the future, autistic trans stories might yet come into their time.

Introduction

McCallum and Tuhkanen (2011) remark that “living on the margins of social intelligibility alters one’s pace” (p. 1). Elsewhere I have noted that the longstanding discourses used to capture disability (in more than one sense) are also used to pitch disabled bodies and minds into the temporal slow-lane. Diagnostic terms from the past (“arrested development”, “degeneracy”), and the present (“developmental lag”, “cognitive delay”), in addition to colloquial terms in everyday parlance such as ‘slow’, all give more than a subtle impression that the label of intellectual disability is assumed to be synonym for going nowhere fast (Pyne, 2017). Elsewhere I have also remarked that in the youth gender clinic, those who are deemed ‘delayed’ can be literally delayed in their pursuit of affirming care. For autistic¹¹ trans youth, with their intelligibility in question, slow may also be the pace of clinical response to their needs.

¹¹ I use the term “autistic” rather than “person with autism” in keeping with autistic community preference for highlighting autistic identity as indivisible from autistic people. Some interviewees might separate autism from Asperger’s, however I use the term autistic only. Autism and Asperger’s have been clinically separated at different times but were brought together in the fifth revision of the Diagnostic and Statistical Manual (DSM-5) in 2013.

This chapter reports on a discourse analysis of qualitative interviews with clinicians who serve trans youth seeking to transition – professionals responsible for making decisions regarding approving (or not) young people who seek puberty blockers and hormone therapy. Eighteen clinicians across six countries were asked to describe the cases they find straight forward or easy, and those they find difficult, uncertain, or challenging. Interviewees overwhelmingly offered the example of autistic youth as difficult cases, and did so regardless of their country of practice, health care funding model, specific profession, or institution. Indeed, the potential overlap between autistic and trans lives has become an object of increasing curiosity and study, as well as a social fact in the field of trans health (Strang et al., 2016). In this way, autism, both real and imagined, is curiously taking centre-stage in trans health. Though this study did not begin with a focus on autistic trans youth, it became, in part, a study of how autistic trans youth are heard and not heard in the gender clinic - a study of the stories clinicians tell about autistic trans youth, and the stories clinicians tell about the stories those youth tell them.

Drawing on the literatures of queer temporalities, critical autism studies, and transgender studies, I explore the interpretive repertoires clinicians use in their talk about Autistic trans youth's readiness for puberty blockers and hormones. Without a medical test or biological marker to differentiate the trans from the non-trans, the autistic from the non-autistic, both transgender and autism constitute what Duffy and Dorner (2011) call "narrative conditions" - both autistic and trans identity must be storied. With major changes in the public narrative of how trans youth have been viewed over time - from disorder to diversity so to speak - the story that now authenticates some trans youth and

makes intelligible their narratives, offers no mode of doing the same for autistic trans youth. In this study, while clinicians show great concern for the youth in their care, the youth's stories seemed to fail, both in content and form. Autistic youth became unreliable narrators in the clinic and took on a troubling status as "other" in relation to the expected trans youth subject. Against a template of the authentic trans story, the narratives of autistic trans youth appear scrambled and out-of-order, strange and disorderly, lacking in resolution, or simply remnants of another time. The space left by the absence of a usable narrative was instead filled with what Yergeau (2018) calls "god theories" about autism as lack (p.11). Yet despite evidence of trouble hearing autistic narratives in the clinic, a growing neurodiversity movement and the ability of some clinicians to engage autistic youth outside of neurotypical narrative, are promising indicators that autistic trans stories might yet come into their time.

In the next sections of this chapter, I set the discursive stage for my study by considering how autism, both real and imagined, has come to take centre-stage in the field of trans health. I begin by tracing the convergence of autistic and trans ways of being, first through the history of the twin behavioural treatments imposed on autistic and gender non-conforming children, and then through the convergence of simpatico social movements working to reframe and depathologize diversity. Influenced by queer temporality studies, I reflect on the central and confounding role that narrative plays in autistic and trans lives, exploring how autism and transgender have been storied, and how these individuals have come to story themselves. With my study organized by the question of what makes puberty suppression and early transition thinkable and possible at

this moment in time, I am especially interested in how temporality, narrative and story shapes the thinkability and intelligibility of youth who present at gender clinics, in particular autistic trans youth. Elizabeth Freeman's (2010) concept of *chrononormativity* guides an inquiry into the normative modes of time that may structure the clinic and come to seem, in Freeman's (2010) words, like "somatic facts" (p.3).

Autism and Transgender: Together at Last

Between December 2016 and January 2017, in the span of approximately one month, essays and op eds began to appear on small and large media platforms alike making the same strange claim: "The Transgender Movement Targets Autistic Children", read a headline in the aptly named "CRISIS Magazine" (Ehrhard, 2016). "The Transgender Movement is Preying on the Autistic", read another blog title (O'Neil, 2016). And in the *National Post*: "How Trans Activists are Unethically Influencing Autistic Children to Change Genders" (BBC, 2017). During this same month, a controversial BBC documentary aired alongside multiple accompanying news articles featuring a Canadian psychologist suggesting: "Transgender Children Could Actually be Autistic" (Nsbuga, 2017). To what do we owe these peculiar headlines?

There are numerous starting points for tracing the convergence of autistic and trans ways of being, however a logical beginning is with the twin behaviour modification programs that sought to extinguish all outward signs of both. At the University of California, Los Angeles in 1960s and 1970s, psychologist O. Ivar Lovaas developed treatment techniques based in behaviourism that aimed to stop autistic children from behaving in ways identified as, well, autistic. Lovaas' brutal techniques are well-

documented, including the use of electric shock, electrified floors, cattle prods, food and water deprivation as well as the techniques suggested by the title of a 1965 *Life Magazine* profile of Lovaas: “Screams, Slaps and Love” (Grant, 1965). Additionally, Lovaas trained a fleet of parents, teachers and research assistants to implement the treatment now known as Applied Behavioural Analysis (ABA) or Intensive Behavioural Intervention (IBI) – a treatment he called at the time “building a person” (Silberman, 2015).

It has not escaped the interest of critical disability scholars that at the same time Lovaas was developing treatments targeting autistic “traits” for elimination, he was also writing the grant to fund and supervise his doctoral student George Rekers’ work - the “Feminine Boy Project” (Gibson & Douglas, 2018; Liang, 2017; McGuire, 2016; Silberman, 2015; Yergeau, 2018). Reker’s program, also at UCLA, also using the techniques of behaviourism, sought to extinguish boyhood femininity in the hope of avoiding the future outcomes of homosexuality or transsexuality (Bryant, 2006). Unlike the autistic program, the primary aversive used with gender non-conforming children was withdrawal of parental affection. Though this too was cruel, the distinct absence of the cattle prod suggests a hierarchy of sub-humanity. While the autistic treatment could be said to have trumped the other in brutality, ABA has not been prohibited the way LGBT “conversion” therapy has in some jurisdictions in North America. In Ontario in particular, LGBT conversion therapies were banned in 2015 (Legislative Assembly of Ontario, 2015) yet ABA services are viewed as best practice by many and in 2016 received a \$333 million funding increase in Ontario (Gruson-Wood, 2016; Province of Ontario, 2016). Controversially, in 2016, autistic activist Amy Sequenzia declared it time to consider

ABA as “autistic conversion therapy” and to view it in an equally immoral light (Sequenzia, 2016). Despite the modern trajectories of these “treatments”, in the beginning, there was one stated vision for both: to make the children “indistinguishable from others” (Silberman, 2015, p. 285). A temporality of cure, moving (often racing) toward a future with no autism, no matter the cost, still haunts autistic bodies and minds with “treatments” peddled by those who hope to modify them.

Autism research and knowledge production has from the start been saturated in gender. Hans Asperger himself wrote in 1944 that autism was an “extreme variant of male intelligence” (Frith, 1991, p. 84). The historical treatment of mothers of autistic children is rooted in gender failure with formative autism researchers Leo Kanner (1943) and Bruno Bettelheim (1967) postulating that “refrigerator mothers” caused autism through lack of warmth during child-rearing, in short, arguing that mothers cause autism by failing at womanhood (Douglas, 2013; Epstein, 2014). The mothers of gender non-conforming children have also been assigned causal responsibilities, though often as overly-warm, not cold (Stoller, 1968). Influential researcher Simon Baron-Cohen has for decades purported to explain higher rates of male autistic diagnoses by theorizing autism as an “extreme male brain” (Baron-Cohen, 2002). It is now increasingly common for autistic women to seek diagnosis later in life after feeling they have been misunderstood (Kourti & MacLeod, 2018).

Autism research and knowledge production eventually collided in the 1990s with clinical discourses about gender non-conforming subjects in a small number of case studies about gender diverse autistic young people. A variety of theories were offered to

explain these children, including that of “obsessive compulsive disorders” (Landen & Rasmussen, 1997), “co-occurring disorders” (Mukaddes, 2002) or the suggestion that gender expression is an “unusual interest” or “intense preoccupation” of some autistic children (Williams et al., 1996). Yergeau (2018) points out that the suggestion of autism causing queerness is intriguing given that early twentieth century moralism believed the reverse, that deviant sexuality caused cognitive difference: “And so, the age-old question for autistic queers: Which came first - the autism or the gay?” (p. 28).

These case studies repeat autism’s diagnostic story, though often with contradictions. Williams, Allard and Sears (1996) suggest a child’s gender variant expression is an autistic “preoccupation” despite the child showing an interest in all things feminine, while the clinical profile of a “preoccupation” is a focus on one or two objects. In Landen and Rasmussen’s (1997) case study, a 14-year-old autistic youth is described as identifying as male since age 8, refusing to wear girl’s clothing, refusing to use the girl’s washrooms and correcting those who use the wrong pronoun: “She claims that she is a boy”, write the authors (p.171). Despite what might be read as quite clear statements from the youth, potentially troubling the definition of autism that authors rely on (impaired communication and language comprehension), a theory is explored that the youth’s gender may be a “ritualized and obsessive compulsive behaviour” (p.171). That this young person might narrate this story differently, should not need saying.

Clinical interest in a possible trans and autistic overlap picked up in earnest with a systematic study by De Vries et al. (2010), who reported that children with gender dysphoria in their clinic had an autism spectrum disorder (ASD) diagnosis rate of 7.8% -

roughly five times the general population of 1% (Lai et al., 2014). A number of other studies found increased autistic symptoms among gender dysphoric adults (Jones et al. 2012; Pasterski, Gilligan & Curtis, 2014) and children and adolescents (Skagerberg, Di Ceglie & Carmichael, 2015; Van der Miesen et al., 2017). Other studies have investigated rates of gender variance among autistic children, finding that autistic children were 7.59 times (Strang et al., 2014) and 7.76 times (Janssen, Huang & Duncan 2016) more likely to express gender variance than their non-autistic peers. There are also studies that demonstrate no relationship (Nobili et al., 2018) and some suggest that incompatible methodologies in these studies make the meaning of the data difficult to discern (Turban & van Schalkwyk, 2018). Despite the noted overlap, there are also suggestions that trans people and autistic people are or should be distinct. De Vries et al., (2010) seem to suggest that autistic people will be rigid and trans people flexible: “For several youth with ASD, their ASD-specific rigidity made enduring gender variant feelings extremely difficult...in our society a considerable amount of flexibility is needed to deal with gender variant feelings (p.934-935). Turban (2018) writes that trans youth thought to be autistic might only show these “symptoms” because of the effects of marginalization, which would potentially “reverse” once the youth is affirmed as trans.

Clinical interest and literature regarding autistic trans people has continued to expand, including the first set of international practice guidelines (Strang et al., 2016) and professional trainings specific to clinical practice with autistic trans individuals (First Event, 2018). In many cases, this literature misses an opportunity to train a trans optic on autism’s truth claims, often taking what Yergeau calls autism’s “god theories” as a basic

starting point. Jacobs et al., (2016) however, do strongly defend the autonomy and rights of autistic trans individuals, responding in a letter in a journal with the statement: “These are their [autistic people’s] lives, not ours” (p. 175). In addition, trans health professional Julie Graham, the parent of an autistic trans child, turns the lens back on professionals by presenting her child’s taxonomy of neurotypicals as “Highly Interactive Emotionals” (HIE) who demonstrate “impaired logic, difficulty tolerating diversity, and a high need for social approval and conformity” (Adams et al., 2016). Graham demands clinicians reflect on how a neurotypical-centered clinical setting might bombard autistic people with sounds, lights, vague questions, excessive eye contact, confusing directions, and then suggest the overwhelmed individual has a communication problem (Adams et al., 2016).

In the mainstream public, the connection between transgender and autism seems to have been made in popular culture and a number of recent events have brought this further into the public eye. In February 2016, a young American autistic trans man, Kayden Clarke, was fatally shot in his Arizona home by police when his suicidality was interpreted as a threat to officer safety (Abeni, 2016). A month earlier, Clarke had uploaded a Youtube video describing his frustration with his health care providers who had told him it was necessary to “fix his Aspergers” before he could transition (Clarke, 2016). Clarke’s death sparked anger from trans and autistic communities and the Autistic Self Advocacy Network (ASAN) issued a statement stating there was no excuse for barring an autistic trans person from transitioning based on that individual’s informed consent (ASAN, 2016). Several months later a long form article in *Spectrum* explored

Clarke's death (Rudacille, 2016), and later that year an article in the Atlantic pointed out that autistic trans people are sometimes delayed when trying to transition (White, 2016).

Perhaps the most recent form of attention to autistic trans people could be described as worrying. After a mother of an autistic youth posted a story to a well-known transphobic website (see Levinstein, 2016), multiple online forums reported that trans activists were attempting to recruit autistic children and that clinics were giving out hormones and surgery to autistic youth with no questions asked (Erhard, 2016; Ruse, 2016). This and similar stories seem to rely on familiar formulations of autistic people as vulnerable perpetual children (Stevenson, 2010) and trans people as cunning and deceptive (Bettcher, 2007). Further, in the negative reactions some parents have to autistic trans children, another troubling temporality can be seen, with children described as though they have died or been kidnapped. In the relatively new online movement of parents who reject trans youth, a parent of an autistic trans youth with the twitter handle "FightingToGetHerBack" writes: "After trusting mental health professionals to help my autistic gender-confused daughter, I have lost her. Now I'm fighting to get her back" (TransCriticalMom, n.d.). This temporality of premature mourning is commonplace to both trans and autistic community, with a whole genre of books and articles written by the parents of trans children bearing titles such as "Grieving a Child that is Still Alive" (Moss, 2014), as well as books and articles written by the parents of autistic children titled "The Stolen Child" (Hewetson, 2002) and "Persistent Mourning" (Midonek, 2015). In response, trans advocates respond with commentaries such as "Transition is not death"

(Lester, 2014). One of the first recognized autistic self-advocacy statements was Jim Sinclair's essay "Don't Mourn for Us" (1993/2012).

Today, the social movements of autistic and trans community crisscross over familiar ground, steering the public conversation toward diversity and away from pathology, defining and redefining terms, creating culture. With the ever-expanding possibilities of digital life, complex online autistic and trans worlds play host to fine-grained internal debates on politics and passing, power and pride. Some autistic people have begun to claim themselves as "neuroqueer", creating not only space to be both neurodivergent and queer, but offering a new rendering of autism as, in and of itself, a neurology of a queer nature (Yergeau, 2018). A yearly gathering for autistic trans people at the Philadelphia Trans Health Conference had 100 attendees in 2017, with 150 expected in 2018.¹² While public and clinical attention turns toward a possible neurological overlap between autism and transness, the political overlap between these kin social movements unfolds in real time.

Narrative Malady, Normative Temporality: Storying Autistic and Trans

In continued areas of overlap, autism and transgender relate through the linguistic terms that stem from the Greek root *autos* (self) and the Latin root *auctor* (author), bearing unmistakable meanings for autistic and trans "forms of life": *authorship*; *authority*; *authenticity*; *autonomy*; and *autobiography* / *autie-biography*. Despite the effort invested in the search, there exists no biological marker that differentiates trans or autistic individuals from those who are non-trans and non-autistic. No test can settle this

¹² Personal communication Noah Adams, July 2018.

question and so diagnosis rests on criteria or “symptoms” met when observing or conversing with individuals, and in the case of minors, their parents. Hence both autistic and trans constitute what Duffy and Dorner (2011) call “narrative conditions” - both must be storied. Yet while Osteen (2008) writes that autism seems “uniquely resistant to narrative” (p.17), significantly, the opposite could be said of trans identity, with trans life often uniquely defined in narrative terms.

Transtextual Narrative: Trans Narratives over Time

In her text on the history of sex change in America, Meyerowitz (2002) points out that America’s first public transsexual, Christine Jorgensen, managed to become a media darling and household name in the 1950s despite having done the unthinkable: changing her sex. While she did face ridicule, she was at times beloved. Stryker (2018) notes that while confronting bedrock beliefs about sex and gender, Jorgensen also represented a post war rugged individualism that was at once soothingly feminine, yet thoroughly American. Against a looming socialist horizon, Jorgensen represented the America that America wished to be – a nation so free that even a man could become a woman. In the context of a hostile space race against the Soviet Union and the splitting of the atom, she represented the triumph of science over nature (Stryker, 2018). To note the popularity of Jorgenson’s story is not to suggest that she was received with ease, but simply that a narrative may work for a time, for a variety of reasons.

In the 1960s, Harry Benjamin was understood as the compassionate “father” of transsexuality. Having coined the term and penned the first clinical text (see Benjamin, 1966), Benjamin became a lead author of sorts in the story of transsexuality. Jay Prosser

(1998) reads Renee Richards' autobiography *Second Serve*, for her tale of her clinical encounter with Benjamin. In her telling of it, as she recounted "her story", she sometimes paused and searched for words, during which time Benjamin would helpfully supply them. Richards (as cited in Prosser) wrote that she felt sincerely understood by Benjamin and tellingly remarked that he "could probably have told the story without my help" (p.107). Writing of the implications of this encounter, Prosser (1998) contends that Benjamin's filling in of the gaps in Renee's story, his supply of the very phrasing, can be understood not only as compassionate, but also silencing: "He can indeed tell the story without her help" (Prosser, 1998, p. 108). Benjamin later denied Richards her bid to transition because her account of her sexuality did not square with his prototype of a "true transsexual" - a decision well within his right as what Prosser called the "primary author" of the story. This account highlights many areas of interest, one being the possibility of clinical protocols functioning as "simulacra." With clinical protocols deriving from research with trans people, the clinical picture of a trans person is ostensibly a copy of a trans person. Yet in Renee Richard's story, we see the original (Richards) compared to the copy (Benjamin's clinical protocol) and deemed inauthentic.

In 1991, Sandy Stone (1991/2006) penned the essay "The Empire Strikes Back", what has since been called the "protean text" from which trans studies grew (Stryker, 1991/2006, p. 221). Stone addressed, among many subjects, the "diagnostic battlefield" (p. 232) of the gender identity clinic where 99% of applicants seeking sex-change procedures were once denied (Meyerowitz, 2002). Under these conditions, transsexuals studied clinical texts like Benjamin's and creatively produced any narrative likely to meet

with approval, a series of performances then written up by clinicians as research findings, tautologically confirming their own hypotheses. As Stone wrote, the successful narrative was one that neutralized the threat of sex-change by remaining unambiguously heterosexual, also neutralizing any threat posed to male power with only consistently submissive and deferent versions of femininity on offer. Stone (1991/2006) notes the anger these sexist narratives were met with by radical feminist theorists: “No wonder feminist theorists have been suspicious. Hell, *I’m* suspicious” (p. 227). According to Stone, transsexuals had been complicit by allowing their narratives and bodies to be used as “meaning machines” for the purposes of others (p. 230). Addressing an excerpt of text from Lili Elbe’s biography/autobiography, she asked: “Not by whom but *for* whom was Lili Elbe constructed?” Stone proposed transsexuals as themselves “a *genre* - a set of embodied texts” (p. 231) and the clinic as a “technology of inscription” (p. 230). She urged transsexuals to speak authentically about their complexity and to “write oneself into the discourse” (p. 232) - to rewrite the story. Stryker (2006) remarks that the transgender movement that answered Stone’s call, took trans people “from the clinics to the streets” (p. 2). The story has been queerly disrupted ever since (Bornstein, 1994; Chu, 2018; Spade, 2006; Wilchins, 1997).

Within the same decade, Jay Prosser (1998) returned to transsexual narratives with his text *Second Skins*, proposing that the requirement to narrate oneself in the gender clinic turned all transsexuals into autobiographers. Moreover, given that for some, transition offers the only possibility for livable life, Prosser wrote that transsexuals must be “arch storytellers” (p. 113) since “there has probably never so much at stake in oral

autobiography” (p.108). “Tell the story persuasively and you’re likely to get your hormones and surgery; falter, repeat, disorder, omit, digress, and you’ve pretty much had it” (p.108). With clinicians having already realized that some transsexuals fabricate their narratives, Prosser notes that they adopted a policing model to sniff out the veracity of patient stories, with the result that transsexuals came to play “criminal” to clinician’s “detective.” Recalling Stone (1991/2006), Prosser (1998) proposed that in these often-adversarial encounters, transsexuals became texts presented for the clinician’s potential (mis)reading, pointing out that the common trans verbiage used to indicate that one has been noticed as trans in public (to be “read”) is no coincidence.

In addition to addressing narrative in the clinic, Prosser responded to the hostile climate of 1990s queer theory and poststructural feminism, and the accusations that transsexuals, as evidenced by their autobiographies, were desperate conformists who tamed the radical potential of non conformity (see Hausman, 1995), capitulated to normative gender roles (see Halberstam, 1998), and basically had “bad politics” (Davy, 2011, p. 169). Prosser replied that in the twentieth century, autobiographical narrative was the primary means by which transsexuals forged a workable life, thus if transsexual autobiographies are conformist, they conform first and foremost to the genre of autobiography. What Georges Gusdorf (as cited in Prosser, 1998, p. 116) called autobiography’s “original sin” – the retrospective shoehorning of life’s disorder and chaos into a story that coheres – was also the transsexual’s mode of composing the self - the “autos” in autobiography (p. 119). Prosser wrote that for transsexuals, narrative is a “second skin.”

Decades later, the implications of this thesis continue to be debated in the field that has come to be called transgender studies (Amin, 2014; Bhanji, 2013; Crawford, 2013; Salamon, 2010). By taking as its object of study, not transgender people per se, but the discourses and conditions through which their lives come to require explanation, trans studies too has shifted the narrative (Stryker, 2006). Declining to study trans people as a rare minority, trans studies instead trains its sights - its “trans optic” - on a range of other subjects with the insights available to those who are askew in the world (Salah & Plett, 2014). Trans studies returns to the clinicians who once wrote their stories, their “self-appointed minders” (Stryker, 2006, p. 11), and as Stryker (2006) notes, the field is now in a position to treat that clinical oeuvre as its “archive” (p. 14).

In the inaugural issue of *Transgender Studies Quarterly*, Amin (2014), returns to Prosser’s account of transsexual narrative to critique its normative mode of time, drawing on Freeman’s (2010) concept of *chrononormativity* as a “mode of implantation, a technique by which institutional forces come to seem like somatic facts” (Freeman, 2010, p. 3). According to Freeman (2010), constructed patterns of time and fabricated temporal orders are summoned to “maximize productivity” (p. 3), while insider status is achieved through the mastery of time – traversing life’s course in the authorized sequence. Amin (2014) notes, as Cadwallader (2014) does, that the clinical trans narrative is chrononormative, dictating a required set of “narratemes” and a predetermined beginning, middle and end. Additionally, the emerging field of trans poetics and literature has loosened what Imogen Binnie (2014) calls the “death grip on the cultural microphone” enjoyed by dominant groups. Following Jean Baker Miller, Binnie (2014) suggests that

new trans fiction is a sign that the trans community has reached past simply refuting false stereotypes and critiquing dominant values, and is now entering a third phase of “creating new systems of thought” to “describe our world on our own terms” (n.p.).

In the public story of trans life, the tale of trans children and youth has seen particularly seismic change. Developing alongside Lovaas’ autistic behavioural therapies, the original gender clinics for youth aimed to eliminate and prevent the “devalued adult outcomes” of transsexuality or homosexuality (Bryant, 2011, p. 37). Treatment was justified by the association of trans and gay life with problems like unemployment, exclusion, violence and suicide (Rekers et al., 1977), in essence, social or literal death. Yet longstanding battles for trans depathologization have since been particularly successful with respect to children. Responding to research that historically framed young trans people and their parents in terms of psychopathology (Zucker & Bradley, 1995), research now reports on both trans children and their parents as healthy and stable (Hill & Menvielle, 2009; Olson et al., 2016). Psychological and intelligence testing are now part of many trans youth assessments and published studies help to understand how successful trans youth are understood. In a follow-up report about a trans youth who was approved for transition, the word “normal” appears 17 times in four pages (Cohen-Kettenis et al., 2011). In another, the term “functioning” appears 30 times in eight pages (de Vries et al., 2014). In yet another, youth who are not approved for surgery are described with the terms “confusion”, “unstable”, “psychopathology”, and “problematic” (Smith et al. 2001).

In 2013, after years of debate, the DSM-5 removed the diagnosis of *Gender Identity Disorder*, long contested as a lifetime diagnosis and disorder of the identity. The

replacement, *Gender Dysphoria*, is now a bodily distress that can be treated and resolved with transition. Changing media narratives have rhetorically reframed trans adolescents (with limits) as figures of life: promising, life-affirming, “inspirational” (Perkins, 2015). At times trans youth are now portrayed as exceptional, “ahead of their time” (Dibiasi, 2015), “extraordinarily articulate” (Olya, 2016), “mature beyond their years” (Legge, 2015). Notably, these designations rely on the ability to narrate one’s experience and the images circulated are often of white, middle class, able bodied, able minded trans youth. Non-binary gender presentations are increasingly more intelligible and increasing numbers of gender clinics now provide youth with the ability to block puberty and transition young, in essence, new futures, though importantly, not for all (Pyne, 2017). When a 2015 media headline announced trans youth as “Finally Normal” (Shapiro, 2015), the question remains, if not a Pyrrhic victory, was this at least a victory with costs?

Autie-Narrative: Autistic Story and the Story of Autism

The term *autism* derives from the Greek root *autos*, meaning *self*. In a famous scientific coincidence, it is said that German researcher Hans Asperger and American researcher Leo Kanner both named the condition they were observing in their separate child research populations “autism”, both intending similar meanings, an *isolated self*, one who relates to oneself, not others (Silberman, 2015). In her incisive study of autistic rhetoric and neurological queerness, Yergeau (2018) points out that autistic people are assumed to be outside of rhetoric - the ability to persuade in speech or in writing. Rhetorician Todd Oakley (1999) writes: “rhetorical practices must... pose some form of intentional agent to be coherent, and there is no better evidence to that effect than studies

of autistic people, beings who lack the human rhetorical potential” (p. 102). The consequences of this discourse are far-reaching and the public stories told about autistic people by non-autistic others have been highly persuasive, narrating autism as a story of incoherence and lack of intention, and autistic people, in Yergeau’s (2018) words, as “non people.” (p. 34)

Gibson and Douglas (2018) note that in the early days, autism was deliberately partitioned away from the prior existing category of “feeble-mindedness.” As a category tainted by race and class associations, to have a “feeble-minded” child was unacceptable to the white middle and upper-class families in which many of these children, just beginning to be understood as autistic, had been born. The status of these families drove the development of new diagnostic language stressing the non-hereditary nature of autism so as to avoid polluting the family name and ensure the appearance of non-culpability for the parents (Gibson & Douglas, 2018).

Despite the concern to not appear culpable, the culpability of parents would later be opined on for decades, with mothers blamed for their alleged emotional coldness (Bettelheim, 1967; Kanner, 1943), for having allowed vaccinations (McCarthy & Kartzinel, 2009), or for failing to commit to behavioural treatments (Grant, 1965). However, in the early days of autism research, it was one particular type of culpability that elite families likely feared – that of “degeneracy” or “bad genes” – therefore bad people or non-people (Wilson, 2003). That these children were often male, white, and born to highly-educated parents, motivated the bid to save them materially through extreme treatments, as well as discursively through new diagnostic language. Whiteness

and wealth would also make possible other extreme treatments to “cure” autism for example, at the Orthogenic School for Disturbed Children at the University of Chicago, where Director Bruno Bettelheim (1944-1973) instituted a “whites only” policy and high tuition fees intended to keep out (and in) particular autistic bodies (Epstein, 2014).

One of Bettelheim’s unfortunate contributions to autism’s narrative was to describe it as a prison and children as suffering from a living death (Bettelheim, 1967). That Bettelheim himself had survived Buchenwald and Dachau, unfortunately made this story all the more persuasive when he likened being autistic to living in a concentration camp (Epstein, 2014). Later accused of abusing the children in his care, Bettelheim was part of a long tradition of autism’s narrators more concerned to describe autism as itself a violence, than prevent the actual experiences of violence autistic people face. When it came time for O. Ivar Lovaas to conduct his behavioural treatments at UCLA, the idea that autism was a horrendous fate was already easily understood, yet Lovaas’ treatment were so violent (Grant, 1965) that he developed new discourses to justify it, declaring it an act of love and commitment. Lovaas famously said: “After you hit a child, you can’t just get up and leave him; you are hooked to that kid” (Chance, 1974).

Modern autism research does a subtler form of damage, but as Savarese and Savarese (2010) write, the consequences of all disparaging depictions are tragic. Influential concepts like Theory of Mind, most closely associated with researcher Simon Baron-Cohen, holds that those who lack Theory of Mind (autistic people) lack the ability to comprehend that others have beliefs, desires, intentions, and perspectives (Baron-

Cohen, Leslie & Frith, 1985). Theory of Mind holds that autistic people lack comprehension not only of others, but also of themselves. For the autonomy and self-determination of autistic people, Yergeau (2017) contends that Theory of Mind is “a disaster”, rendering autistic self-expression and self-advocacy suspect, unreliable and essentially a series of symptoms. The theory that autistic people are “mindblind”, also Baron-Cohen’s (1995) work, means they would be unable to read other’s emotional states or comprehend “thought, knowledge, beliefs, desires, feelings and intentions” (Oakley, 1999, p. 102). Yergeau (2018) points out that this list is everything that makes a person a person. Even more troubling, the stated ability of neurotypical people to “mind-read” is framed as an evolutionary adaptation, with the implication that autistic people exist in a less evolved form (Baron-Cohen, 1995). Duffy and Dornier (2011) write that this research is saturated by a science of pathos regarding the lives of autistic people, what they call “scientific sadness” (p. 201).

When Yergeau (2017) states that Theory of Mind is a “disaster”, the implication is that autistic people are seen to have no insight into themselves or their own lives, and thus paradoxically, cannot represent themselves and the only people with anything relevant to say about autism are non-autistic people. Researchers Uta Frith and Francesca Happé (1999), who are not autistic, title one of their articles “What is it like to be autistic?” A number of contradictions seem obvious. McGeer (2009) points out that to follow Theory of Mind to its end conclusion, it would seem that autistic people’s narratives should actually be more authentic and trustworthy, not less, because they are developed alone without the external influence of neurotypical group-think (mind-reading). Moreover,

autism researchers themselves show limitations in their Theory of Mind when they speak of autistic people as utterly unknowable and write “us” to refer to neurotypicals, and “them” to mean autistic people. Baron-Cohen (1995) addresses his audience: “Now, you and I are mindreaders” (p. 2). Given that Theory of Mind suggests a failure to imagine other minds, it is notable that these authors fail to imagine an autistic audience for their own writing, a fact that Yergeau (autistic herself) points out, as she reads it.

McGuire (2016) writes that the vast majority of what comprises the public narrative of autism does not emanate from scientists but from “autism advocates”, as distinct from “*autistic* advocates”, with the latter primarily autistic self-advocates and the former primarily the families and professionals in the lives of autistic people. The parents of autistic people in fact have played key roles in the story through their memoirs and writing. Passionately advocating fashionable (but erroneous) theories of autism, some of these books elevate those theories to new heights or perhaps new lows, making troubling theories readily absorbable by lay audiences. It should not be in question whether these parents care for their children, and indeed their enthusiasm for curing their children may well be a reaction to the pathologizing theories of the past. Yet one of the stories that these texts contribute to, is the idea that autism is, as McGuire writes, a “thing”, and moreover, a thing that must be fought in militaristic fashion.

In her memoir, Karyn Seroussi (2002) writes that her child’s autism derived from a vaccine reaction and she sets out to conquer it in a quest that Silberman (2015) calls “biblical” (p. 64). Seroussi writes: “The shadow of the beast has fallen over my home,

and my doorway has been darkened by its dreaded countenance” (p. 201). The introduction to Seroussi’s memoir is written by psychologist Bernard Rimland of the organization “Defeat Autism Now!” (DAN) who joins Seroussi to claim that her son was cured with vitamins and minerals. In this way, parent narratives have had their own chrononormative temporality, “racing against the days” toward cure, coupled with persuasive testimony about having found that cure (Maurice, 1993). Significantly, in parent accounts it is often a temporal difference in the child that is cited as evidence of trouble – a child who gazes at the wrong things for the wrong amount of time, eye contact too brief, happily watching sunbeams and playing by themselves, but for too long. Autistic children are said to not learn to talk on schedule, or talk but then stop talking in a temporal reversal of a child development textbook. In some families, these temporal differences seem in turn to precipitate the urgency of cure (Maurice, 1993; Seroussi, 2002). The goal of fixing is also advocated by the controversial parent-run organization *Autism Speaks*, for which the logo of a puzzle piece tells a story about autistic people as fundamentally incomplete, and arguably a deeper meaning, that autistic people are in need of fundraising dollars, to fund research, to find a cure, so that there can be no more autistic people. Kafer (2013) writes that disability is assumed to have no place in the future. Yergeau (2018) writes that the best future for autism, is thought to be no autism.

The most troubling aspect of the assumed “non-rhetoricity” of autistic people, is that it denies their humanity (Yergeau, 2018, p. 11). This can perhaps best be seen with respect to non speaking individuals. Psychologist Gilligan (1982/1993) expresses a common sentiment with the statement: “To have a voice is to be human.” (p. xvi).

Writing about autobiography for non-speaking people labelled with intellectual disabilities, Anne Fudge Schormans (2005) notes that in ancient times disabled people were viewed as non-human due to an association with the divine or the demonic, yet this harmful idea lingers in the language of human intelligence and development. Lacking a history other than one of “others acting either on their behalf or against them” (p. 118), Schormans notes that medical case studies are often the only conduits through which people’s stories are told. Yet Schormans (2005) points out that the case study also seems to function more as the clinician’s autobiography, a conduit to convey the author’s expertise and not the personhood of “the case.” When Lovaas called his treatment regime “building a person”, the meaning was unmistakable (Silberman, 2015). Speaking about the discourse of an “autism epidemic”, Yergeau (2018) writes: “More people are becoming non people” (p. 34).

Unfortunately, the fields of autism research and advocacy engage very little with what autistic people have to say. A body of writing - memoir, essay and critique - has been growing since the 1990s with Temple Grandin’s *Emergence: Labelled Autistic* (Grandin & Scariano, 1996), Jim Sinclair’s *Don’t Mourn for Us* (1993), auto (autie) biographies by Donna Williams (1992) and Dawn Prince (2004), as well as foundational video testimonies by Mel Baggs (2007), and essay collections such as *Loud Hands: Autistic People, Speaking*. There are also a growing number of racialized autistic advocates forming movements and organizations to influence the priorities and analysis of the wider autistic community. The collection *All the Weight of our Dreams: On Living*

Racialized Autism brings together many of these voices (Brown et al., 2017).¹³ Taken together, these works offer profoundly important messages, often reframing the so-called “symptoms” that are targets for autistic treatment elimination (for example “stimming” meaning self-stimulating movements and “echolalia” meaning unusual word choice or phrasing) as forms of communication vital to autistic people’s wellbeing. This writing points to the need for a total overhaul of how autistic people are addressed clinically and beyond. Yet at the end of an article about autism, Frith and Happe (1999) finally consider the views voiced in autistic autobiographies, followed by the remark: “However, there are grave limitations with this type of material. While the accounts are intriguing, it might be a mistake to take what is said at face value (p. 18). Frith and Happe (1999) acknowledge there are limitations to autobiography as a genre in general, however, they end with an astonishing comment about autistic autobiographers over-focusing on their own perspectives. As Yergeau writes: “Often, autistic stories are not beheld as stories at all, but rather as symptoms...” (p. 2). Moreover, Yergeau (2018) notes that when autistic people do speak articulately, it is often said that surely these people are not autistic - a simulacra example of the real thing (the autistic person) compared to its copy (the stereotype) and deemed inauthentic.

The disorder narrative that has defined autism has been most powerfully contested by the concept of “neurodiversity”, coined in 1988 by Australian autistic researcher and activist Judy Singer (Muzikar, 2016). Autistic academic Nick Walker (2014) outlines the

¹³ Activists like Lydia Brown, an autistic genderqueer person of colour, argue against a progress narrative in autistic community, pointing out that autistic people of colour are often misdiagnosed and criminalized and the most likely to still be incarcerated in facilities practicing punishing aversive therapies (Brown, 2016).

various meanings that gather around the term. According to Walker, *neurodiversity* is first the simple indisputable fact that human minds differ from one another. Second, the *neurodiversity paradigm* is a perspective that regards human minds, despite neurological differences, as equally valid and recognizes these differences as subject to power relations like other devalued forms of human difference. Third, the *neurodiversity movement* is a social justice movement seeking civil rights and justice for neurodivergent people (Walker, 2014). As a paradigm or perspective, neurodiversity contests the basic truth claims of the official autism story, including but not limited to the assumption of deficit. Indeed, Walker (2015) states that he began to function better when he ceased trying to behave as a neurotypical. Further, there are indications that the neurodiversity paradigm is weakening the “death-grip” of the official autism story. A researcher at the University of Montreal, Laurent Mottron, brought an autistic researcher onto his team, Michelle Dawson, who prompted his new understanding of autism as a human variation that can be adaptive and even superior (Mottron, 2011). Having since worked with many more autistic researchers, Mottron’s group was the first to discover how high autistic people score on intelligence tests, if the test used is not language-based (Dawson et al., 2007).¹⁴

A final narrative in the contested story of autism is the emerging field of critical autism studies (CAS). As an offshoot of critical disability studies, CAS treads familiar ground, inquiring into how differences come to matter, and why they count as “trouble” (Clare, 2017). CAS returns the gaze, recasting the dominant theories of autism, rather

¹⁴ In my view, intelligence tests remain highly problematic despite these interesting developments.

than autism itself, as repetitive and reflective of a limited imagination (McGuire, 2016). CAS challenges the “whatness” of autism, proposing it as neuroqueerness (Yergeau, 2018), an “interpretive category” (McGuire, 2016), and a “genre of stories” about personhood (Narby, 2016), that reveal the profound anxieties of non-autistic people (Hacking, 2009a). Ensuring not to disappear autism as only a social construction (David & Orsini, 2013), Stuart Murray (2008) insists we recognize autistic *presence*. Scholars work to engage non-speaking people (Savarese & Savarese, 2010) and language and rhetoric are often key themes, as the field theorizes the growing literature of autism narratives (Dolmage, 2014; Duffy & Dorner 2011, Hacking, 2009b; McGeer, 2009; Murray, 2008; Osteen, 2013; Yergeau, 2018).

In these next sections, I outline this study’s methods and analysis and bring theories about trans and autistic narratives to bear on the clinician’s talk about autistic and non-autistic youth, their stories, their authenticity and their intelligibility in the clinic.

Methods

In this project I conducted 18 interviews with clinicians who work with trans and gender diverse youth across six countries. Interviewed clinicians were professionals providing assessments for puberty blockers and/or cross sex hormones, most often through their positions in the disciplines of child psychology or child psychiatry, pediatric or adolescent medicine, pediatric endocrinology or social work. Health and mental health care funding models vary widely across these countries, however, these distinctions are not the focus of this analysis. Numerous American and Canadian clinicians were interviewed, while others practiced in Western Europe, Oceania, and Southern Africa.

Due to the highly specialized nature of care for gender diverse youth, the clinician's city and country of practice will not be identified as this could identify them. These professionals were identified as potential interviewees through their public roles as authors, commentators in the media, or as members of research teams. Interviewees were invited to participate via email and interviewed in person either in their city of practice, at a professional conference, or remotely via Skype or telephone. For clinicians who had played formative roles in the development of care for trans youth, additional historical questions were posed. In accordance with the McMaster University Research Ethics Board, participants provided consent for recording and transcription of their interviews.

This study is a discourse analysis of talk about puberty suppression, early gender transition and trans youth, as it is spoken about by the clinicians who work with trans youth. Discourse analysis is a collection of research approaches investigating the use of language in the production of knowledge and meaning (Van Dijk, 1993). Emerging from the postmodern and post structural influence on the academy, discourse analysis was part of the linguistic turn in the social sciences and humanities, in which language is viewed as constitutive of, rather than descriptive of, the world (see Foucault, 1972). Graham Gibbs (2015) points out that language is sometimes not at all descriptive of the world.

Discourse analysis challenges the distinction between talk and action, insisting that talk is itself a type of action (Edley, 2001) as well as a tool not for describing reality, but for doing it (Gibbs, 2015). While the term can be defined differently, I use Carabine's definition of discourse as a group of statements that "cohere" to make meaning and have political effects (Carabine, 2001, p. 268). Discourses become available in the context of

historical power relations (Wetherell, 1998), hence some are more credible than others as “facts” (Edley, 2001). Thus, discourse is closely tied to power – the power to appear natural, logical, rationale, true. Discourse analysis has the ability to “unfreeze” discourses (Bloor & Bloor, 2007) and expose them as contingent interpretations, specific to time and place, rather than inevitable.

I organize this study specifically around the analytic concept of “interpretive repertoires”, first proposed by sociologists Nigel Gilbert and Mike Mulkay (1984), who found during their study of scientific explanation, that scientists explained their activities through inconsistent and sometimes contradictory “interpretive repertoires” - self-contained discursive systems. Gilbert and Mulkay (1984) proposed variation and inconsistency as the norm in scientific discourse and perhaps all discourse. Potter and Mulkay (1985) suggest that contradiction ought to be the focus of analysis, rather than a broader thematic analysis which might smooth over this talk and unwittingly make scientific discourse appear more coherent and less chaotic than it is. Some argue that discourse analysis should only be used for analyzing written text (Briggs, 1986), however in an interpretive repertoire analysis, the spontaneous discourse in interviews makes inconsistency more apparent and the opportunity to observe participants discursively labour to resolve contradiction, is highly instructive (Potter & Mulkay, 1985).

Detailed instructions on how to analyze for interpretive repertoires are scant, however Talja (1999) proposes three steps including: identifying contradictions within each participant’s discourse; identifying contradictions among and across participant discourses; and connecting those discourses to their social histories. As discourse analysts

have noted the significance of pattern and function (see Wetherell & Potter, 1988), I add to this above list, the additional step of identifying patterns in discourse variation to aid in understanding their function. As stated, my theoretical framework centres around time, temporality and the question of how puberty suppression and early transition become “thinkable”, thus this analysis looks specifically for temporal discourses as they relate to trans youth in the gender clinic.

Prosser (1998) notes that trans health care assessment has typically operated with a “hermeneutics of suspicion” (p. 113) with trans people’s speech regarded as suspicious by their clinicians. Indeed, one clinician mentioned being “skeptical” of autistic youth and another unknowingly used policing discourse such as “corroborate the story”, “sticking to his story” and “the jury is out.” Discourse analysis itself involves a stance of suspicion toward speech, and so in this project I reverse the “hermeneutics of suspicion” and cast the gaze back on clinicians. My reversal of this stance, however, indicates a methodological choice and not ill will on my part nor ingratitude for clinicians’ work as helping professionals in the lives of trans youth. Indeed, this study reveals not problems with individual clinicians, but systemic problems that linger in the long process of transforming a practice that still carries the historical burden of unjust power relations.

Results

In interviews, clinicians were asked to describe some of their “easy” or “straightforward” cases in addition to their “difficult” or “challenging” cases - those in which they might have been unsure or conflicted. Elsewhere I note that discussion of race rarely occurred unprompted in these interviews (Pyne, forthcoming). In contrast, the

discussion of autism was initiated frequently by clinicians, with most answering the question of difficult cases with stories of autistic youth in general or a specific autistic youth in particular. Indeed, almost every interviewed clinician spoke about autism in relation to the gender diverse youth they work with, most unprompted. Clinicians were aware of the studies that correlate autism and gender non conformity, and also had their own observations about the increase in autistic trans youth presenting to gender clinics: “...there is a higher correlation in the ASD population and so we have, we definitely see that in clinic, I can't give you numbers but we absolutely see that.” When asked if their clinic was seeing an increase in autistic youth, another clinician stated: “Oh yeah, we all are.”

While a very small number of clinicians reported no issues working with autistic youth, the vast majority reported many uncertainties, describing work with autistic youth as “tricky”, “tough”, “challenging”, “complicated” or “extremely complex.” Clinicians noted the need to approach work with autistic youth carefully, describing their approach as: “hesitant”, “more thorough” and “very cautious, very cautious.” One clinician stated that they would “proceed cautiously, carefully” and with “a second opinion”, while another would be “a lot more careful before jumping to conclusions.” After describing to me some very serious challenges with insufficient funding and government resource allocation, another clinician stated: “So those are some of the complex cases, but I think the more complex are questions around ASD [autism spectrum disorder].” Several clinicians mentioned autistic youth patients who they were booked to see soon: One clinician said “I’m sure that’ll be difficult.” Another clinician noted the disabilities that

would complicate assessment of an upcoming patient, remarking that approval for hormone treatment was “not likely optimistic.” Another clinician shared: “I’ve never been in a position where I would say the comorbid psychopathology bothers me so much that I don’t think we should give hormones. Having said that, I am about to see a young person who might well fall into this category.” One clinician, when speaking about the easy or straight-forward cases, mentioned “no autism” as part of this profile.

Clinicians were not asked to describe the source of their knowledge-base regarding autism or other labels of intellectual disability, however, it is likely that this varied. Despite this, there were repeating patterns in what clinicians believed autism consisted of, what Yergeau (2018) refers to as “the whatness” of autism (p. 9). One common discourse was that of “rigidity.” On this basis, one clinician questioned whether autistic youth could handle transition: “It asks a lot of flexibility, being in medical treatment, going to a hospital. Are all these individuals able to do that?” Another clinician cited what they felt were rigid autistic thinking patterns: “...when you're cognitively delayed then you tend to think of things in black and white.” Another asked whether autistic youth might pursue gender transition due to a lack of flexibility: “Is it because of difficulty with, like, flexibility of thinking...?” Although it was common in interviews for clinicians to accept that autistic youth are “rigid”, curiously the opposite was also common, to worry that autistic youth might be pliable, malleable, and too hastily “trying on gender dysphoria” as one clinician suggested. One interviewee spoke of a youth who was “probably somewhere on the autism disorder spectrum” but whose trans identity they doubted: “...when he got into high school he became exposed through the Gay-Straight

Alliance...he became aware of this concept of transgender and he felt that that fit exactly... [his] solution as to why he had not succeeded in making friends precipitated this revelation that, in fact, it's because there was a gender disconnect..." This clinician reported discomfort with how the youth's identity seemed sudden (to the clinician) and seemed rooted in struggles not obviously about gender. Overall, clinicians framed autistic youth as both rigid and unmoving, as well as also overly-impressionable and impulsive, and both of these states seemed to cast doubt on their trans identities.

Clinicians noted during interviews that treatment for autistic youth occurred on a different timeline: "those ones take time" reported one clinician. Another confirmed "this is going to take longer to figure out." One clinician had stated that moving quickly was the best practice for working with trans youth because "sometimes this kid can be damaged by me delaying the intervention." Yet in relation to autistic trans youth, the same clinician later stated that moving slowly was the best practice: "we just want to proceed cautiously, carefully, and those are cases I think it's always good to have a second opinion." One clinician stated: "...there's some pretty Aspergery kids that I think the psychiatrists have often spent a lot of time on", while another clinician summarized being presented with an autistic trans youth as: "I think that it might slow things down a little bit." Indeed, discussion of autistic youth was generally the only time that clinicians used the word "slow" to describe their treatment approach. One clinician described their approach to autistic trans youth as "more cautious and more slow", while another used the phrase "really, really slow."

It is important to note that no clinician reported that they would deny outright an autistic youth who sought to transition. Some clinicians shared genuine affection for the autistic youth in their care: “I love this kid.” Some mentioned that despite barriers, autistic youth will “...still communicate the best that they can...” One clinician did not feel that working with autistic youth was difficult at all: “...that’s not caused difficulty in my mind...” However, this was rare and the more common response was hesitancy. One clinician stated that being autistic “...doesn't preclude kids from getting blockers in our service... but I feel more comfortable if... yeah.” Delaying through a slower assessment process was most typical: “I think that it [autism] does make the medical team especially much more thoughtful about starting a cross-sex hormone.”

In the following sections I explore how clinicians’ ‘talk’ about their work with trans youth can be grouped into two interpretive repertoires - the authentic trans youth story, and that of the questionable or dubious trans youth story, with autistic youth emblematic of the latter. While interviewees were not asked specifically whether youth were “authentic”, there were many indications that youth’s authenticity as trans was of importance. One clinician stated: “we don’t have an MRI test or a blood test yet, to say who is and who is not trans.” When clinicians were certain, they made statements such as: “There was no question in any of our minds that this was a transgender male.” Conversely, when uncertain, clinicians commented that a youth’s narrative showed “less authenticity” and clinicians asked themselves questions such as: “What is that? Is that really trans?” and even “What is trans?” In an article by clinicians Bonfatto and Crasnow (2018), they write: “...we draw on our countertransference with families to explore the

communications of the child, and to locate the authenticity in their narratives...” (p. 3)

Clinician Diane Ehrensaft (2011; 2016) writes often in support of youth being able to live in the gender that feels most authentic. Thus, the concept of authenticity is relevant to trans youth care and these interpretive repertoires are organized around authenticity, with progress toward treatment unfolding at very different paces. The perceived authenticity of the trans youth narrative seemed to be shaped by received ideas about autism, yet also shaped by the presence or absence of chrononormative time patterns expected in authentic trans stories.¹⁵ I begin with a discussion of the authentic trans youth repertoire.

“It’s so Natural, it Doesn’t Stand out as a Story”: The Authentic Trans Youth Story

During interviews, clinicians commented on the dilemma of having no biological marker or medical test to confirm gender dysphoria or trans identity: “We don’t have that yet and so we are at the mercy of collecting history...” Collecting history, for the purpose of this process, is soliciting a story. One clinician summed up the main criteria for determining youth readiness: “I guess it’s that story.” When clinicians spoke about the simple cases that were easy to deal with, there were a number of common patterns. One clinician noted: “I mean the straightforward ones in my opinion, kind of just all blend together and it’s just like things seem to follow a pattern and there’s a lot of common narratives... there doesn’t seem to be much difference from ‘easy patient’ to ‘easy patient.’” Viewed as familiar and authentic-seeming narratives, clinicians at times did not seem to recognize these stories *as* stories. One clinician stated: “It’s so natural it doesn’t

¹⁵ I specify when I bring in discussion of youth deemed questionable but lacking an autistic label or diagnosis.

stand out as a story.” As I will argue, this naturalness or authenticity, was largely grounded in chronological, or more precisely, *chrononormative* time.

Amin (2014) writes that expected trans narratives are “diachronic”, they unfold over time. Clinician’s success stories were no exception. Indeed, timing was crucial to the stories’ reception. Youth deemed as easy cases had typically been attending the clinic or seeing other professionals since childhood: “...those will be easiest, so, let's say we follow them to the verge of puberty and things are consistent, persistent, insistent this way, those will be a little bit different than those who walk in to my office 11 years old and want the hormone blocker. Chances are that the assessment will be very fast ... because of the long history of it.” Another clinician stated: “... there are the ones that we know from childhood already... and I think most of the cases that come back around the age of 11, 12, start of puberty, are then quite straight forward.” One clinician clarified this is so due to worries about whether youth will continue in their identities: “So it’s not so much the age, it’s how long you’ve been known to people and somebody’s known you since you were nine and the story isn’t changing...”

In most cases, young people had not seen a professional at an early age and so their own verbal narrative of their childhood took on even greater importance. Ideally youth told a story in which they had always felt the way they do now about their gender. One clinician paraphrased: “I was always this very female boy or I was always this very boyish girl.” One clinician described a trans boy as having: “a long, long standing history from day one of never wanting to wear a dress, never wanted to be feminized in any way, shape, or form.” Consistency was important to the authentic story: “...we had a very clear

story, very consistent in terms of long-standing identification with the opposite gender, and I felt very good about that diagnosis.” One clinician stated: “...he was able to give us the story which was completely coherent and consistent.” Another summarized that youth stories should ideally show an “unwavering understanding of themselves.”

The next stage of the straight forward story involved the youth’s reaction to the onset of puberty: “...it’s a several-year history of well-consolidated gender dysphoria that is now worsening with the onset of puberty, worsening with the onset of facial hair... breast development... the onset of menstrual cycles.” One clinician summed up this stage of the story: “...but then puberty started and it really made me suffer, I felt so bad.” However, clinicians also felt that suffering should primarily be limited to gender dysphoria and ideally not complicated by other issues. One clinician described this story: “they’ve been functioning very well otherwise... they might have had a period of depression but once they had spoken out or had come out, then it often cleared quite quickly.” Another summarized a straight forward youth as having: “...done all their homework and going to school, good student, and has dysphoria but that hasn’t taken over their life.” When these ‘narratemes’ were present, the treatment pace was described as a natural progression with a momentum of its own, almost inevitable: “...and then we just move forward...”

The narrative features of early identification (“I was always this very female boy”) as well as worsening distress at puberty (“I felt so bad”) were punctuated with common images and metaphors. One clinician shared that they routinely ask young people about their relationship to the mirror: “But sometimes it’s just very clear... one question I

always ask is ‘How do you feel when you look in the mirror? What comes up for you?’ Some say, ‘I never look in the mirror.’” Another clinician mentioned the storied reactions of trans boys to their menses was instructive for the assessment: “I had an absolute fit when I got my period” paraphrased one clinician, and another recalled: “I’ve had people say these are monthly murders of the mind.” Clinicians recounted that some youth expected when they were young that they would grow into the gender they identified as at puberty: “I thought it was something that would happen when you are an adult.” Another clinician recalled what youth tell them: “I somehow assumed that it wouldn’t happen to me’... so they’re still holding out for their magical thinking that their body might change into the direction that they thought it would or somehow hoped it would.”

Clinicians recalled that sometimes there was inconsistency in the authentic gender story, however, this was framed as a youth’s last effort before summoning the conviction to transition: “There was a time when he tried to be more feminine. He worked very hard at sort of imitating what it was like to be a girl and found...that it didn’t come naturally and it made him feel really dishonest.” As part of the assessment, parents were also spoken with and one clinician described the easy cases as those in which parents “corroborate” the youth’s story. Another clinician reported that even when parents do argue against the youth’s trans identity, there are sometimes clues that the young person is indeed trans. For example, when one trans boy’s parents objected because he had dressed quite feminine just the year before, the clinician understood this story as part of the trans boy’s process of coming to terms with his identity: “And I’m thinking, okay this was their last-ditch effort to give being a girl a go.”

In the interpretive repertoire of the authentic trans youth, the success of these encounters seemed to rely on youth's verbal communication: "I think communication is one of the key things." Indeed, some youth were quite assertive in their appeal for treatment, and this was generally accepted: "He went on to Lupron [a puberty blocker] relatively promptly and was very eager and pushed me very hard to authorize testosterone, but we did that with full support." For clinicians, the ability to communicate verbally was grouped together with intelligence: "...how the child is able to express his or her feelings, it's about the intelligence of a child who can understand things." Intelligence and articulateness came up repeatedly as aspects of what made some youth easy to approve. One youth was described as: "...obviously super smart so he could talk about everything he understood." Another youth's story was told as: "smart, articulate, able to express herself well, supportive family...I put her on blockers and she saw a psychiatrist then yeah it was all very straightforward." In fact, the first known trans youth to undergo puberty suppression in the early 1990s was described in this way: "the first kid was very intelligent, IQ above 130, very articulate..." Paralleling clinical literature that reports on intelligence testing with trans youth, one clinician mentioned: "we've done some IQ tests in some kids 'cause we have just thought like they're functioning well above their expected norms... and they have had high IQ's..." The intelligence of the parents was also noted: "I think [child's name] represents the easiest case and the parents were intelligent educators, both professionals so I know that they understand the discussions we've had." Among clinician's stories about autistic youth, the only one offered as non-problematic was a youth described as "one of those genius Aspergers." In the profile of

the ideal youth, “no autism” was specifically mentioned: “I’ve had, oh gosh, how many kids like that, lots actually, who come early, supportive families, articulate, intelligent and it’s just straightforward, right, no comorbidities, no autism...” This list of markers of wellbeing was summed up as: “two supportive parents”, “smart”, “already transitioned at school” and “in schools where they have had no resistance” and “a big circle of friends.” The clinician summarized: “So the kids that do well anyway. The trans version of that.”

In many cases, when clinicians described the youth they find straight-forward to work with, it was often through a vague sense of finding a particular youth to be credible: “So when you say easy, it’s easy because the child or the youth comes with a story that’s very clearly indicative of who they are.” Statements like this were common, for example: “...the easy ones are easy because they’re just convincing”, and “it’s just who they are, you know.” One clinician remarked that at times it was “obvious” when kids are a good candidate: “...their appropriate level of sophistication the way they think and you meet them, it’s kind of obvious, like after you just do an assessment, to get to know whether this kid is thinking in a clear way.” One clinician recalled that sometimes it is so unmistakable that the youth themselves don’t have much to say: “It’s just so bloody obvious can’t you see it?” I say to them, ‘Yes, I can see it.’ Indeed, this clinician found humour in the effort to have youth explain their self-evident gender identity: “This is just the way it is.’ So they have little to say and they get a bit annoyed at me I think for asking them questions [laughter].” At times clinicians seemed to be saying that the easier youth were the ones they personally related to: “when I put myself in their shoes I can perceive them to be as they say they are.” One clinician stated: “I can really strongly identify with

these kids who are...they're really desperately trying to help themselves.” In some cases, clinicians expressed their admiration, with one describing a youth as: “really a high achiever, really great marks, also just an amazing person, an amazingly kind and conscientious person, just one of those people that I hope my kids grow up to be like, just a really good human being...”

Ultimately, the key feature of an authentic trans youth story is that it ends well. One clinician mentioned that he got involved in this work because his first patients had been so happy with their transitions: “...the first guy was so bloody happy, as were number two, three, four, and five...” Clinicians mentioned the good feeling of being able to help trans youth, as compared to other patient groups: “...all day long we’re diagnosing diabetes here, something that’s never going to waver either way... but here you’re like, ‘hey I can actually help you, I can change your body and make you happier’” Indeed, clinicians much preferred working with trans youth over several other groups of patients. One clinician described an arrangement with colleagues: “I took the transgender kids and they took the obese kids because I don’t like doing obesity.” Another clinician made a comparison to adolescents living with eating disorders: “...we all have kids with anorexia tell us to ‘F-off, I don't want you, I don't need you and just let me... let me starve to death’... And yet the gender program is full of young people saying ‘I really need your help, I want your help. Thanks so much for providing me service. Thank you for saving my life.’... like, you know, it's a whole... it's a 180 flip. You can see why I’d like working in gender...” This clinician went on to clarify: “I feel sympathy for the eating disorder patients because they're unwell. The gender kids aren't unwell. They just

need our help and I find that much easier. I think it's a different situation because there isn't anything wrong with them.” One clinician who had been practicing for many years recalled that he used to think trans youth were unwell and now sees them differently:

The thing that has changed for me by working with young people, is this concept that there is a problem... I remember when I first worked with what I would call true trans kids, with the concept that they were very unhappy with their body... This thing of them saying well, there isn't a problem, you know, and it's a complete paradox to have a young person who is unhappy about their body but says that they don't have a problem. To me initially I thought well of course there's a problem... It's very interesting to me that consistently so many of these kids, they don't come and say 'Heal me father, I'm a gender fucked up person.' It's more like 'I'm in the wrong body. Deal with it. I don't have a problem.' But there's some weird wisdom in this, and this is one of the reasons I feel a need to advocate for them against a diagnosis...

Clinicians were proud of the positive impact they'd had and shared stories about past patients and their progress: “His life went from sort of being in hospital for a suicide attempt to just having all these great plans for the future...” This same clinician summarized: “It's a very, very nice story” and later commented: “it's so natural it doesn't stand out as a story.”

“How Do I Get My Head Around This?”: The Questionable Autistic Gender Story

When clinicians spoke of autistic trans youth, they drew not from the repertoire of the authentic story, but from that of the questionable story. Differing from the authentic story both in pace and structure, content and form, the questionable story was influenced and by the absence of an expected chrononormative narrative in the clinic. Yet autistic youth's stories, when similar to other youth, also seemed questionable when regarded through received narratives about the “whatness” of autism (Yergeau, 2018, p. 9).

When clinicians recounted the stories that autistic trans youth told, as well as their own clinical responses, the common narratemes of the authentic story were often absent or askew. Clinicians reported that with autistic youth, they failed to perceive the longstanding story that the clinic anticipated. One clinician recounted: "...a very recent case I have is someone in my day treatment, my day program, who I have known for the past two years, who is now 15, and six months ago has decided that she is trans female..." While some inconsistency in youth's past gender expression was absorbed into the authentic story (as a last-ditch attempt at being 'normal'), the inconsistency for autistic youth seemed to scramble the story. Another clinician reported: "...she came out like abruptly, no history of being feminine whatsoever throughout childhood...there was never any sign, and then it was like, okay, at nine now I'm trans." Another described autistic youth as: "...all of a sudden, there is this cross-gender identification..." Notably, these descriptions of "abruptness" and "late onset" are similar to an online narrative currently popular among non-supportive parents of trans youth who reject what they call the "social contagion" of (again, their term) "rapid onset gender dysphoria" (4thWaveNow, 2016). To date all narratives and descriptions of this "condition" are either penned by parents or based on parent-report, rather than the youth themselves, raising questions about whose condition it is.

Unlike in the authentic repertoire, in which clinicians found parents often "corroborated" the child's story, the opposite was often true in these cases. One clinician reported: "...the adolescent expressed or did a coming out to the parents at age 15...to say 'I feel I'm a woman.' The parents were completely flabbergasted..." While the

authentic repertoire allowed for some parental disagreement, explained as the identity potentially not being visible to parents, it was unclear if that explanation was available for autistic youth. Another clinician recalled: "... it doesn't match at all with the parent's experience of the child growing up." Yet clinician's remarks also raised questions about the framing of abruptness and whose temporal experience this might be. One clinician admitted the youth themselves *do* report longstanding gender variance: "You see also that late-onset type of... I don't know if... if you should call it late-onset because normally, they, when they explain it to us, they recall that the feeling has always been there." Another clinician similarly remarked: "... we don't have much of a history of any cross-gender experiences or ideations, *other than the child's self-report...*" [author's emphasis]. It is unclear in these accounts, what meaning is being given to the youth's self-report, but it is noticeably different from how these reports are received by youth deemed authentic.

In clinician's representations of their autistic patients, not only was the narrative of the longstanding or early childhood gender story missing, but a number of other aspects of the plot were out of sequence. One clinician discussed concerns over an autistic youth who wanted to wait to socially transition (to change her name, clothing and public appearance) until she was sufficiently feminized from estrogen, a reversal of the expected chronology. Protocols have historically been quite rigid regarding the requirement to socially transition prior to hormones and trans adults have often pointed out that these policies put them in danger as they try to navigate daily life as their felt gender without the aid of hormones. This clinician, however, felt this youth was being rigid by wishing to stray from the protocol: "One of the problems is this person had a very rigid view on the

trajectory, like, ‘I will transition to the female role when I’m feminine enough.’” This request also bears a resemblance to that of an autistic youth described by clinician Parkinson (2014) in a case study: “He would despairingly plead for female hormones but I would point firmly to the Standards of Transgender Care that he must first live three months full time in role in the ‘target’ sex” (p. 84). Unlike Parkinson, clinicians interviewed in this study did not deny treatment outright, but did report that the atypical request stymied the process. Of interest, is that the 22 clinicians who recently authored a set of clinical guidelines for working with autistic trans people, failed to reach consensus on a small number of issues, one of which was whether autistic trans people must follow transition steps in order, first social then medical, with some authors believing that this created unnecessary stress and barriers (Strang et al., 2016).

Other aspects of autistic youth’s stories continue to position them in the questionable repertoire. Elsewhere I have asked if the expectation that trans people will explain themselves through a discourse of misalignment – an inner self versus an outer self – might disadvantage autistic trans youth (or others, such as non-binary youth) who may not account for themselves in this way (Pyne, 2017). In interviews, this question remained pertinent. One clinician described assessments with autistic youth as “very complex” for a number of reasons, including their lack of a recognizable explanation for their transition desire: “...they explain it as if ‘I’ve always felt different than others. I’ve always felt I didn’t belong to others or I didn’t connect to others.’” Another clinician said of an autistic youth: “She’s on puberty suppression at this point but it took a long time for me to get there as the provider recommending it, because I wasn’t convinced that her core

gender identity was necessarily female.” Similar questions appear in the clinical literature. De Vries et al. (2011) question if autistic youth who present to gender clinics have a true “core cross-gender identity” or if they merely “feel different” (p. 2277). Parkinson (2014) suggests that an autistic youth he saw was not “essentially female” (p. 84) and described another, who was denied hormones, as having “always had the feeling of being different...” (p. 85). Parkinson writes that denial of transition care was positive for these youth, even according to the youth themselves, but in any case, it is evident that the story of feeling different is not a usable narrative in the gender clinic.

The image of autistic people as lacking, arose when clinicians wondered if the autistic youth in their care represented true cases of gender dysphoria, or whether youth had mistakenly muddled the issues of sexual orientation versus gender, or that of gender expression versus gender identity. One clinician stated: “...we know that kids on the autistic spectrum naturally have a difficult time with some of the more abstract concepts around sexuality and around gender, and so, it can be really, really challenging.” This clinician elaborated: “...sometimes autistic kids and teenagers have a more linear and concrete way of understanding the world. So they may say, for instance, I’m born male, but I feel attracted to males, that must make me a girl.” In addition, clinicians were concerned to know if autistic trans youth understood the distinction between gender expression (how one dresses, behaves, expresses oneself) and gender identity (how one sees oneself, who one is). One clinician stated: “if the kids have significant autism or severe delay... because of whatever developmental disorders or issues that the kid is... [they might be] confused with idolizing different gender roles and gender expressions and

mixing that up with gender identity...” Another clinician explained the worry with autistic youth: “Is it because of difficulty with...distinguishing between gender expression and gender identity?” This question exists for anyone considering transition and may be part of any clinical assessment process – does the individual wish to transition medically or express gender variance in other ways? Yet clinicians primarily raised this question when speaking about autistic youth.

As part of discussing this concern, some clinicians also included the worry that autistic youth might still believe that gender is binary: “...how well do they understand gender as a spectrum, I think that can be challenging...so... they would maybe be misguided by the binary system...” This is curious for a number of reasons, not only because there is a history of trans youth attempting to teach clinicians that gender is not binary, but also because some studies show that autistic people actually identify as non-binary in quite high numbers (Sedgwick, 2018).¹⁶ It is likely that discourses of “rigidity” (AutismInitiatives, 2010), “Theory of Mind” (Baron-Cohen et al., 1985) and also discourses of general “autistic lack” (Yergeau, 2018), function to naturalize doubt about autistic people’s self-knowledge. However, the question of whether autistic youth grasp the modern distinction between gender and sexuality, or grasp that gender is not binary, are questions that have an important historical and thus temporal context and later I explore why the implications of this are more serious than they first appear.

¹⁶ In Sedgwick’s (2018) relationship study, while 19 neurotypical non-binary individuals participated, 134 autistic non-binary individuals were recruited.

Additionally, communication was a major theme in clinician's accounts and this concern over communication took several forms. One clinician discussed being uncertain about a youth that was less insistent than others: "He...had never asked his parents to use female pronouns. He had thought about another name but had never insisted on its use." On the other hand, other youth were described as too insistent, without providing a proper story: "...he came in saying, 'I want hormones.' Right?... He'd just go, 'I want hormones, I want hormones.' Another clinician described a youth with a similar profile to autism (a "great deal of difficulty communicating" and "probably had some learning and expressive difficulties") and this youth did not seem to have a useable story: "...he could kind of give us an inkling of what was going on inside, but any sort of follow up, or probing questions, he had no capacity to respond...kind of holding to his story, no matter how thin, saying things like, 'I would go to bed every night and pray that I'd wake up a girl'...he never really became any more conversed since, or insightful, despite the fact that he kept saying he wanted to start high school as a female." In both these cases, clinicians reported that without an intelligible story, they could not provide hormones and had to discontinue blockers.

While it was a hindrance for the clinic if the story was wrong, if the story was absent, this void was more troubling still. One clinician recalled an autistic youth:

...he couldn't explain anything about his feminineness and, or where all that came from and why he would want to have breasts, what that was from, and probably he was either using too many drugs,¹⁷ or too maybe 'on the spectrum', to the point he couldn't even begin to describe why he would want to transition.

¹⁷ This youth had previously disclosed drug use to the clinician.

The effect of having no usable narrative was clear. Another clinician stated: “I don’t feel like I ever got to the nub of where this came from, because he would say, ‘Oh, I don’t know,’ or ‘I don’t remember.’ There was just this lack of interest in really engaging.”

This clinician went on: “...he didn’t speak a lot, so I always felt like he was withholding from me. It kind of almost felt like he had a secret, and he wasn’t going to tell me what that was” Another clinician stated:

So, most kids can explain ‘this makes me unhappy, I don’t care about this, this is what I really want.’ But this kid couldn’t verbalize any of that. We were having conversations, so it wasn’t like he – it wasn’t like he was so out-to-lunch, like, autism-wise or whatever that he couldn’t carry on a conversation. It’s just that the conversation was kind of vacuous...there was no content. Like, why do you want breasts? ‘Well, I just – I just think I need breasts.’

The above mention of “vacuous” conversations with autistic youth is reminiscent of another clinician who remarked that some youth were worrisome because they had “empty identity developments” that they presumably might try to fill with trans identity.

In the cases above, clinicians felt they could not provide treatment and the contact ended: “He just wanted me to approve him for hormones. I never could and he stopped coming.”

In an article about autistic youth presenting to a gender clinic, clinicians De Vries et al. (2010) write: “Worrisome are the adolescents that dropped out of care, probably finding their own ways to sex reassignment, without psychiatric treatment or medical attention.”

The problem of being an unreliable narrator in the clinic was evident. One clinician stated: “...those are just kids who are difficult to know what their...what is trans... like is that really part of the umbrella or are we already outside the umbrella? Right? So, the umbrella gets bigger and bigger, but people who just want to have breasts, but can’t explain why?” This question of whether those who lack the expected story are

indeed trans, demonstrates the central importance of story itself, in assessment. One clinician offered a guess that roughly 25% of the youth who present to their clinic do not have gender dysphoria at all, and when asked why such youth would even present to a clinic seeking to transition, if they are not trans, the clinician replied: “They’re confused.” Unsurprisingly, clinicians worried about non-speaking youth as well, especially those labelled with an intellectual disability. One clinician described a youth who was seen by their colleagues, rather than seen personally by this clinician: “I think she’s probably autistic...on top of her Downs [Down Syndrome], she’s probably autistic too.” This clinician did not suggest denying care to this non-speaking youth, but when noting the potential challenges, the clinician stated: “I’m glad I wasn’t there.”

If the absence of an expected narrative from autistic youth left something of a void in the clinical encounter, that void was easily filled with official discourses about autism. One clinician described their task as: “...to find out if this is really like a separate problem or is this part of autism, and if it is due to your autistic short comings.” This clinician went on to say: “...it’s often quite complex because they often have a history of different obsessions, different rigidities, different stereotypes. Often, the parents have stories that maybe even in childhood there was a period they wanted to be, maybe sort of a fairy tale figure, or later on, they were focused on something else.” Presumably many young children play out various wishes or character roles, however in this case, the presence of autism seems to change the meaning. Raising further questions about “obsessions”, another clinician asked if the desire to transition could be a “perseveration”, a term used to label the reiteration that can be part of the intense focus of autistic

presence: "...the most basic of the concerns is that people, the medical team, worry that maybe this will not continue, like, their gender identity may not persist because, is it maybe a perseverative thing, is it kind of a perseveration and might desist?"

Significantly, several youth were described as not looking as expected, in terms of their physical appearance: "...there was nothing feminine about him, not in any way he had his appearance. He did have long hair, but it was very kind of male-ish, oily, kind of teenager stuff. So, I just didn't get it." Another clinician remarked: "... her gender expression was rather male typical...she didn't want to comb her hair and it's tangled. It was all grown out. It was tangled. It was not like she wanted to tend to her appearance to evoke femininity, which is the huge hallmark character of experiencing gender dysphoria." A common public (trans positive) discourse about trans youth is that they are expressing their natural or authentic self. Clinicians spoke this way about patients who they viewed as authentic, youth who are: "thriving and flourishing and living as the authentic gender that they are." Yet some autistic trans youth were described as not working hard enough at that which was paradoxically said to be 'natural': "I'm going to call him 'he' because he always presented as he. In fact, he presented as he to such an extent that he had very obvious adolescent body odor as a male, and there was no attempt to kind of cover that." Another clinician stated: "She wants to have people recommend her as female but she didn't really seem to learn to do the work. There was no motivation from within that." Another clinician summed up how difficult this could be for clinicians to place within their understanding of transgender: "I'm thinking, God, you just look like such a guy. How do I get my head around this?" No clinician commented on the

physical appearance of trans youth who were deemed credible or authentic. In fact, physical appearance was only discussed when not fitting expectations. However, presumably this could mean clinicians would evaluate physical appearance in other sessions as well. One clinician who had been practicing a long time, remembered that early media coverage of trans children helped in their view to make the public meaning of transgender more positive: “They’re cute, young people who have this big problem are cute, whereas... men who want to be women, that was more the message they gave before, then also we have these sweet kids, who also have the same problem...cute little transsexuals...” It is likely then that physical appearance plays a part in how trans youth are received in clinics and elsewhere.

Having the wrong narrative, or an unrecognizable narrative, was clearly a drawback in the clinical process. Yet so too was having a narrative that too closely matched the familiar story, lest it appear unoriginal. One clinician mentioned an autistic youth who they described as: “...using language that is clearly scripted from the internet...” with the clinician questioning whether this was coming from “their internal sense of who they are versus from some outside source.” Another clinician recalled meeting with a youth they felt was likely autistic: “...the adolescent reported very clear information about gender dysphoria which sounded a little bit from, well, from the internet. Maybe even certain sentences that you would say... like, less authenticity... very formal...” Thus, the familiar story could potentially be so familiar as to tip over into the inauthentic. In one case, a clinician reported feeling that an autistic youth’s story was not ideal: “...if you start your story with hello I’m transgender and its effects, people will,

generally they will react with very stereotypical questions. Are you really going to cut your penis or whatever?” This clinician then unironically suggested how the youth’s story could be better told: “...if you’re able to start your story with ‘I’... ‘I am a person and I am born as a male but I always had feminine interests... this developed during my life experience and I also got distressed by my developing body. I went to a psychologist or expertise center to find out what could help me. I’m now in a phase of puberty suppression...’ You know, it’s a good story, and it’s about you...” This clinician worked with young trans patients to help them express themselves, sometimes artistically, which certainly sounds positive. However, in the context of questioning the authenticity of stories, it is curious that a clinician would then offer to supply the wording for the story themselves, as presumably this is also not authentic. It should not go without saying that this proposed story edit matches the medical protocol for early transition care.

Additionally, distress or suffering also plays a central role in the story of trans youth and transition care. One of the original Dutch clinicians who developed puberty blockade for trans youth, recalled the practice evolving as part of the Christian response to suffering in the Netherlands: “... it started at a university actually completely paid for by Christian people. This was because they thought it was, we have a word for that, it's called “Barmhartigheid”, it's because of compassion with the people you’re living with, that you should help those who need... who suffer most.”¹⁸ One interviewed clinician stated: “...if young people are really, really, persistently over a reasonable amount of time

¹⁸ In addition to “compassion”, the word “barmhartigheid” also translates as “mercy”, “mercifulness” or “charity.”

- we could discuss what that means - are really suffering in the sexed body they've got, we are completely open to the idea that they would want some treatment for that.” This triple use of the adverb “really”, helps to signal the centrality of suffering to the authentic story. Yet in the questionable story, the presence or placement of suffering tends to be askew. In the authentic repertoire, youth begin the clinical process in distress, which will worsen (or has already worsened) with unwanted pubertal development, and then distress should recede with blockers or hormone therapy. Dr. Norman Spack, who initiated puberty suppression treatment in North America, pronounced: “The minute these kids even know they’re going to get the puberty suppressants, their suicidal thoughts melt away” (Fernandez, 2015). But in the questionable story, youth did not necessarily get better, or worse, when expected. Not only did youth present long past the point when pubertal distress might have brought them to the clinic (for example, late teens) but distress also did not always show up on time. One clinician spoke about a youth that left them uncertain, because the gender story had been unclear. The clinician eventually removed the puberty blocker to look for evidence of dysphoria or distress, but when distress did not appear sufficient, treatment was stopped: “So what we did, is we withdrew the Lupron and we were kind of looking to see if that would precipitate a bit of a dysphoric reaction as puberty began up again. At which point, he did express some concern, shall we say, about the fact that his erections were returning. But other than that, no, so he’s remained off Lupron at this point...” At the time of interview, this remained unresolved for the clinician: “I don’t know if we made the right choice or not.”

The final sequence that was askew in the questionable story, was the ending. Several clinicians mentioned the happiness that youth typically show after transition: “I mean, somebody will come in with this grin on their face, they’re just so freaking happy, for the first time in 5 years...” Another clinician recalled: “...he comes in, he’s just the happiest guy you’d ever want to see and he pulls up his pant leg and shows me his leg hair [laughter]...” A clinician suggested that when youth do not get happier, this can pose a problem for the clinic:” So, the really bad social phobias are hard too, because they won’t leave their room, and it’s hard to tell if they’re even happier or more functional, right?” A number of youth, not all necessarily described as autistic, worried clinicians when they didn’t follow the temporal schedule of getting better: “[This Trans Youth] was on Lupron and again completely thrilled...But then [This Trans Youth] became more distraught, he became more anxious, more depressed, and when we talked to him about it, he indicated that in fact his negative mood predates any of this stuff... and also, desperate to start testosterone.” This clinician elaborated on the concern: “So the concern from our end was whether his urgent need to start testosterone earlier than protocol at the age of 16 was a measure of his dysphoria and perhaps contributing to his depression, or was this depression sort of comorbid and separate, and he had this fantasy belief that by starting testosterone, he would be better?” Thus this clinician was unsure about approving testosterone for two reasons, A) because the youth had not gotten better as planned, on blockers, and B) because the youth might incorrectly expect to get better, on testosterone. Another clinician also mentioned their interpretation of an autistic youth’s unrealistic expectations: “I also want after treatment, that all my problems that I have now, solved...”

and: "...this is the only thing that can solve my other problems, my difficulties in school, my difficulties in connecting to other people." The clinicians' expectations were thus somewhat contradictory. While they clearly expected youth to get better with treatment, at times they also considered delaying treatment because they felt that the youth was unrealistically expecting to get better.

At the conclusion of interviews, I asked clinicians what they wished for the trans youth in their care – what they hoped and wanted for their futures. Their replies were moving and emotional, often showing their deep commitment to supporting trans youth into their future lives. Many replied simply: "Happiness." Yet there were also contradictions with this goal. When one clinician spoke about a youth whom they suspected might not be trans, they recalled asking the youth: "'Is it possible that you're looking so much to be happy...?' I don't know if these are the words I would have used but, 'You're striving so much to be happy that you're trying, you know, solution A, solution B, solution C, solution D, until you find the one that kind of clicks?'" The clinician clarified: "...was this sort of a means to an end and the end wasn't necessarily realigning gender, but the end was being happy?" Another clinician said: "...just putting a kid on hormones makes them happy for the short term, but that doesn't fix them..."

Lastly, many clinicians noted that the profile of the trans youth that they see has changed. One clinician recalled the history of their clinic: "We were running this crazy marginalized service that was a bit disapproved of, but we knew we were doing good... you really felt good about offering this, and you still can, clearly, but it's got way more complicated." Some clinicians found their work more complicated because there are now

more non-binary youth presenting: “...the nature of the referrals are also changing a little bit over time... we're getting more referrals of young people who may have gender fluidity experience...” The changing mental health profile of youth was central to this discussion. One of the original founders of puberty blocking treatment noted that in the beginning, clinicians were under intense scrutiny and used a high bar to assess the mental health status of youth: “...we were very strict, in the beginning we wanted them to function well and there were much higher standards than now, so no major psychopathology...” In contrast, currently more youth are described as: “...very, very troubled...” One clinician who works in medicine rather than in mental health remarked: “It’s ridiculous, social anxiety is just – I never saw it when I was training, it was rare, nobody cut, ever, ever, ever until 10 years ago, 15 years ago...that was never part of my training.” This clinician went on to say: “...we have lots of really well-functioning kids, but we have a lot of messed up kids and the hormones... hormones are not going to fix poverty, hormones are not going to fix psychosis, we have a few kids who are psychotic, and it’s not going to fix autism, the Asperger’s kids who are...who are...who are just not functional for other reasons... that doesn’t fix them...” While this point about the structural influence of poverty is important, notably, the questionable story seems to remain questionable in part because it does not end with a fix.

Finally, two clinicians notably strayed from the common questions and concerns that clinicians had about autistic youth. These clinicians seemed less unnerved by the story or lack of story provided by autistic youth. One clinician agreed that an autistic youth he worked with offered a story that differed from the norm, but felt the story had its

own internal consistency: “every time that I meet with him and sort of keep trying to dig and pull out more...there's some internal consistency in what he's sharing with me.” This clinician described how they addressed inconsistencies with this youth: “...if you challenge him on ‘Well, your teacher said you wore a dress once and they were confused’... and he’ll kind of explain the rationale for why he wanted to wear a dress that day. It has nothing to do with gender identity. It was just, he likes that color and, ‘Oh, I’m going to wear that...’” This clinician took to using other modes of assessing youth, rather than narrative: “I find with the autism spectrum, most of them are drawn to video games or some type of online activity and I find asking questions about that is often telling of gender to some degree... people would choose characters that kind of reflect them and that they see part of themselves in...I find that’s a good predictor, clinically...” This clinician found this strategy worked specifically with autistic youth, as neurotypical youth are more likely to deliver what I am calling the chrononormative story that unfolds in an expected temporal fashion: “...because a neurotypical individual... they're more likely to give you that narrative and you don't necessarily need to probe deeper than that.”

Another clinician mentioned a similar strategy, but not limited to autistic youth:

When I talk to kids, it’s less about clothes and toys, although that’s usually part of the story... but how do you dream? How do you see yourself in the future? How are you doing imaginative play? What are your avatars looking like in your gaming? How are you exploring gender in other domains of your life besides these things that may be incorrectly gendered like toys and clothes and things? So it’s really about trying to tap into that internal experience that people are having...

Indeed, this clinician reported seeing enough autistic youth of a certain profile that they now consider these youth to have a familiar story. When asked if they these cases are complicated, they stated: “Not for me because I’ve seen it so many times!”

Another cohort of kids...18 or 19 year-old assigned male at birth coming into the clinic with their completely befuddled parents...kid’s totally masculine presenting... ‘Our kid told us this a month ago and I don’t understand it because there was nothing about my kid’s childhood where they said they were girl, they didn’t want to paint their nails or come flouncing in in their sister’s clothes... there was nothing about this until last month and...my kid has Asperger’s...I don’t think they are really female...’

Offering a different interpretation of the “abrupt” trans coming out story - the story that often violates chrononormative expectations - this clinician did not interpret this as casting doubt on youth’s authenticity. They went on to state that they find that this “cohort” of young autistic trans women are often lesbian or pansexual and not overtly feminine themselves, thus confusing in a society that expects trans women to be hyper feminine and heterosexual. This clinician felt that later presentation at the clinic could be due to feeling confused by these expectations:

And I’m like...they are not preoccupied with ‘I gotta go out and buy makeup’ ... because that’s not what they’re about. In fact they’re almost always super smart they are super into gaming ...and it might have been confusing for them, because in a heteronormative society if I’m assigned male at birth, and I like women, that’s how it’s supposed to be, so why doesn’t this feel right? And then there’s this period of... ‘Oh because I’m actually female, attracted to women.’

Given that these stories might be unintelligible in another clinic, this clinician raises the vital question of how and when stories become familiar and ‘natural.’

Discussion: Narration, Time, Story

As mentioned, an interpretive repertoire analysis is attentive to contradictions in discourse and originally developed out of research analyzing contradictions in scientist's talk about their work (Gilbert & Mulkay, 1984). Similarly, there are no shortage of contradictions in these interviews when discussing the assessment of youth. While some youth are viewed as authentically trans when they are insistent about their treatment wishes, others who insist on treatment are regarded as unintelligible. While some inconsistency in past gender expression can be absorbed into the authentic story and even considered evidence of a trans identity, other inconsistencies in past gender expression are viewed as threatening to the veracity of the story. While some who speak very little about their gender can be seen as credible and “just who they are”, others who speak little are seen as confusing and the process often does not proceed. In some cases, it seemed that similar story themes could be evidence of either authenticity or doubt.

In an interpretive repertoire analysis, contradictions are key to understanding the function of the discourses at hand (Wetherell & Potter, 1988). For this reason, I focus discussion on contradictions that provide windows into the temporal implications of chrononormative discourse for autistic trans youth in the gender clinic – contradictions regarding rigidity and flexibility, comprehension of modern gender ideas, the temporality of getting better, and narrative authenticity. With trans experience largely defined by narrative, autistic trans youth have formed something of an “other” in the gender clinic.

Autistic youth were frequently described as “rigid” in their thinking, reflecting common scientific discourses about autism (APA, 2013; AutismInitiatives, 2010). Yet

they were also paradoxically questionable due to possibly being too malleable, easily influenced, or donning a trans identity on a whim. This contradiction exists in the public realm as well. Parent blogger Kathleen Levinstein (2016) insists that her autistic teen identifies as transgender due to watching the television show *Degrassi* and attending PFLAG meetings. Similarly, an anonymous parent on the same website (pseudonym “FightingToGetHerBack”) maintains that her autistic teen plans to transition due to attending a school presentation on the topic (Anonymous, 2018). This latter parent suggests that the child’s “autistic thinking” is that which makes them “vulnerable to the false belief that she was transgender” (Anonymous, 2018). With both rigidity and whimsy claimed as “autistic thinking” in clinician interviews and public discourse, it seems the “whatness” of autism (Yergeau, 2018, p. 9) may itself be “flexible” and available to non-autistic others for contradictory purposes. In some cases, both rigidity and its opposite flexibility, were used to cast doubt on autistic trans youth.

A further contradiction in clinician’s talk was the concern that autistic youth who present to gender clinics might not understand that gender is not binary, despite the long history of trans people trying to teach clinicians that gender is not binary, and despite the high numbers of people who, some studies are finding, are both autistic and non binary (Sedgwick, 2018). This concern was paired with an even more common concern, which was whether autistic youth could understand the distinction between gender and sexuality, or the distinction between gender expression and gender identity. As stated, the question of whether any individual wishes to transition medically or express gender variance in other ways, is likely a question pertinent to many, and perhaps this is considered for all

who present at clinics. However, clinicians voiced this question specifically when speaking about autistic youth. Aforementioned theories about autistic “rigidity” accompanied this question, however I would like to suggest there is also a more serious meaning animating this query, relating as well to chrononormative time.

In *Imagining Transgender: An Ethnography of a Category* (2007), Valentine writes about the evolutionary leap represented by the 1990s emergence of the category of transgender. Gender and sexuality have been historically yoked together in myriad ways, culturally through social positions like “the sissy” (Grant, 2004) and “the fairy” (Chauncey, 1994) and diagnostically through what Prosser (1998) calls the crowded category of the “invert”- a hodge-podge of sexual and gender violations joined by the assumption that homosexuals were “inverted” versions of males and females. As Valentine (2007) writes, the emergence of the category of transgender was the result of gender and sexual meanings being worked out over the course of the twentieth century until they emerged as separate domains – gay people and trans people are different types of “things”, and any given individual has both a gender *and* a sexuality. Forming the basis of “LGBT cultural competence” trainings and “trans 101” seminars, the distinction between sexual orientation and gender identity now signals a modern truth. We view gay men *as men*, in contrast to the inversion theory of the past, in which it was assumed that gay men wanted to be women. To muddle-up this distinction is now seen as backwards, unevolved, anachronistic, and stuck in the past. Indeed, Valentine (2007) writes of the individuals who did not make sense of their lives through this (at the time new) categorical split, and chronicles their relegation to what Amin (2014) calls “atavistic

modes of false consciousness.” I am suggesting that this concern about autistic youth can permeate their care so effectively because lingering eugenic ideas, as well as modern notions like Theory of Mind, make autistic people available to be categorized as evolutionary throwbacks, as beings of an earlier time, premodern, unsophisticated, slow. While it is certain that clinicians did not intend this characterization, ongoing theories of autism-as-lack, as contrary to modernity, are theories that continue to structure how autistic trans youth are seen.

A third contradiction in clinician talk was the need for youth to get better and resolve their distress, paired with doubts about both the youth who did not get better, as well as the youth who had expectations of getting *too much* better. This temporal or chrononormative schedule of sorts, had specific placements for specific types of suffering, but in the end, resolution was programmed. In the care of these youth, clinicians had devoted vast amounts of time and energy. Those based in hospitals often launched their clinics with no resources, sometimes unbeknownst to administrators if support was lacking. The range of accomplishments was extraordinary, spanning government lobbying for funding, media commentary to change public attitudes, counselling for struggling parents, all in addition to their primary work with youth. Some clinicians had no funding to support their trans health work and added this to full schedules with other patients. In this context, there was considerable investment in the ability to help and to heal the youth in their care – the ability make youth happy. “Happiness”, was in fact what clinicians most wished for youth, and as noted, several confided they preferred trans youth over other patient populations, precisely because of

how trans youth could be helped and how grateful they were. The work felt good, clinicians told me, and their fulfillment was moving and genuine. Questions arise however, from considering Duffy and Dorner's (2011) analysis of autism research as a science of pathos, which they refer to as "scientific sadness" (p. 201). With sadness also permeating public narratives and public views on autistic people. The question might be asked then, what happens if happiness is missing, what happens if clinician fulfillment is missing?

In the public discourse around autism, parent memoirs often focus on the emotional absence that parents can feel with their autistic child. Having learned to expect and value neurotypical affect, parents can be bewildered and disappointed, angry and grieving, over the unrecognizability of their child. Many call autism devastating and some unfortunately choose metaphors of monsters and beasts, kidnapping and death, to describe their parenting experience. Harmful experimental treatments (and in the case of vaccinations, the harmful absence of treatment), might be traced to the desperation of parents who hope to see their child engage in the ways they have learned to identify as good and right, healthy, normal, and human. Given this common scene, might clinicians question this as well? If a clinician was unable to engage with autistic youth on their own terms, might the emotional connection they associate with warmth and humanity, gratitude and connection, seem absent? Given the chronology of medicine, described by one clinician as "assessment, diagnosis, sanctioning treatment, happy person", might the permanence of autistic presence appear to thwart this unspoken contract? Given that clinicians spoke about relating to some trans youth, able to see them simply for who they

are and offer them swift treatment, how might the history of discourses such as autistic-as-unknowable, impact their ability to see autistic youth for who they are and offer treatment in a timely way? When a clinician warmly spoke of a patient as “one of those people that I hope my kids grow up to be like”, how likely is it that a clinician would hope their kids grows up to be autistic?

While the history of medicine and mental health care with trans children is riddled with pathology and pity, disorder and doom, this is no longer the case in the affirming clinics that now serve trans youth. When one clinician stated that they enjoyed working with trans youth because it’s “not an illness model of gender”, as the interviewer I commented “Well, it used to be.” The clinician replied “Yeah used to be, but it’s not now.” This change is quite recent. The converging of multiple social forces has resulted in the opening of new futures for trans youth. Widespread mobilizing by trans communities, parents, and professionals, has created new discursive and material resources for trans youth to draw on in creating valid identities. The changing “tipping point” media narratives, perhaps made possible by “cute” and sanitized images of trans children, have allowed for a trans social position that is potentially “Finally Normal” (Shapiro, 2015). The DSM-5 shift to *Gender Dysphoria* as a resolvable form of trouble, as well as the justificatory story about how trans youth must transition to be happy, are all forces that potentially set the stage for autistic youth and others who do not fit this narrative, to be doubted as to whether they are in fact trans at all? Might the chrononormative story of getting better, the story that has made puberty suppression and

early transition possible, now structure and limit who can be considered a trans youth, on the basis of whether or not they get better?

Amin (2014) suggests that to say that something is chrononormative is not to say that it is bad. However, in answer to Prosser's argument – the argument that narrative facilitates transsexual transition and healing - Amin (2014) responds that “if the retrospective construction of a coherent transsexual plot narrative proves healing to some, it is at the expense of episodes, or even fleeting moments, that would fracture or exceed it” (p.220). Amin (2014) suggests that while there is efficacy for some, narrative of the required genre is not available to all, and has the potential to further alienate those unable to pour themselves into a coherent mould. Amin (2014) does not elaborate, but here we might read in the fate of autistic trans youth, non binary youth, in addition to potentially some Indigenous or racialized youth whose temporal or conceptual ideas of gender may vary from Western medical narratives (Roen, 2001). If, as Prosser (1998) argued, narrative is a trans person's “second skin”, what does this mean for those who lack the expected narrative? Are some youth left without “skin” in the clinic so to speak, without a narrative to protect them, without the legibility to be “read” and helped in a timely way? To consider what is at stake in timely access to treatment, we need only look to clinician's own words, who write about the importance of developing triage systems to serve youth as quickly as possible (Eade, Telfer & Tollit, 2018), because treatment is “lifesaving” for trans youth in the short-term (Olson, Rosenthal, Hastings & Wesp, 2018; Segal, 2016) and in the long-term, a “lifetime advantage” (De Vries et al., 2011, p. 2277).

Chapman et al. (2017) write about the “moral economy” of the helping professions, an economy that requires “the clinician” to win the classic power struggle with “the disease” in order that the mandatory rescue of “the patient” can take place. Chapman et al. (2017) write that if the moral economy is not satisfied, there is trouble. In their writing, they primarily mean when a helping professional is themselves marked as “diseased” due to, for example, their own mental health struggle. However, there is also trouble if the clinician fails to defeat the disease. As Cadwallader (2012) writes, “unexpected suffering” creates a problem for medicine, when a patient does not get worse when expected, or better on time. In interviews, clinicians spoke of how their clinic population had changed over time to include now youth who are “very very troubled.” As one clinician stated, “hormones don’t fix autism.” Indeed, the history of autism shows a staunch resistance to cures and fixes, an insistent autistic presence. In the autistic writing anthology *Loud Hands*, Bascom writes: “We are fine” (p. 10), and “Autism just is” (p. 10).

The transgender movement, including the movement for depathologization, has made great gains for trans communities, in particular for youth. Paradoxically, the legitimacy of early transition seems to have opened the door for youth to present at clinics who would not have been approved in the past, when, as one clinician put it, “we were very strict...we wanted them to function well and there were much higher standards than now.” Yet, the standards within the clinic continue to revolve around certain kinds of functioning, certain kinds of wellness. This analysis suggests that the discourses that have been mobilized to make early transition possible, reach the outer edge of their potential,

their finite end, when faced with autistic trans youth who are not considered to be “functioning well”. Those who by choice or by circumstance defy the chrononormative trajectory of “getting better.” The unintelligibility of autistic trans youth in the gender clinic indicates that the movement for depathologization cannot take us where we need to go. We need a new movement, a new story.

Writing about the genre of autobiography, Julie Rak (2005) writes that popular autobiographical narratives used to consist of a crisis that was then resolved by the end of the text. The genre is changing however, writes Rak (2005), and autobiographical narratives are now more likely to feature a crisis that does not resolve. In the trajectory of autie-biography, Temple Grandin’s (1996) first book “Emergence” declared that she had been cured and “emerged” from autism. Dawn Prince-Hughes’ (2004) more recent autie-biography, on the other hand, declared: “I emerged into the beauty of it [autism]” (p. 1). Turning the cliché of autistic “emergence” on its head, Prince challenges the inherent value of out, rather than in, when it comes to autism.

In the historical trajectory of trans narratives, Jay Prosser’s (2014) in-process project “Digital Trans” suggests that the internet age has made possible new narratives about trans life, and as a result, new genres of trans life. The cohesive transsexual autobiography (written retrospectively by a solitary subject) has now arguably been overtaken by the YouTube transition video (fragmented, networked and uploaded in real time). Prosser does not name the new forms he believes possible for trans life, but simply notes that the YouTube transition video requires neither a beginning, middle nor end, and further, unlike autobiography, uploaded consecutive life episodes need not cohere with

one another. The need for a coherent chrononormative story to explain the desire for transition may be waning, and in fact Amin (2014) calls for precisely this in his discussion of trans temporality: “Since a modernist progress narrative is being institutionalized along with the category of transgender, an attentiveness to non-chronological, non-progressivist temporalities of gender variance...could prove critical...” (p. 221).

In his book chapter *Telling Sexual Stories in the Late Modern World*, Ken Plummer (1995) presents stories as part of the web of action that makes up social life. Stories are dependent on an “interpretive community” to hear them, argues Plummer (p. 116). A story can be heard when the audience has been sufficiently “rendered ripe” for it, a process intimately tied to social change (p. 116). As example, Plummer uses the gay coming out story, told privately to friends and lovers for decades before it could enjoy its life in the public realm as a result of the gay liberation movement. Plummer’s point is that “stories have their time” and may not be able to be told before there is an audience in place to hear them (p.109,116). In these interviews, it was evident that the audience was often not in place to hear the stories of autistic trans youth. “How do I get my head around this?” said one clinician. Yet a small number of clinicians also reported engaging autistic youth outside of conventional narrative: “How do you dream? How do you see yourself in the future? How are you doing imaginative play? What are your avatars looking like in your gaming? How are you exploring gender in other domains of your life...?” In addition, one clinician had seen enough autistic trans youth that they were able to perceive familiar themes across their stories, often not heterosexual, often not gender

normative, often a surprise to parents. These clinicians, as well as the autistic biographers who insist we listen “In Their Language” (Baggs, 2007) and hear their “Loud Hands”, may have the potential to usher autistic trans stories into their own time.

Conclusion

Trans experience has been historically expressed and defined by narrative, both in the public realm and in the gender clinic (Prosser, 1998; Stone, 1991/2006). Prosser (1998) writes that narrative is a “second skin” for transsexuals. In contrast, Osteen (2008) writes that autism is “uniquely resistant to narrative” (p. 17) and Yergeau (2018) writes that autistic people are assumed to be non-rhetorical. This analysis finds that autistic trans youth, who present with narratives that diverge from the expected story, or with no narrative discernible to clinicians at all, have formed something of an “other” in the gender clinic. The trans rights movement broadly, and the affirming approach to trans children specifically, increasingly wields a narrative that works to make puberty suppression and early transition possible for some trans youth. Yet these narratives can work against autistic youth. The discourses of trans youth being intelligent, articulate, and unusually mature for their years, are discourses unavailable to many autistic youth, whose intelligence is often not captured on standardized tests, whose experiences may resist telling in an “articulate” mode, and who are often seen as younger than their years. These assumptions and views about autistic people are embedded by the historical and present discourses of autism. Further, the story of trans youth becoming happy and well-functioning after transition, would seem to work against autistic trans youth who may be seen through the lens of what Duffy and Dorner (2011) call “scientific sadness” (p. 201),

as not functioning, and with an autistic presence that does not (and need not) “get better.” Yet the growing voices of autie-biography and the changing genre of trans narratives, indicate that the stories of autistic youth may find their audience yet – and, as stories, may yet come into their time.

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CHAPTER FOUR

The Temporality of Privilege: Trans Youth of Colour and the Trouble with Triage

Abstract

In a time of expanding futures for trans youth, some are able to ‘buy time’ by blocking puberty and transitioning young. While controversial, the option of puberty suppression (‘blockers’) for trans youth has been hailed by clinicians as “lifesaving” for halting the crisis of unwanted puberty, and “a lifetime advantage” for reducing visibility and protecting against future victimization. In the media, acquiring blockers before the onset of puberty is often referred to as a “race against time.” A matter in question however, is that gender clinics report they primarily serve white middle class trans youth. The following analysis presents a discourse analysis of interviews with health and mental health clinicians across six countries as well as interviews with community level experts working with racialized trans youth. Drawing on queer and trans of colour critique, sociological works on time and social power, and the literature of queer temporalities, I explore the repertoires of time evident in clinical talk about blockers and trans youth futures and consider their consequences for racialized trans youth. I propose that the temporal repertoire of urgency or crisis-time, often meant to characterize the experience of all trans youth, is most likely to reflect white middle class trans youth and to secure their services. Meanwhile, the families of racialized trans youth, beset with multiple struggles of survival, must often triage resources and cannot afford to ‘race against time’ nor ‘buy’ it. Using Berlant’s (2011) juxtaposition of the *event* and the *situation*, I argue

that an over-focus on the *event* of pubertal crisis for trans youth in general, can obscure the *situation* of trans youth of colour in specific (i.e.) ordinary long-term structural racism, in the face of which, racialized trans youth lack the stability that gives the term ‘crisis’ its significance. Ultimately, the ability of puberty blockers to act as a “switchpoint” to guide already privileged trans youth into even more privileged futures, threatens to widen the existing racialized opportunity gap in trans communities.

Introduction

We are living in a time of expanding futures for transgender youth who are able to “buy time” by blocking puberty and transitioning to a new gender while young. Twenty years of clinical research and writing by medical and mental health practitioners has indicated (though not without controversy) that trans youth benefit when puberty suppressing treatment allows them to avoid some of the distress and harm that has come to be associated with transgender lives writ large (Hembree et al., 2017). In contrast with previous generations, in which gender non-conforming young people had access either to pathologizing services that sought to correct them (Bryant, 2006), or no services, the growing number of “gender affirming” clinics now offer young trans people the possibility of greater autonomy over their bodies, their futures, and their future bodies. According to the Dutch clinicians who first offered puberty suppression to trans youth, this treatment is “a lifetime advantage” (De Vries et al., 2011, p. 2277). According to some “affirming” clinicians and advocates, the ability of blockers to avert the crisis of

puberty is “lifesaving” for trans youth (Olson, Rosenthal, Hastings & Wesp, 2018; Segal, 2016). A matter that remains in question however, is that clinics across a number of countries report they are primarily serving white middle class trans youth and it is unclear what this means for others.

The following analysis places this racial disparity front and centre in the clinical care of trans youth. I report on a discourse analysis of interviews with health and mental health clinicians across six countries – those clinicians who make decisions to approve (or not) the youth who seek puberty blockers or cross-sex hormones. In addition, I report on interviews with community level experts working with gender diverse children and youth. Drawing on queer and trans of colour critique, sociological works on time and social power, and the literature of queer temporalities, I explore the repertoires of time evident in clinical talk about blockers and trans youth futures and consider their consequences for racialized trans youth. While elsewhere I have remarked that the discussion of puberty blockers is shot through with discourses of time (Pyne, 2017), here I wish to explore what *kind* of time this is. Specifically, I propose that the temporal repertoire of urgency or crisis-time, so often used to characterize the experience of all trans youth, is in fact most likely to reflect the experience of white middle class trans youth, and most likely to secure their services. Using Berlant’s (2011) juxtaposition of the *event* and the *situation*¹⁹, I argue that an over-focus on the *event* of pubertal crisis for trans youth in general, can obscure the *situation* of trans youth of colour in specific (i.e.) ordinary long-term

¹⁹ The “event” and the “situation” were originally theorized by Badiou (2013), however my interest more closely parallels Berlant’s (2011) use of these terms.

structural racism. Further, the ability of puberty blockers to act as a “switchpoint”²⁰ to guide (some) trans youth into vastly improved futures, indicates that the disproportionate support received by white trans youth in gender clinics, however unintentional, functions to widen the existing racialized opportunity gap within trans communities. Lastly, recent attempts to implement a triage system in youth gender clinics to rapidly respond to *the event* of puberty, risks further deprioritizing trans youth of colour and their complex, ongoing, and common-place *situations* of ordinary crisis, or as Berlant (2011) terms it “crisis-ordinary”. Attempts to assist trans youth in a timely fashion are to be commended, however I propose that “crisis time” is currently a temporality of privilege that maintains the ongoing troubling *situation* of trans youth of colour.

Puberty Interrupted

In Utrecht, Netherlands in the early 1990s, Dutch endocrinologists Henriette Delamarre-van de Waal and Louis Gooren as well as psychologist Peggy Cohen-Kettenis were the first to prescribe gonadotrophin releasing hormone agonist (GnRHa) treatment to transgender youth with the goal of delaying unwanted puberty (Gooren & Delemarre-van de Waal, 1996; Kreukels & Cohen-Kettenis, 2011). Dubbed “pubertal blockade”, “puberty suppression” or “blockers”, the technique involves introducing GnRH agonists that act on receptors in the pituitary gland to inhibit the release of the luteinizing hormone and follicle-stimulating hormone and suppress pubertal development for a time. This practice has been used since the 1980s to delay the premature onset of puberty (Central

²⁰ Kathryn Bond Stockton (2006) and Jasbir Puar (2011) use the term “switchpoint” in the context of gender and race, albeit differently than I do.

Precocious Puberty) in cisgender (non-trans) adolescents until deemed more socially appropriate alongside their peers (Ward, Ward, McNinch & Savage, 1985). Yet despite years of testing within adolescent medicine, the first use of this treatment with trans adolescents prompted Dutch media to claim “chaos and confusion” and “the world turned upside down” (Schöttelndreier, 1999).²¹ While media response has somewhat calmed, commentators who remain critical continue to reference blockers in the temporal terms of civilizational decline, as “the destruction of children” (Russell, 2013), or “society’s rock bottom moment” (Walsh, 2014). On first report in 1999, Dutch psychoanalyst Iki Halberstadt-Freud claimed this treatment was “destroying young people” (Schöttelndreier, 1999). Nearly 20 years later, American psychoanalyst Lisa Marchiano (2017) repeated the discourse of “destruction”, warning that youth are “seduced away into peril” by puberty blockers and labelling early gender transition with the dramatic temporal term “epidemic” (p. 345-346).

Aside from Marchiano (2017), contemporary medical and mental health professionals voice their worries in the more moderate terms of health and ethics. Clinicians raise concerns over the loss of fertility that can accompany early transition (Vrouenraets et al., 2015), as well as mental health factors that may complicate assessment (Viner et al., 2005; Vrouenraets et al., 2015), questions of medical necessity (Viner et al., 2005), the absence of long-term data regarding health outcomes (Vrouenraets et al., 2015) and the maturity of the youth in question. Clinicians and

²¹This is a Dutch to English translation of Schöttelndreier (1999) in the Utrecht Newsblad newspaper.

bioethicists have suggested that blockers could “disrupt” gender development (Vrouenraets et al., 2015, p. 370; see also Spiegel, 2008) and “push” adolescents toward transition (Stein, 2012, p. 490). Some argue trans youth may change their minds, raising anxiety over possible regret and whether youth will “desist” from or “persist” into a trans identity, and further, whether this can be predicted at puberty.²² It is not uncommon for bioethicists or clinicians to state that all options should be pursued prior to blockers and prior to acceptance of a trans identity (Stein, 2012). Steensma et al. (2011) write that puberty is the key time when a future gender identity may become known (p. 499).

Despite ongoing controversy, influential institutions have taken stances that support the use of blockers, including the Endocrine Society (Hembree et al. 2009; Hembree et al., 2017), the World Professional Association for Transgender Health (Coleman et al. 2011), and the Canadian Pediatric Endocrine Group (CPEG, 2012). Yet proponents must work to counter received wisdom regarding the unstable nature of adolescence and the dominant logic of a “wait-and-see” approach. Proponents explain that puberty is an urgent cross-roads and sensitive time-window for trans youth, making intervention necessary for preventing the immediate distress of a “wrong body” and the risk of self-harm and suicidality (McFarling, 2016). Additionally, they point to the urgency in protecting future quality of life by reducing the extent to which youth will be visible as trans people in the years ahead and thus exposed to discrimination and violence (Cohen-Kettenis, Delmarre-van de Waal and Gooren, 2008; Giordano, 2008; WPATH,

²² Elsewhere, colleagues and I have argued that this preoccupation with predicting future identities, appears to be rooted in the desire to fend off transition if possible and thus devalues trans life, doubts young people’s authority, and deprioritizes their present-day wellbeing (Temple-Newhook et al., 2018).

2011). The “reversibility” of puberty blockers is key to their discursive success, as this allows youth to “buy time” for a number of years (as with Central Precocious Puberty), and then to take either the path of transitioning or allowing endogenous puberty to take its course. Indeed, affirming clinicians redirect the discourse of concern by pointing out that unlike blockers, which are reversible, endogenous puberty itself can be irreversible with some changes requiring surgery to undo (chest growth for trans boys) and others impossible to undo (skeletal growth or voice change for trans girls) (Hembree et al., 2009). Affirming clinicians stress careful assessment and do not suggest a cavalier approach, yet also argue that time is of the essence and some clinics have implemented triage systems to fast-track pubertal age youth (Eade, Telfer & Tollit, 2018). In the media, blockers are referred to as a “lifesaving treatment” (Segal, 2016) and a “race against time” (Hirsch, 2015). In media appearances, some clinicians make similar points. On ABC News, Dr. Johanna Olson reported that she asks unsupportive parents: “Would you rather have a dead son or a live daughter?” (Bentley, 2011). Dr. Norman Spack states: “The minute these kids even know they’re going to get the puberty suppressants, their suicidal thoughts melt away” (Fernandez, 2015). Importantly, what is known regarding high levels of trans youth suicidality is disturbing and my own work has sought to raise awareness (see Bauer, Pyne, Hammond & Francino, 2013; Bauer, Scheim, Pyne, Travers & Hammond, 2015; Travers et al., 2012;). Thus, my purpose in highlighting crisis discourse is not to suggest that this is not a true account, but to establish the temporal repertoire at play.

From both these perspectives, for and against early treatment, puberty itself represents a fork in the road with blockers acting as a type of “switchpoint”, to use a railway analogy, through which futures diverges. On the one hand, for those who are suspicious of blockers, treatment threatens to prematurely switch youth onto a course of transitioning and thus there is grave concern to ensure a cisgender path remains open and even encouraged. On the other hand, for those in favour, blockers are needed to avert oncoming negative futures both proximal and distal. While I concur that puberty is a crucial juncture for trans youth, this debate is missing what I believe to be the most important “switchpoint” in the care of trans youth – puberty as the point at which already privileged trans youth are moved onto a track toward a better future. Without denying the reality of crisis for trans youth in need of care, other questions emerge when considering that the youth currently benefiting from these options are disproportionately white. For instance, what does the future hold for trans youth of colour and when will it be their time?

Trans Youth of Colour: If Not Now, When?

The figures that populate mainstream trans history are overwhelmingly white, with trans people of colour often conceptualized as what Syrus Ware (2017) calls “new entities” (p. 172). While this silence implies that trans people of colour have somehow lived less public lives, the opposite has often been true. In *Transgender History*, Stryker (2008/2017) writes that in the 1960s, while more privileged white trans people were furtively organizing in private in suburban homes, people who we would today call “trans youth of colour” were quite literally fighting for public space in the street during the

Compton Cafeteria Riots in San Francisco (1966) and Stonewall Riots in New York (1969). Ware (2017) suggests this erasure of knowledge about racialized trans lives reflects the threat these histories might pose to the narrative in which white LGBT communities remember themselves as having led progressive change for all.

Histories of transgender clinical encounters are similarly focused on white trans subjects, yet alternative histories can be found. In the 2011 documentary “Diagnosing Difference”, African American activist Miss Major remembers that in the early days of clinical trans services, clinicians did not care to hear about any issue not directly pertaining to gender (Ophelian, 2011). The realities of race and racism would presumably be one such issue. In this vein, scholars have recently found records of clinicians at the University of California, Los Angeles expressing skepticism or indifference to trans women of colour when they prioritized escaping racialized street harassment and violence, rather than surgery.²³ In a well-documented 1950s encounter between a young trans woman named Agnes and clinicians at this same UCLA clinic, Agnes’ femininity (which was deemed successful) was described in veiled racialized and classed terms such as “peaches and cream” complexion, “not garish”, and “like a lady” (Garfinkle, 1967/2006, p. 60). In his recent text *Black on Both Sides*, C. Riley Snorton (2017) reads records of Black trans individuals living publicly in 1950s and 1960s America, and while persistent criminalization is evident, so too are alternate ways of forging a trans life.

The present-day realities of trans people of colour have not been a priority in the field of transgender health. Despite this lack of attention, a growing number of studies

²³ Personal Communication, Chase Joynt, April 5, 2018.

offer some perspective. In Canada, the Trans PULSE project found that trans women of colour were less likely to have a family doctor (Scheim, Zong, Giblon & Bauer, 2017) and that Indigenous²⁴ trans and gender diverse people experienced high levels of poverty (47%), homelessness (34%), unmet health care needs (61%), violence due to being trans (73%), and incarceration (20%) (Scheim, Jackson, James, Dopler, Pyne & Bauer, 2013). In the same study, HIV risk was greatest in the presence of both high levels of reported racism *and* transphobia, with the same effect not found among white trans respondents suggesting “potential limits to resiliency” in the face of both racism and transphobia (Marcellin, Bauer & Scheim, 2013, p. 98). According to this study, the mutual support assumed among trans people was rendered questionable by racism: approximately 1/3 of racialized and Indigenous trans people had felt uncomfortable in trans spaces because of their race or ethnicity (Marcellin, Scheim, Bauer & Redman, 2013).

In the American context, findings from the most recent US Transgender Survey point to deep patterns of inequality. While levels of poverty were dismal for all trans people - more than twice as likely to live in poverty than the US average - for trans people of colour in specific, they were three times as likely to live in poverty. The unemployment rate for trans people of colour (20%) was four times the national average (5%). Twenty percent of Black trans people did not have health insurance, almost twice the US average of 11% (James, Brown & Wilson, 2017). Trans respondents were living with five times the national rate of HIV (1.4% compared to 0.3% HIV+), yet Black trans respondents were living with 22 times the national average (6.7% HIV+), and Black trans

²⁴ The term used in this study was “Aboriginal”, referring to First Nations, Inuit or Metis people.

women 67 times the national HIV rate (19% HIV+) (James et al., 2016). Indeed, scholars point out that patterns of exposure to HIV and violence are so extreme for trans women of colour (in specific) that extrapolating these burdens to all trans people (in general) functions to distort any potential conclusion or solution (Lamble, 2008).²⁵ In one study, trans people of colour experienced higher rates of anti-trans discrimination than white trans people within hospitals, emergency rooms, and ambulance care (Kattari, Walls, Whitfield & Langenderfer-Magruder, 2015). Indeed, such discrimination in places of urgent care raises questions about the very concept of “emergency”, as do the high rates of emergency room avoidance for fear of transphobia. In one study, 1 in 5 trans respondents did not seek emergency medical care in the past year, despite requiring it (Bauer, Scheim, Deutsch & Massarella, 2014).

For trans people of colour who are specifically youth, research finds they labour to meet unmet needs across many fronts. In a study with young ethnic-minority trans women, the majority struggled to find basics such as food and transportation (65%), safe places to sleep (46%), medical care (41%), and jobs (63%), while 1 in 5 was HIV+ (22%), over half faced sexual assault (52%), police harassment (53%), arrest (67%) and incarceration (37%) and 59% were doing sex work (Garofalo et al., 2006). A Human Rights Campaign report entitled *A Time to Act* found that of the 97 trans people who were murdered in the US between 2013 and 2017 (in cases where race was documented), young trans women of colour were profoundly over-represented with victims recorded as

²⁵ Regarding extrapolating estimates of HIV burden, personal communication with Ayden Scheim, June 20, 2018.

91% trans women, 89% people of colour, and 3/4 under age 35 (HRC, 2017). Citing these statistics is not intended to suggest that white trans women or trans people in general experience safety. Indeed, daily life can be potentially violent and dangerous for any trans person, however, young trans women of colour are worthy of specific attention.

Despite qualitative (Singh & McKleroy, 2011) and quantitative research (Bauer, Pyne, Francino & Hammond, 2013), that cites profound mental health improvements associated with medical transition (for those who desire it), in one study 12 out of 13 trans youth of colour reported receiving the message that they should “wait to grow up” before they can know who they are (Singh, 2013). In 2014, artist and activist Laverne Cox spoke of the murder of trans women in the US as an “epidemic” (Democracy NOW, 2014), and in 2015 as a “state of emergency” (ABC News, 2015). Yet since these striking statements, the number of murdered young trans women in the US has only risen, nearly doubling between 2014 and 2017 (HRC, 2017). In Ramirez, Gonzalez and Galupo’s (2018) research about the 2016 Orlando Pulse Nightclub shooting, the expected temporality of “shock” often attributed to public violence, is challenged by their finding that queer and trans people of colour found the event more of a reminder of *constant* vulnerability, rather than an abrupt shock.

Research on parental support for trans youth has not had a large focus on racialized families but where it has, results are mixed. Ryan, Huebner, Diaz and Sanchez (2009) and Ryan, Russell, Huebner, Diaz and Sanchez (2010) found that Latino LGBT youth reported more rejecting behaviours from parents and lower levels of acceptance

from parents than non-Latino white LGBT youth, yet no theoretical exploration of this finding is offered and the authors state simply that Latino and immigrant families “appear to be less accepting, on average, of LGBT adolescents” (p. 210). In contrast, Grant et al., (2011) asked over 6,000 US trans adults if their families were as strong today as they were before they came out, and findings demonstrate the opposite of assumptions about race and transphobia: White trans respondents were some of the least likely to report their families as still strong, while Black, Asian, American Indian and Latino/a scored higher.²⁶ Chang and Singh (2016) point out that the intergenerational aspects of racism affect both trans people of colour and their parents.

Clinical literature on trans youth tends toward silence regarding race and ethnicity, yet a recent study that analyzed US health care billing found significant racial disparities in access to puberty blockers. For the puberty blocking implant of histrelin acetate (commercially known as Vantas), researchers found that between the years of 2004-2016, 74% of youth recipients were “white non-Hispanic.” However, this was only the case for billing associated with a transgender-related diagnosis (gender identity disorder). When the same medication was prescribed for the more common “on-label” purpose of delaying early-onset puberty (central precocious puberty), the billing was done at a near 1:1 ratio for white youth as compared to “minority” youth (Lopez, Solomon, Boulware & Christison-Lagay, 2018). Thus, the racialized disparity was unique to trans youth. Based on economics alone, it is not difficult to draw inferences with the cost of puberty blockers

²⁶ Qualitative methods might prove promising for exploring meanings around the concept of “strong” or “supportive.”

reaching \$24,000 USD²⁷. While some aspects of trans health care began to be covered during the Obama administration, blockers for the most part did not (Kuper, 2014).

Elsewhere I have remarked on how apt the phrase “buying time” has turned out to be, as a descriptor of puberty suppression (Pyne, 2017). Yet importantly, in this study, whether clinicians practiced in privatized care with imposing costs, or in socialized health services without, their clinics served a majority of white youth, disproportionate to their own region’s demographics. Marginalized trans youth, poor and racialized youth in particular, would seem to have a temporal experience distinct from the “race against time” around which trans youth care is organized.

The Racialized Politics of Time

In *Black Skin, White Masks*, Frantz Fanon (1952/2008) writes that “Every human problem cries out to be considered on the basis of time...” (p. xvi). Indeed, time, as objective measurement and temporality, as time’s “social patterning” (Amin, 2014) have been recurring features of work by thinkers of colour, in particular Black scholars and cultural producers. James Baldwin’s fictional characters often spoke of race and time when remarking on the “American Express” life and white society’s amnesia regarding its own racist crimes: “They [white people] have the shortest memories of any people in the world” (Baldwin, 1978, p. 136). Postcolonial scholars write of the disruption of colonial time into and onto invaded territories (Nanni, 2012), and conversely the disruption that

²⁷ This is a general cost with physicians actively pursuing alternatives such as newer drug profiles, hospital philanthropy, and lobbying insurance companies and pharmaceutical companies based on compassionate grounds.

subaltern and post slavery time now poses to the faux universality of modernity's progress narrative (Bhaba, 1991).

Queer and trans of colour critique (QTCC), has pushed the study of gender and sexuality to contend with “analyses of racial capitalism and the racial state” and is also centrally concerned with time (Ferguson, 2018). Queer of colour critique got its start through the re-remembering of “home” from the perspective of queers of colour, both excluded from the protections of a national home due to racism and from the protections of their familial homes due to homophobia (Reddy, 1997). Challenging Western genealogies of Modernity, queer of colour critique returns to familiar political divides (liberalism and Marxism) to rethink the congruence of even contradictory traditions through their joint abjection of queers of colour (Ferguson, 2004).

With an analytic lens attuned to silence, queer of colour critique points to gaps between the theories of white queer publics and the incommensurate knowledges of queers of colour (Johnson & Henderson, 2005). In response to Edelman's (2004) psychoanalytic incitement to abandon the future, Muñoz (2009) argues that queers of colour cannot afford a “romance of the negative” and have no choice but to invest in better times (p. 1). Contemplating white queer theorists who opine on straight-acting dance in Black ball culture, Marlon Bailey (2011) points out the missing context of relentless violence in which Black queers must learn to switch off queer affect as a life-saving skill, rather than a normative script. In a study of Black community responses to HIV/AIDS, Cathy Cohen (1999) writes that the crisis of the AIDS epidemic, while radically altering the time perspective of white gay men and pre-figuring the literature of

“queer temporalities” (Halberstam, 2005), was experienced differently in Black communities, where the abbreviation of life and abandonment by health authorities was already a long-standing tradition.

A sense of “debilitating ongoingness” (Puar, 2011, p. 149) permeates queer of colour theory. Christina Sharpe (2016) writes of the “deeply atemporal” legacy of pain and untimely death wrought on Black peoples *in the wake* of the transatlantic slave trade (p. 5), as well as the enduring capture and punishment of Black peoples through many societal systems, far outlasting any legislative or educational programs believed to have ended such treatment. Rinaldo Walcott (2016) writes of the “unfinished business” of modernity and the “longue durée” of Black unfreedom. Troubling the idea of the past as *passed*, Sharpe and Walcott insist on theorizing the “afterlife” of racist atrocity. However, as Syrus Ware (2017) notes, it is also vital to resist viewing Black queers as merely the conquered victims of time. Thus, movements such as Black Lives Matter and Afrofuturism become important foci as direct action projects and bodies of speculative critique responding to the need to imagine a just and livable Black future (see Walcott, 2017; Womack, 2013). As Rod Ferguson writes, we must see the possibility of “pleasure and alrightness” that persists in the Black queer present (Ferguson, 2004, p. 1).

A more recent body of trans of colour critique is taking shape with theorists looking critically at the failures of mainstream trans progress agendas, both the failure to comprehend the centrality of race to anti-trans violence (Juang, 2006; Lamble, 2008) as well as to question racist and carceral logics in the uncritical quest for state recognition (Snorton & Haritaworn, 2013; Stanley & Smith, 2015). Aizura (2013), Amin (2016) and

Dutta and Roy (2014) note the colonial agenda visible in the “new frontier” of trans rights, and Ellison, Green, Richardson and Snorton (2017) critique the academic field of trans studies as a locale where Black trans experiences of precarious life are used as a springboard to other things, “presumably white things” (p. 162). Scholars question mainstream trans temporalities, including: the idea that trans people of colour are new and following in white trans footsteps (Snorton, 2017); the use of “transgender” as the modern designation for gender variance, with other concepts rendered backwards (Valentine, 2007); the progress narrative that applauds the upsurge in trans visibility despite the increase in violence against trans women of colour (Gossett, Stanley & Burton, 2017); and the false universality of transition as a temporary disruption to an otherwise assumed stable citizenship (Bhanji, 2013). Summing up the temporal problems associated with race and trans status, Syrus Ware (2017) writes: “Trans lives of colour follow a different temporality” (p. 172).

The Event, The Situation, The Temporality of Privilege

Outside of queer and trans of colour critique, sociological study also links time with social power. Bourdieu (2000) wrote of chronically poor and unemployed youth as outside of economic time with their ties to the future, their “practical relation to the forthcoming” askew (p. 223). For Bourdieu, this “plurality of times” proved the link between “power and the possible” (p. 224), and specifically that the future is “inscribed” on bodies (p. 235). On a larger scale, Bauman (2000), Breu (2012), and Zhou (2012) write of the unevenness of temporalities in the transnational scene, where life is lived at vastly different paces depending on one’s power position in the world system. The

relation between time and privilege, what I am calling the “temporality of privilege”, is also evident in challenges to the well-worn sociological theory of illness as a “biographical disruption.” Finding that cancer diagnoses among chronically poor women are more likely to be experienced as “biographical continuity” rather than “disruption” (Williams, 2000, p. 52), scholars clarify that such an event does no less damage for those who do not claim a crisis, and in fact can do more damage, absent the resources to withstand it (Sinding & Wiernikowski, 2008). Walter Benjamin (1968) wrote: “The tradition of the oppressed teaches us that the ‘state of emergency’ in which we live is not the exception but the rule” (p. 254).

Literary and cultural critic Lauren Berlant (2011) draws on Badiou’s (2013) temporal concept of the *event* in order to explore the *situation* of ongoing crisis in poor and racialized communities, arguing that since these crises are now constant, trauma is no longer the temporal register that best captures precarious life (i.e.) it’s not an event... it’s a situation. While we commonly speak of “epidemics”, “crises” and “catastrophes”, Berlant writes that this is a misrepresentation of the “duration and scale” of chronic social problems (p. 100). She proposes the term “crisis-ordinary” to better capture the temporalities of ongoingness and “living on” as the definitional feature of some people’s existence – neither states of exception nor banalities but “upsetting scenes of living” or “slow death”²⁸. Playing on the genre of the “situation comedy”, structural inequality is now, in Berlant’s words, a “situation tragedy” making the theorizing of endemic time

²⁸ In *Slow Death*, Berlant takes a position on body size that I do not endorse. I do use her theorizing on crisis and time, but as fat activist Charlotte Cooper notes, Berlant’s essay is “groaning with fatphobia” (Cooper, 2013).

rather than only epidemic time, key to understanding the present state of marginal life as both “at an extreme and in the zone of ordinariness” (p. 97).

Methods

This project involved 18 interviews with clinicians working with trans and gender diverse youth across six countries. Interviewees were professionals providing assessments for puberty blockers and/or cross sex hormones, often through their positions as child psychologists or child psychiatrists, pediatric or adolescent medicine specialists, pediatric endocrinologists or social workers. Health and mental health care funding models vary across these countries and span private for-profit systems and socialized health care; these distinctions are not the focus of this analysis. Numerous American and Canadian clinicians were interviewed, while others practiced in Western Europe, Oceania, and Southern Africa. Due to the highly specialized nature of care for gender diverse adolescents and youth, the city and country of practice, as well as the gender of clinicians will not be identified, as this could identify them as individuals.

When an absence of discussion about race and ethnicity in these interviews suggested an issue of significance, a demographic question was posed to all interviewees over email regarding the racial or ethnic make-up of the youth served by their clinics. The majority of clinicians responded (13), with some providing formal demographic data collected from patient charts (5) and others offering estimates from their own recollections or perceptions (8). In addition, due to clinicians reporting low numbers of racialized youth receiving services, ten community stakeholders were interviewed who

work with trans youth of colour or Indigenous trans youth²⁹ in connection with social service agencies or community groups. For these individuals, I use pseudonyms unless interviewees requested to have their real name used. I describe their work in general terms so as not to identify them. Participants provided consent for the recording and transcription of their interviews, as per the McMaster University Research Ethics Board.

This study is a discourse analysis of talk about puberty suppression, early gender transition and trans youth, as these are spoken about by the clinicians and community stakeholders proximal to trans youth. As a collection of research approaches investigating the role of language in the production of knowledge and meaning (Van Dijk, 1993), discourse analysis views language as constitutive of, rather than merely descriptive of, the world (see Foucault, 1972). Indeed, Graham Gibbs (2015) points out that language is sometimes not at all descriptive of the world. Discourse analysis challenges the distinction between talk and action, insisting that talk is itself a type of action (Edley, 2001). Rather than a tool for describing reality, language is a tool for doing reality (Gibbs, 2015). Though defined in various ways, I use Carabine's definition (drawing from Foucault) of discourse as a group of statements that "cohere" to make meaning and have political effects (Carabine, 2001, p. 268). Given that discourses become available in the context of historical power relations (Wetherell, 1998), they are intimately tied to power with some enjoying more credibility than others (Edley, 2001). Discourse analysis works to "unfreeze" (Bloor & Bloor, 2007) discourses and expose them as contingent, specific

²⁹ As Lee (2018) points out, Indigenous trans youth have distinct histories with colonialism and are not necessarily served well by the term "person of colour". I attempt to separate these issues where possible and a separate analysis is being prepared specific to Indigenous trans youth.

to time and place. Sterne (1999) suggests the goal is not only to understand what a discourse means, but how it organizes the very possibility for meaning (p. 262).

A study of puberty suppression and early transition for trans youth could take many foci, however, this analysis begins from the assumption that the discourses pertaining to this technology are as significant as the technology itself. GnRH agonist treatment existed for more than a decade before it was used with trans youth. Once initiated in the Netherlands, it was another 16 years before offered in the US, and later still in the UK despite the proximal location to the Netherlands. Follow-up data on the safety of blockers has been important, yet this treatment was offered by some before data was available and continued to *not* be offered by others afterwards. Puberty suppression technology exists in jurisdictions where it is not offered or offered sparingly. Similarly, the technology exists to provide cross-sex hormones directly at puberty, thus cutting-out the middle stage of blockers and better mimicking the pubertal arc of other youth, yet this is not done. Hence, this is not a simple story of scientific progress and the technology itself is only one element in the scene. This study focuses on the discourses that bring that technology into use, determine its eligible and ineligible candidates, justify speeding or slowing access, and define its successes and failures. Garner (2014) reminds us that with the ability to materialize bodies in specific forms, medical discourse is itself a technology.

From the existing strands of discourse analysis, this study is organized around the concept of “interpretive repertoires”, first proposed by sociologists Nigel Gilbert and Mike Mulkay (1984) in their study of scientific explanation. Gilbert and Mulkay (1984) found that scientists spoke in multiple and at times inconsistent registers when explaining

scientific activities. Analyzing participant speech, Gilbert and Mulkay (1984) found that scientists drew from varied “interpretive repertoires” as they spoke (self-contained discursive systems), and proposed variation as the norm for all discourse. While some researchers argue that discourse analysis is appropriate only for written text (Cruikshank, 2012), in the case of an interpretive repertoire analysis, the spontaneous discourse circulating in interview settings makes variation more apparent and the opportunity to observe inconsistency in real time can surface unique perspectives (Potter & Mulkay, 1985). Detailed analysis instructions are scant, however proposed steps include: identifying variation within and across participant discourses; connecting discourses to their social histories (Talja, 1999); and searching for patterns in the function of discourses (Wetherell & Potter, 1988). Lastly, as my theoretical framework centres temporality and the question of how puberty suppression and early transition becomes “thinkable”, this analysis looks specifically for temporal discourses as related to trans youth in the gender clinic.

Results

The majority of young people currently seen by clinicians in youth gender clinics are white. This is so for clinicians interviewed in this study and perhaps others as well. While there are various ways to understand this phenomenon,³⁰ here I explore the temporal dimensions of this disparity that are racialized through the interpretive repertoires of the *event* and the *situation*.

³⁰ Although stakeholders in this study discuss trans youth of colour who seek medical transition, it is also possible that these technologies appeal more in a Western context (Roen, 2001; Dutta & Roy, 2014). For a discussion of the connections between bodily plasticity and Whiteness, see Schuller (2017).

Clinicians in this project identified their patient-base as majority-white either during their interview, or after the fact in answer to a specific demographic question posed to them. Indeed 100% of those who responded stated that their patient-base was majority white. Some clinics had not formally collected data of this kind, however based on their own perceptions, clinicians offered their best general estimate of what percentage of their patient base would be described as white. Across a number of clinics, the perceptions were: 75% white; 80% white; 80% white; 90% white; and between 90-95% white. Some clinicians were only able to state generally that “whites are overrepresented” in their clinic or that “the majority of kids we see are Caucasian”.³¹ In the clinics where formal data was collected, clinicians were able to share statistics about which they could be more certain, such as: 60% white; 85% white; 91% white; 92% white; and 98% white. One clinic³² reported that for younger youth ages 12 and under, 70% were white, and for older youth ages 13 and over, 56% were white. While this latter statistic of 56% may seem more reasonable, it is notable that this clinic is in a large diverse urban centre in which white residents make up only 29% of the population. Similarly, the clinic with 60% white patients is located outside of Europe and North America in a city in which white residents comprise only 16% of the population. Even the clinic with 75% white patients is located in a highly diverse city in which only 33% of the population did not identify as a visible minority.³³ Thus, even the clinics with a relatively lower white majority (56%,

³¹ One clinic’s data was omitted because they could confirm only Indigenous (24%) versus non-Indigenous patients (76%) and it was not specified how many of the non-Indigenous patients were white.

³² This clinic had race/ethnicity data documented for only half of their patients.

³³ Population statistics are based on most recent census reports from each city, not named to preserve anonymity.

60% or 75%), still confirm a racial disparity that is highly pronounced when placed in their regional context.

Admittedly some of the above figures are only clinician's estimates and therefore subject to error, yet the consistency remains striking given that the overrepresentation of white trans youth is reported from clinics spanning across those with formal data and those without, across cities with populations as low as 700,000 and as high as 12 million, and across six countries and four continents.³⁴ Given this disparity, the nature of clinician's interview talk or non-talk about race was significant. For the most part, clinicians rarely brought up the topic of race unprompted. For this reason, instances when this did occur were of great interest, and in fact often followed a pattern of displacing transphobia onto racialized people. Within interviews in which clinicians broached the topic of race themselves, it tended to be when they described the type of families that are unsupportive of trans youth. One clinician characterized transphobic parents as follows: "They're often of an ethnic background. Anybody who's deeply Christian or deeply Muslim... or Muslim at all." This clinician went on to state the centrality of religion in these matters and while the term "deeply Christian" would seem to identify Christian fundamentalism specifically, all Muslim families are singled out with the phrase "Muslim at all." Ultimately, unsupportive parents were summarizable by one clinician as "ethnic" or "from backgrounds where being trans doesn't fly." In one instance it was said that: "The Asians aren't allowed to be trans."

³⁴ Clinicians from one clinic did not provide demographic data or estimates.

In another interview, a clinician spoke about the general state of societal transphobia:

Every time I start to feel comfortable that there is this change taking place [improvement in transphobia], I see examples where it just isn't. And if we look at some of the religious faiths, Muslims and others, they're just never going to accept trans people or homosexuals... gay marriage. It's just not going to happen in those communities.

Here this clinician also assigns the social problem of transphobia to Muslim people, assigning them into a stagnant pre-modern state in which progress is “not going to happen.” This clinician went on to say, when referencing what they deemed the transphobia of Muslim communities: “And some of those are very prolific in that they breed [clinician laughter]. They have a lot of kids.” Here, well-worn eugenic images about the animality of non-white bodies are summoned with the phrase “they breed.” Given this clinic location in a majority-white non-Muslim country, ideologies of invasion, immigration and the clash of civilizations (Huntington, 1997) might be conjured through the image of an expanding Muslim population “they have a lot of kids.” While Muslim people do not constitute a “race”, Considine (2017) notes that they are racialized regardless with racial meaning extended to Islamic social and religious practices. Edward Said (1985) was one of the first to use the term “Islamophobia” to signal a demonizing form of racial hatred and superiority. As Poynting and Mason (2007) remark the construction of the Muslim “Other” as a “folk devil” in western societies is a crucial feature of our time (p. 63).

Though one might be tempted to view the above expressions of racism as contradictory to a discussion on trans rights, scholars of race and sexuality clarify that

these power relations are in fact central to contemporary Western queer and trans movements. Jasbir Puar (2007) writes that the tenuous inclusion of queer subjects within the nation depends on the production of Orientalized others who are marked for detention, deportation, death – at times with the participation of queer subjects. Jin Haritaworn (2015) exposes the queer or trans subject in Europe as worthy of state care only in relation to the newly appeared figure of the “homophobic migrant” - the recipient of policies and acts of racial hatred that queer and trans people are complicit in when conducted in our names. Roderick Ferguson (2018) writes that violence against queers is often conveniently identified as a threat from outside the nation, rather than within. These authors write of the special place the Muslim Other plays in these moral dramas.

Expressions of racism and Islamophobia in the interview excerpts above were not necessarily typical of the clinicians who work with trans youth. Indeed, those statements were rare and significant not for their commonality but for their punctuation of the otherwise prevailing silence about race. Yet silence about race should also be of no comfort. In his foundational text *Aberrations in Black: Toward a Queer of Colour Critique* (2004) Roderick Ferguson’s turns to Althusser to theorize the void at the intersection of race, gender and sexuality. In that silence, suggests Ferguson, “an ideology has gathered” (p. 5). In the absence of talk about trans youth of colour in these interviews, an ideology can also be glimpsed regarding the whiteness of the clinic space.³⁵ When the topic of race was prompted in interviews, it was primarily racialized clinicians who responded: “Oh I love this topic... I can talk for half-an-hour on this.” Notably, these

³⁵ And by extension, the whiteness of the interview space as well, which I am implicated in myself.

racialized clinicians rejected claims regarding families of colour being more transphobic, and indeed, suggested that this idea can contribute to the whiteness of the clinic by alienating families of colour and dissuading them from attending. One clinician referenced life patterns common in some cultures, such as living with one's parents or extended family into adulthood, and pointed out how such practices are misinterpreted by clinicians tasked with evaluating "maturity": "So, how would the client feel, so I need to buy into the white model, to lead the white lifestyle, to declare the white independence, so that I can be in my doctor's mind – my white doctor's mind - I can truly deserve this treatment?" The insights of racialized clinicians led me to interview a number of community service providers working closely with trans youth of colour to further shed light on issues of race in the clinic. Together, these interviews highlight two distinct discursive temporalities (interpretive repertoires), the focus of the remainder of this analysis.

"Urgent and Emergent": The Event

As noted, among those who advocate for puberty suppression and treatment for trans youth, the temporality of the discourse at hand is one of crisis-time. One clinician spoke of pubertal age youth who meet the criteria for blockers, stating: "... it becomes urgent and sometimes emergent for us to follow that pathway." In medicine the term "emergent" refers to a level of emergency beyond urgent care, indicating potential loss of life if untreated. Discussing trans youth whose bodies are on the cusp of puberty, the clinician stated: [Colleague] and I work in such a way as to consider that an emergency,

and to try and intervene through puberty blockage as quickly as possible.” Another clinician described assuring youth they would be seen within one day if puberty begins:

What I've said to her parents and all the other parents is ‘We don't know when your child might enter puberty, but I know that they're distressed about that so here's a blood form to take home with you. If the child notices changes in between appointments and they're really distressed, feel free to go to your local pathology place and get the results and if there's any rise, we'll book an appointment in 24 hours and see you and examine you’... I'm just trying to allay their anxiety about ‘If I'm going to puberty, what happens if I can't get in to see you?’ So I always say ‘I'll see you within 24 hours.

Another clinician stated that once they have known youth long enough to establish appropriateness, it is important to “green light” the treatment after a “quick assessment” because: “sometimes this kid can be damaged by me delaying the intervention.” To be clear, these are certainly compassionate responses to youth who are, or potentially will be, in pain. The question that emerges is in regard to whose pain is in view.

In recounting the story of one family who had attended their clinic, a clinician recalled a father (with a well-paid job) demanding to know why his child could not start puberty blockers immediately, and why he had to wait, according to clinic protocol: “[...] he was just like adamant and angry that there should be any delay. He made the comment, yeah, he made the comment ‘why should we have to experience and observe our child’s suffering with this dysphoria, just to satisfy a protocol?’” This clinician recalled that the boy’s family “couldn’t bear to see him in such distress”, “isolated, left behind if you will” and that the father didn’t “see any need for that” since this youth deserved to “keep pace with his biological peers.” Though this clinician did express some difficulty with this pressure, they felt the youth’s diagnosis was certain, and in the end conceded and approved the youth for blockers more quickly than the protocol called

for: “[...] we did kind of, um, short circuit the number of sessions until he got on to Lupron.” At the next appointment, the family brought a small food item to share and the clinician joked that more was likely on the way when this youth sought to begin cross-sex hormones: “That was nice of them [laughter]. So I expect there are going to be [small gift] again pretty soon, looking for testosterone [laughter].”³⁶ This clinician described the family’s position as follows: “Just because the protocol says 16, why do we have to wait until 16?” While information about the race or ethnicity of this family was not collected, the ability to express anger toward an authority figure, to refer to an institutional policy as “something you “see no need for”, as well as to navigate the norms of professional settings with subtle gestures of gift giving, are all elements of entitlement and privilege. The point is not that youth *should* be delayed, as the risk in denying access to care has been documented (WPATH, 2011). Yet the ability to have one’s needs attended to urgently as an *event*, remains associated with a temporality of privilege unavailable to others who may live in an alternate temporal *situation*.

Perhaps the most pronounced expression of the crisis-time repertoire, is what seems to be a recent strategy for managing long wait times by triaging young trans patients. One clinician stated: “...we’ve actually had to develop a very specialized triage system where we have had to use the child’s age, use how long they have been on the waiting list and then use any special considerations like if they are just starting puberty...” Here the clinician is reporting that wait times are being managed by prioritizing pubertal

³⁶ This food item was a small gesture of thanks and the clinician is not suggesting anything as serious as bribery.

age youth in order to provide blockers during the key time window. This clinician goes on to say: “[...] we really want to cater to the needs of youth who are close to needing, for instance, puberty suppressing hormones, because we know that the risk of developing secondary sex characteristics is often permanent.” Other sources indicate that triage practices are also used elsewhere. A news article about a Canadian clinic states: “With a wait list of up to three years, Raiche says physicians have no choice but to triage patients. Those who haven't started puberty yet are given top priority” (Lee, 2017). In addition, a recent scientific paper from an Australian clinic also describes the development of a triage pathway system for managing wait times: “This system enables those patients who will benefit most from puberty-blocking treatment to be fast tracked...” (Eade, Telfer & Tollit, 2018). Further, a European community stakeholder remarked in an interview that she too was recommending her local clinic take up triage practices. While efforts to serve trans youth in a timely way are to be commended, there are notable consequences to which needs are prioritized.

“That’s Something for Someone Else”: The Ongoing Situation

In contrast to the crisis-time of the event, a second temporal repertoire emerged in interviews with both clinicians and stakeholders, specifically pertaining to trans youth of colour: the chronic ongoing situation. In interviews with clinicians who were themselves racialized, they gestured to an alternate temporality for trans youth of colour and their families in which simultaneous urgent needs compete for finite time, energy and resources, thus affecting whether a gender clinic would even be contemplated:

There are a lot of immigrant families, or families that are not necessarily immigrant, but from other cultural backgrounds, who are struggling with

some of the day-to-day reality of just being in [Western Country]. So, this is not, this is not the primary issue in their minds. It's like finding access to make sure they get to a local healthcare center to get their vaccines for their kids, because they don't really know where they're supposed to go for that.

In contrast to the previously mentioned father who strongly advocated for his son to access treatment ahead of the protocol, the clinician above described the situation of immigrant parents with respect to advocating for their child: “They're not empowered at all to be able to do that. They're already sort of displaced members of society, and they don't fit in regardless of the trans nature of their child or not.”

Additionally, key stakeholders who were interviewed about trans youth of colour, also echoed the temporal discourse of ongoing struggle. Kian, a trans community support worker who works with young trans newcomers, commented on the lives of immigrant parents of trans youth:

And one of the main things is that particularly for youth who are in that position, when you come to a new country you're so busy trying to survive and in many ways survival becomes your first priority. And that as parents you don't really sit down and have that conversation with your child. You really don't have time for it. You're working most of the time. Like both parents are working or both guardians are working and they're trying to survive.

The scenarios described above seem to reflect a very different process of “triage” for these families as they labour to allocate scant resources, both material and psychic, with “survival” as “the most primary issue.” Laverne, a community worker who is herself a young Black trans woman, recalled a discussion with her mother after her early adult transition:

I think what I've noticed even going to the [local support group for parents of trans youth] is that a lot of the parents are white and they usually have money. You can't help but notice that. I was actually talking to my mom

about it and I was like, ‘What would you have done if I had come out when I was a lot younger, a child?’ She’s like, ‘I don’t know. I probably would not have acknowledged it.’ Because she’s saying she was first of all, you know, she was a single mother. She didn’t have that much money. She was working all these jobs and it would have been too much for her to deal with.

Laverne later elaborated on this temporal register of triaging what one can “deal with”:

I was saying earlier if you are a Black single parent and you have a trans child, that’s one more thing you don’t want to have to think about. You don’t want to think about, ‘Oh, well, do I have to find you a therapist? Can I afford it if you want hormone blockers?’ When I was talking to my mom, she said ‘I would not have been able to handle that. I was barely surviving. I was barely able to feed you and feed myself and pay rent. It would have been too much for me to even think about.’

One racialized clinician commented on how the place of immigrant or racialized families in society affects how they respond to their child coming out: “they’re just sort of like, on the fringes, and it’s like, “Well, now here’s one more thing that makes this even fringier.”

When stakeholders described the lives of racialized trans youth and their parents, they peppered their interviews with phrases like: “barely surviving”; “one more thing”; “ongoing issues”, “another worry”; “too much”. Laverne stated: “I think a lot of them [trans youth of colour] are focused on just surviving work, quite a few of them are sex workers, and they are just focusing on getting work and clients and stuff like that. Yes, survival, money.”

Many of these stakeholders were racialized young trans adults themselves and spoke of gender transition in a temporal register noticeable for its non-linear and drawn-out pace, citing the need for some youth to stop and start for reasons of waning support or finances. Jackson, who works with Black trans youth, stated:

Because so many youths start their transition and have to stop. So it's scary for them to start, saying, you know, changing their preferred pronouns and – and then having to go back and be like well no and it's almost like three steps forward and two back and it's just constant ongoing...a lot of the youth there, they might have money or a job and be able to pay for stuff and then they lose their job and then they don't have the money to pay for whatever it is they were paying for or however it is they were getting it. Whether it be through a doctor or not. The access has been cut off.

One racialized clinician suggested trans youth of colour must strategize to ensure their basic needs are not threatened before they attempt transition: “they calculate it very, very carefully.” Several stakeholders suggested that as a result, trans youth of colour initiate transition later. Laverne suggested that safety concerns hold youth back and Kian suggested that worries about unsupportive employers has the same effect. When asked about Indigenous trans youth, one clinician was uncertain if these youth present to the clinic later, but did find that their transitions took longer due to lack of life stability: “I think, if there is one trend with youth who are, as you mentioned, sort of, disadvantaged for any reason, I don't know so much if they present later, but perhaps, their transition maybe takes longer in that they initially connect with resources and, sort of, jump around, or maybe they also fall away for a little bit of time and then they reconnect.”

Speaking about this non-linear transition path for many Indigenous trans youth, another clinician illustrated how the reality of their unstable lives runs counter to eligibility criteria:

The follow-up becomes prolonged or they follow up for a period of time and then there is an absence, a few missed appointments, and then there might be a re-emergence and typically this is when a social worker is changed or they are at a different group home setting or something else – they've been removed from their home, when it wasn't supported but now they are in care and it [transition treatment] is supported, or there is active drugs or alcohol issues or other things like that that are going on. So they are typically, the involvement in follow-up is a lot more sporadic and unfortunately then that starts to bias us around stability,

around – stability of psychosocial supports which is one of the WPATH criteria [criteria for approval].

This particular clinician was aware of and articulate about the intergenerational trauma that underpins Indigenous youth instability. Indeed, they mentioned one Indigenous trans youth who missed a clinic appointment because he was stabbed. Yet they also note the requirement that youth be “stable” as per the WPATH (2011) criteria that “the adolescent’s situation and functioning are stable enough to start treatment” (p. 25). Thus, the concern is that clinical criteria may be modeled on a privileged temporal norm that assumes stability as the bookends on either side of transition – criteria that many racialized and Indigenous trans youth may fail to meet.

When speaking specifically about Black trans youth, community worker Jackson suggests that the power dynamics between clinicians and youth can deter Black trans youth from seeking clinical help if this mirrors power dynamics between youth and other white authority figures, such as teachers, social workers, welfare case managers and food bank staff, or doctors, landlords, police and parole officers. Jackson says: “But everywhere, everywhere they go they're having to ask some white person for permission, for money, for food, for where to live.” Jackson maintains that Black trans youth in particular might not seek early help due to a learned and legitimate distrust of white authority, underscored by their relationship to the ultimate white authority: Police. Jackson shared that young Black trans women who are visibly trans are subject to ongoing police harassment: “...especially if you're expressing yourself in a feminine way and you're looking to the cops like a male, there's a reason to target you even more.” In

fact, Jackson stated that many Black trans youth expect they will eventually be incarcerated:

I think the incarceration piece is because the majority of black youth that's – that's end game for them and you know, as soon as they get stopped on the street or arrested or charged or anything, even spoken to, all their ID and all, everything is written down, they're now known to the police. So it's not going to go well in their mind. Like this can't turn out good and ultimately, I will be incarcerated for something.

As Walcott (2016) and Sharpe (2017) write with respect to the expectation of early death in Black communities, the expectation of early *social* and *legal* death (incarceration) contrasts starkly with the modern “it gets better” progress narrative often applied to white queer and trans futures.

While some clinicians assumed racialized parents are unsupportive of trans youth, this was challenged by others. Laverne and Kian found many families of colour are overwhelmed by the struggle for economic survival. However, a racialized clinician who works with Chinese families shared that even families with financial means may resent having to subject themselves to racialized power dynamics: “...the White doctor already has the authority on high, telling you once again, I have more authority than you. Telling you this is true. Just take it. Live it. And so, it’s just like ‘déjà vu’ again, the whole culture cracking down on me again now.”

In contrast to the assumption that racialized families are unsupportive, Kian, a community worker who works with a range of trans youth including newcomers, had met with many supportive immigrant parents and referred them and their child to their local gender clinic. Kian described what they later heard from these families: “But for some reason when they go there, they don't go back...[...]...I had referred them there because I

figured that would be appropriate and to get them access to health care and what they needed. So, yeah, and then when I followed up they say they haven't gone back. It just wasn't for them.” When I inquired into how often trans youth of colour had returned and reported the clinic “wasn’t for them”, Kian replied: “Oh, I mean, all of them I know are people of color. Probably I will say at least maybe 10 or 15, as far as I remember...”

Kian acknowledged he did not know what each family meant by it not being “for them”, though there are two immediate obvious meanings. On the one hand, this can be a polite way of declining something that one does not want: “It’s not for me.” On the other hand, this can also be a literal statement of fact about who something is and is not perceived to be *for*: “It’s not for me.” The first meaning is plausible and some youth do decide that transition is not for them. The second meaning is also plausible, and it is this meaning that matches how Jackson described young Black trans women’s relationship to the transition options that are out of reach for them, specifically gender confirmation surgery:

It's not an option sometimes. It's just thought of as that's something for someone else who has the money and the time and the privilege and the everything else. That's not something that in reality, as a youth, I'm thinking that I can do. Black queer youth so it's like one thing at a time and talk about that if we get there instead of dreaming about it.

Importantly, the trans women that Jackson is speaking about, who desire surgery but doubt it will ever be part of their future, happen to live in a region where the cost of these surgeries is covered by government health insurance. Yet the list of barriers Jackson recites includes not only “money”, but also “time”, “privilege”, and “everything else.”

Jackson elaborates:

It's like – it's like dreaming of winning the lottery. It's just like a dream. It's like oh that would be nice. But they don't waste time worrying about it because no it's not

going to happen...who's going to look after me while I'm healing? Who's going to pay my rent? Who's going to go to school for me or work for me while I lay around trying to heal?

While trans communities in this particular region celebrated public coverage of such surgeries more than a decade ago, the membership of these youth within that “public” is uncertain. As Bourdieu (2000) wrote, there remains a crucial link between “power and the possible” (p. 224).

Though the temporal repertoire of ongoingness characterized much of the interviews with community stakeholders, they did speak of crisis-time in moments.

Jackson explained that the young Black trans women they work with also feel the crisis of looming body changes:

So, there's a lot of anxiety...You find that the youth are doing things that they might not otherwise do. But, for them, it's a moment of desperation and if it works, then it works, right?... they become more vulnerable, the less access they have... they want to avoid that the – going past that line of facial hair and stuff like that. They don't want to reach that point. They want to start before that because it's just that much more work, right? Like who wants to be harassed just walking down the street?

According to Jackson, these youth also “race against time” to prevent pubertal changes, yet lack options. In this context, Jackson explains that some youth will share hormones:

... a lot of the young people are sharing their medications because they don't have access to medications. A lot of youth will go online to get drugs for either blockers or hormones and if they can't get it then their friend will share with them, knowing how much of a struggle it can be.

It is noteworthy here that the trans youth of colour in question help and support one another because, as Jackson says, they know “how much of a struggle it can be.”

According to stakeholders, these practices of mutual care are common, including in some cases, labour that could be paid social service work in another context. Laverne shared

that she accompanies other racialized trans youth in an unpaid capacity to support them during housing meetings and other appointments, however, the most common appointment they ask for support during are doctor's appointments: "I also do a lot of, I guess, community support. I reach out to people in the community. I meet with them. I go to the doctor with them, that kind of stuff, if they need support in that way... because that can be scary."

This willingness and ability to support one another is a necessary strategy for survival, but also holds an important lesson for clinicians. With fewer options for trans youth of colour to access care, if barriers are erected in clinics, if care is "scary", it creates multiple risks, including street harassment, humiliation or violence, but also the risk that youth will find that their best option for preventing these other risks, is unmonitored prescription use. While the intention of strict clinical protocols is to maximize health and safety, this does not seem to be the effect.

The Temporality of Privilege and the Trouble with Triage

In interviews with affirming clinicians, media coverage and in the clinical literature that advocates for puberty suppression, the common temporal repertoire for speaking about trans youth is that of crisis-time. Within the temporality of crisis-time, the pursuit of blockers is a "race against time" to intervene before endogenous puberty takes youth off course, altering their physiology in ways that could both increase their risk of suicide or self-harm in the short-term, as well as put them in harm's way in the long term through the development of secondary sex characteristics that make them more visible as trans people, and potentially more vulnerable to discrimination, harassment and violence.

As a discourse, this repertoire functions to communicate what might otherwise be a non-apparent rationale for making treatment decisions at a young age, to establish the medical necessity for intervention; and to override the default logic of “wait and see”. The temporal repertoire of crisis-time tends to be drawn on when trans youth in general are spoken of, without reference to race. Notably, in this repertoire, the low numbers of trans youth of colour being supported in gender clinics is understood as a failure of communities of colour to make progress on trans issues in their cultural/religious contexts and therefore a failure to make early intervention possible for their youth.

In contrast, another temporal repertoire of puberty suppression emerges primarily when community experts and racialized clinicians speak specifically about trans youth of colour. In this second temporality, ongoing crises in the lives of trans youth of colour and their families keep them focused on survival. Police harassment, poverty, precarious housing, and intergenerational trauma, keep stability out of reach for many Black and Indigenous trans youth. This repertoire of ongoingness functions to widen the analytic lens to convey both the magnitude and paradoxically the ordinariness of the obstacles facing racialized trans youth and their families. In addition, the figure of the “unaccepting” racialized or Indigenous parent can be reframed in the context of an unequal societal structure rather than an unequal culture. Given that this temporal register is drawn on only when speaking about trans youth of colour, it must be asked whether individuals speaking about trans youth in general are really speaking about white middle-class trans youth.

As Gilbert and Mulkay (1984) note, drawing on multiple, varied and even contradictory discourses is the norm in speech. Yet this particular pattern of variation is concerning. With some exceptions, it was racialized community stakeholders and a small number of racialized clinicians who made sense of the lives of trans youth of colour through the temporal repertoire of ongoing struggle or crisis-ordinary. With some exceptions, it was primarily white clinicians who spoke of trans youth in general through the repertoire of crisis-time, and who interpreted the absence of trans youth of colour from the clinic as a failure of communities and families of colour to evolve and make progress on trans issues. A small number of non-racialized clinicians, when presented with thoughts on ongoing crisis for trans youth of colour, agreed with this analysis and shared their views about what Indigenous trans youth in particular face. They acknowledged that many Indigenous youth cannot access blockers and may take a much longer period of time to transition due to multiple life crises, but in this acknowledgement, the primary problem with the temporal repertoire of crisis-time is evident: In order for a crisis to be recognized as such, there is a requirement that stability precede it. This is true in the discursive sense, as Berlant (2011) points out, the term “crisis” literally means an interruption to a norm that was presumably not already a crisis. But this is also true with respect to the policies and procedures of trans youth care, such as the WPATH Standards of Care document that recommends trans youth be stable prior to treatment - a policy supported by many clinicians. As community stakeholders reiterated, stability is precisely what many Indigenous and racialized trans youth lack.

In contrast with other forms of discourse, clinician’s discourse holds unique sway – namely the power to interpret presentations of (in)stability and to approve (or not) a treatment named by clinician’s themselves as a “lifetime advantage” (De Vries et al., 2011, p. 2277). Clinician discourse also has the power to divert resources toward or away from patients based on interpretations of need, as exemplified by the new triage practices described by some clinics. Research is currently unable to provide a satisfactory answer to the question of whether trans youth of colour present to clinics at a later age than white trans youth. Trans health surveys tend to be conducted with participants over the age of 16 (Bauer et al., 2013) or 18 (James et al., 2016), and the clinicians I spoke with generally do not collect this data. However, the one clinic that did have this data reported that among their patients ages 12 and under, 70% were white. Yet for older youth ages 13 and over, only 56% were white. Another clinician who practices in a privatized system where health care is an out-of-pocket cost, stated: “I think proportionally, who gets puberty suppression is probably disproportionately white.” Whether trans youth of colour cannot afford the private cost of blockers, whether they present at a later age, or whether their transition is prolonged by ongoing crises, the clinics do appear stratified by race and age. White youth appear better able to access care during the time when blockers are most useful, already an advantage, and the described triage practices for younger youth offer the additional advantage of being fast-tracked past a long wait list. It is troubling that gender clinics seem to be unintentionally and unconsciously practicing a form of triage in which the needs of white trans youth are prioritized.

The consequences of this inequity are far-reaching. One clinician acknowledged the gravity: "...this is something that keeps me awake at night..." Indeed, this clinician described treating so many white middle-class youth that they projected a future in which trans women of colour could be the *only* visible trans people: "I have this horror nightmare of, like in 20 years the only identifiably trans people are going to be trans women of color because they are going to be the only women who didn't have the opportunity to get blocked. And then what is that story going to look like?" The clinician clarified that due to differences in hormone uptake, trans men are often able to blend in and select who they disclose to, no matter the age at which they begin transition, but that this is not so for trans women for whom pubertal changes pose significant barriers for them later in life. In this clinician's practice, more privileged trans girls are increasingly able to get blockers to achieve less visibility: "There shouldn't ever be anything wrong with being identifiably trans, and yet there is something wrong with being identifiably trans, especially for trans women, it puts them at such high risk." While there are many non-binary people who live with visibility and may choose it willingly, the risk remains high for transfeminine people. Though trans men and trans women exist in largely equal numbers, of the trans people murdered between 2013-2017 in the US, 91% were trans women and 89% were of colour (HRC, 2017). Bourdieu's (2000) observation about the future being "inscribed on bodies" seems disturbingly apt (p. 235).

At this point, one could simply lament that trans youth of colour are not being better served and hope for improvement. When queried about this disparity, clinicians did note the unfortunate nature of the problem. Yet more than one clinician characterized

the problem as a “biased sample.” One clinician stated: “I think we are still seeing that select sample though, right? Like, who’s able to get it together to get here? Who’s able to, have enough support at some level to make it, to see me, to see the endocrinologist...it is a biased sample.” This is an important insight regarding the forms of race (and other) privileges that can determine access to the clinic. Yet the term “biased sample” derives from a research context and is insufficient for describing a bias in access to a vital service which bears out on real lives and real life-chances. Another clinician, after acknowledging that marginalized youth have multiple barriers that inhibit their passage to and through the clinic, spoke in defense of the clinic’s priorities, stating: “We’re also not a crisis clinic either, right?” However, “not a crisis clinic” is an interesting choice of words, given that youth gender clinics are indeed organized to respond to (and triage) the crisis of gender dysphoria and unwanted pubertal development for some youth, an interruption in an otherwise stable life, a temporality of privilege.

I have outlined some reasons why the racial disparity in access to puberty blockers requires a response that surpasses hand-wringing. Additionally, violence is specifically noted by some clinicians as that which might be avoided through timely access to blockers and early transition technologies. Cohen-Kettenis, Delmarre-van de Waal and Gooren (2008) write: “If the adolescents would make a social gender change without receiving hormone treatment, they may fail to be perceived by others as a member of the desired sex and be easy targets for harassment or violence” (p. 1894). The current revision of the internationally influential “Standards of Care” document (WPATH, 2011) has a section entitled “Risks of Withholding Medical Treatment for Adolescents” which

states: “Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization.” (p. 21). Italian bioethicist Simona Giordano (2008) writes a passionate case for access to blockers that includes a discussion of the violent murder of a Brazilian transfeminine sex worker in Italy, Adrian Torres de Assuncao. Giordano writes that if trans youth have access to blockers and treatment at a young age, they might be spared these tragic circumstances. The above are well-intentioned attempts at advocating for trans youth, yet a problem lingers in their articulation.

White trans women and others in the trans community may face profound dangers and this analysis is not intended to deny this situation. However, the primary victims of murder remain trans women of colour. This fact is well-documented in the United States (HRC, 2017). Canada has seen fewer murders than the US, however many targets have been working class trans sex workers (Verman, 2018), and three Toronto murders or suspicious deaths of trans women of colour (Cassandra Do, 2003; Sumaya Dalmar, 2015; Alloura Wells, 2017), were understood by the community to follow this pattern (CBC News, 2018). Globally, many countries do not effectively document violence against trans people, however, according to Transgender Europe, the highest number of murders are in the Global South and even of those committed in Europe, 1/3 of victims in 2017 were migrants (Transgender Europe, 2017). Thus, in the case of Giordano’s plea for access to blockers, to use Adrian Torres de Assuncao as an example, skims over the fact of her status as a migrant sex worker from the global South, a major factor as we learn from the writing of other migrant trans women (Tourki, 2017). In this context, what does

it mean to cite the deaths of migrant trans women of colour who are sex workers, in order to build support for a clinical program that, for the most part, does not benefit them? What does it mean to use trans of colour, migrant, and sex worker death in service of the betterment of white middle class trans youth? What does it mean to lobby for white middle class trans youth to avoid a fate they would likely have avoided anyway, while leaving those who do meet that fate to face it without the resources of a service devoted to this purpose?

In an essay entitled “Trans Necropolitics”, C. Riley Snorton and Jin Haritaworn draw on Achille Mbembe’s concept of “necropolitics” to explore how the deaths of trans women of colour become “resources” for primarily white trans community improvement projects. Arguing against the grain of a mainstream trans rights agenda, Snorton and Haritaworn (2013) write that in their deaths, trans people of colour become the “raw material” for more privileged white trans agendas. In the classic example, advocates cite trans of colour murder statistics in support of fundraising efforts for community projects that in practice often function to exclude those individuals, or worse, for agendas that specifically bring people of colour into contact with the criminal justice system, such as stiffer sentences Bills and hate crimes legislation. Lamble (2008) and Juang (2006) both point to trans community practices of retrospective remembrance (such as Trans Day of Remembrance events) which render the deaths of trans women of colour as examples of *only* transphobia, against much evidence that these deaths are motivated and made

possible by racism, misogyny, transmisogyny, poverty, sex worker stigma and more.³⁷

Moreover, beyond obscuring the causes of these tragic events, as well as obscuring how white people are implicated in them, a dangerously incomplete memory is then used by trans communities and advocates to lobby for gains that will often not benefit the people who lived through, or died from, these social structures, processes, and events.

This reality points to the most important aspect of Snorton and Haritaworn's use of a necropolitical theoretical frame, through which they signal the special place of some deaths in the production of other lives. Trans of colour death, according to Snorton and Haritaworn (2013), is not ignored or marginalized by white trans communities, and quite the reverse, it is highlighted, and drawn upon to "vitalize" and give life to primarily white trans priorities and agendas. Puar asks: "Which bodies are made to pay for progress?" (2011, p. 153). In this sense, the disparities highlighted in this analysis make clear that the current organization of, and advocacy for, early treatment for trans youth, is not only lagging behind in its support for trans youth of colour, but in place to fail them and to unintentionally benefit from such failures.

It could be said that all trans children were once figures of death due to their representation as being in need of repair to avoid the bad futures of unemployment, violence, suicide, etc. (Rekers & Varni, 1977). Yet young trans people are now arguably symbols of life with the proliferation of their "inspirational" media images – images overwhelmingly white and middle class. To take Snorton and Haritaworn seriously, is to

³⁷ Transsexual artist and sex work activist Mirah Soleil-Ross argued for years against Trans Day of Remembrance due to the use of violence against sex workers to generate support for middle to upper class trans politics.

note that life chances can be transferred from trans youth of colour to more privileged trans youth. This can be done despite good intentions and sometimes *via* good intentions, like the discursive practice of crisis-time and the literal practice of triage that marshals resources for those already the most supported. Though a racialized and classed gap has been present since the earliest scenes of trans health care (Garfinkle, 1967/2006; Ophelian, 2011), this gap is poised to widen if blockers continue to benefit those already in privileged situations. In the words of the clinician who predicted even greater visibility and violence in the future for trans women of colour: this should “keep us up at night.”

Conclusion: A Problem We Should Not Live With

A clinician interviewed for this project referred to the introduction of puberty blockers as “the single most important seminal event in trans care, ever.” The ensuing heated debate has seen blockers positioned by critics as a dangerous switchpoint leading to an undesirable trans future, and by those in favour, as a lifesaving switchpoint to protect against distress and future victimization. This debate misses what may be the most significant switchpoint feature of blockers, the ability to move more privileged trans youth onto a path to an even better future. Through a discourse analysis of talk by clinicians and community stakeholders who work with trans youth, I explored the uneven and racialized patterns of service at gender clinics. Drawing on the literature of queer of colour critique, I considered how these come about. I propose that the temporal repertoire of urgency and crisis-time, while assumed to support trans youth in general, is in fact most likely to secure timely treatment for white middle class trans youth and thus is a “temporality of privilege.” Meanwhile, the alternate temporality of trans youth of colour,

ongoingness or crisis-ordinary, keeps them focused on survival through ongoing crises. In addition, they are less intelligible in their episodic and interrupted paths to transition, without the spectacle of emergency. I argue that while any *event* of crisis for trans youth is serious, “the event” is not the only genre of time that is serious, and urge the field of trans health to reorganize the temporal basis on which trans youth care is provided.

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CHAPTER 5

Conclusion

Trans scholar and poet Cat Fitzpatrick (2013) writes that psychiatry's relationship to trans individuals is different than other diagnoses, because it "exerts power over us primarily through what it does or might deny us (surgery, hormones, legal recognition)" (p. 30). The clinicians interviewed in this study hailed from multiple professions and not only psychiatry, however, Fitzpatrick's (2013) perspective remains important alongside the way interviewees identified themselves, as helpers and as supports to trans youth. Many clinicians felt deeply moved by their work and felt they were not acting as controlling agents. Yet, as has been written many times, historically trans people have tended to regard health professionals as opponents (see Garfinkle, 1967/2006) and have learned over time to successfully "map the relations of power" of the clinic (Stryker, 2006, p.58). The gender clinic is already fraught before one begins.

As I have tried to show, the state of the union for trans youth, so to speak, resists a simple *précis*. A common way that trans youth are storied these days is as an oppressed minority group. Certainly, this is not wrong. However, it would also be unwise to ignore the remarkable surge in life possibilities that have emerged for (some) trans youth in recent years. In Canada, specific protections for youth such as anti-discrimination policies in schools (TDSB, n.d.) and legislation banning conversion therapies for LGBT minors (Legislative Assembly of Ontario, 2015) add to the general adoption of gender identity protections like the 2016 federal trans rights bill (Parliament of Canada, 2016), and a city-wide trans inclusion policy in the city of Vancouver (Dolski, 2016). At the same time that

we are noting these gains in the public realm, it would also be unwise to ignore the tremendous backlash that has risen, most publically in some US states, to legally contest the rights of trans youth to simply use the bathroom in their own school (Stevens, 2018) or change their own names (Knight, 2018). The steep rise in reported murders of young trans women of colour is a horrifying but essential element to include in any analysis of this time (Gossett, Stanley & Burton, 2017).

In the realm of trans health care, changes with respect to children and youth have been profound. The institutionalizing of the ‘affirming model’ of trans youth care³⁸, has seen a growing number of clinics opened in the US, Canada, and elsewhere, to support trans youth in accessing puberty blockers and medical transition care. Despite much controversy and many critics, there has been in fact, an interesting reversal. Where it was once argued that children should be prevented from growing up to be trans in order to avoid bad futures such as unemployment and suicide (Rekers et al., 1977), it is now argued that if trans youth desire transition, then facilitating this is what will help to avoid those bad futures of unemployment (Trans Active, n.d.) and suicide (Bentley, 2011).

In this study, I aimed to pursue the following research questions: How have puberty suppression and early gender transition become thinkable futures for trans youth? What are the conditions of possibility (on the socio-cultural level and in the clinical moment) through which this “form of life” becomes permissible? (Sekuler, 2014). For whom are these futures thinkable and possible and for whom are they not?

³⁸ The affirming model supports young gender diverse people in their self-identities and facilitates their authentic expression, whether that be transition or a more gender fluid expression (Hidalgo et al., 2013)

On the question of possibility, some regard the introduction of the technology of puberty blockers (GnRH analogues) as the origin point of these tremendous changes. One clinician remarked that blockers were “the single most important seminal event in trans care ever.” But as stated in previous chapters, puberty blockers are not a new technology and have been widely used by endocrinologists since the 1980s, simply not with trans youth. Early longitudinal research has helped to argue for blockers as a safe option for trans youth, and yet blockers were offered to trans youth in some regions before that research became available and continued to *not* be offered in other regions afterwards. Similarly, the technology of cross-sex hormones has existed for many years prior to use with youth. In fact, currently cross-sex hormones could be given to trans youth without first using puberty blockers, which at some ages would better mimic the pubertal arc of their peers, yet this is not done. For this reason, I argue the “seminal event” in this story is not the material technology, and in truth is not really an event, but the ongoing development of the discourses rendering it thinkable and possible. Thus, discourse itself is a technology, and with the power to materialize some bodies in some forms through assessment and the authorizing of treatment, then as T. Garner (2014) writes, “discourse is a medical technology” (p.352). This study sought to understand these discourses and mark their political implications, their unforeseen and unseen consequences.

What Makes it Thinkable and Possible?

In Chapter two, I write that the discourse of “cognitive age” allows some trans youth to be considered “ahead of their time” (Dibiasi, 2015), “extraordinarily articulate” (Olya, 2016), “mature beyond their years” (Legge, 2015), “wise beyond their years” (Brown, 2008, p.19), and as one interviewed clinician said, “super advanced” and “years ahead.” In a context in which the public will question, sometimes vigorously, whether adolescence is the “right time” for such decisions, these discourses of maturity and wisdom create the rationale for why *these* youth should be considered appropriate for this unusual responsibility. I also write that the discourse of “asynchrony” is used to make the case for why trans youth must be permitted to transition. To have an inner self at odds with an outer self, came to be seen in medicine as amenable to remedy. In Benjamin’s (1966) early appeals to his fellow physicians to make the case for sex change, he used the metaphors of “dissonance” as the problem, and “harmony” as the goal. The possibility of alignment works to support trans youth who seek transition, with some open questions, as I note in Chapter one, about whether the asynchrony remedied is always that of the youth themselves or at times the visual effect they create for others, what Leonard Davis (1995) refers to regarding disability as a “disruption” in the “perceptual field of others” (p.129).

In Chapter three, I write that the discourses and temporality involved in relaying narrative, enable some trans youth to successfully navigate the clinic process – given the central place of narrative in determining diagnosis and treatment recommendations for trans individuals. The narrative most likely to be perceived as authentic and to make this future possible, begins with youth’s earliest memories of gender difference, moves on to increasing suffering, and concludes with the resolution of distress. Thus, the useable

narrative contains a schedule of expected suffering (at puberty) and expected improvement (with treatment). Trans youth perceived to be authentic and able to access transition are often described as intelligent, articulate, and competent. The phrase “insistent, persistent, consistent” (Hidalgo et al. 2013, p.286) is used by some clinicians to describe youth most likely to benefit from transition and helps guide clinical decisions, though this too is narrative-based. Instances of non-insistence, non-persistence, or inconsistency are dependent on the ability of the authentic-seeming narrative to absorb them. Happiness at the end of treatment was a commonly expected element in the authentic narrative. The discourses of chronological narrative, of being insistent and consistent, and the discourses of resolution and getting better, are conditions of possibility in the clinical moment that work to make early transition thinkable.

In Chapter four, I write that the discourses of emergency, urgency, and crisis-time, are often used to characterize the experience of trans youth seeking puberty suppression and help make the case for such decisions. Since the default logic regarding young people and major decisions tends to be ‘wait and see’, the discourse of emergency communicates what might otherwise be a non-apparent rationale for moving quickly. This discourse frames unwanted pubertal development as both increasing trans youths’ risk of suicide or self-harm in the short-term, as well as putting them in harm’s way in the long term through the development of secondary sex characteristics that make them more visible as trans people, and potentially more vulnerable to discrimination, harassment and violence. The ability to secure blockers is thus a ‘race against time’ to intervene before endogenous puberty takes youth off course. Emerging triage practices focus resources on responding

to pubertal age youth as a priority population in crisis and in need of blockers. Here I am not suggesting that this crisis is inauthentic, quite the opposite, I assume it is very real, but ask questions regarding for whom this discourse of crisis is available. The discourses of urgency and crisis are conditions of possibility at the socio-cultural level that work to make possible early transition for some, based on ideas of priority.

“Others” in the Gender Clinic

All of these discourses discussed in Chapters two, three and four, help to make the case for some youth to access puberty blockers and early transition care. Yet each of these significant discourses also has an “other”, or more than one, who is part of the scene and in some cases goes unseen. The opening up of new futures and possibilities for trans youth, can’t be understood outside of the context of others who lack such options, or any options at all.³⁹ In Chapter two, the ‘other’ most central to the text is a young disabled girl known by the pseudonym Ashley X - a young person who is not marked as trans, but who in 2004 received a similar list of procedures to those sought by trans youth (hormone therapy, mastectomy, hysterectomy), using similar discursive arguments, however importantly, against her will. I compare these processes for what can be learned about these discourses, what they do, and what they are capable of doing. I refer to that difference in terms of “autonomy”, with the race against time to resolve asynchrony and the discourse of cognitive age working to boost the autonomy of trans youth but strip Ashley of hers.⁴⁰ Toward the end of Chapter two I also point to the implications of these

³⁹ Thank you to Katrina Roen and Mauro Cabral for conversations that pointed me in this direction.

⁴⁰ In the final section below, I consider another way to regard this difference, not as autonomy but animacy.

discourses for autistic trans youth. With autistic youth viewed as “delayed” or “younger than their years”, the discourses of maturity, intelligence and wisdom are not available. Further, the discourses of inner and outer asynchrony, seem to be in question for some autistic youth who are at times described in clinical literature as “just feeling different” (De Vries et al., 2010, p.2277) and not “essentially” their gender (Parkinson, 2014, p.84).

Chapter three begins where Chapter two leaves off to consider how autistic trans youth are made “other” in the clinic because they often present with a narrative that is absent the expected longstanding story, absent the expected “narrateme” of distress at puberty, and potentially absent the resolution at conclusion. Autistic trans youth have a complex relationship to the concept of intelligence, with public assumptions often wavering between a form of autistic genius (referred to as savant) or no intelligence at all. Moreover, the matter is in question because verbal articulation is often how such things are judged, and autistic people may express themselves otherwise. Seeming to falter at times in insistency, persistency, or consistency, autistic trans youth are sometimes regarded as unintelligible. At times they leave the clinic and do not return.

In Chapter four, the discourses of emergency and the race against time, so often summoned to characterize the need for puberty blockers and early transition care in general, can be seen to work primarily for white middle class trans youth who are more likely to enjoy the stability that is a stated requirement of clinical guidelines. According to key stakeholders, trans youth of colour and their families are more likely to face ongoing struggles associated with being racialized in an inequitable society, with poverty,

with long work hours at multiple jobs, with housing challenges, and if newcomers, with the day-to-day challenges of trying to meet basic needs. These families may live instead in a state that Berlant called “crisis-ordinary” – both “at an extreme and in the zone of ordinariness” (p.97). In other words, they may not present at a gender clinic nor claim a crisis specific to a youth’s gender experience, because they may be in constant crisis and therefore lack the stability that both materially makes such a move possible, and discursively gives the term crisis its significance. Further, the triage practices adopted in some clinics to manage wait times and help pubertal age trans youth, inadvertently prioritize white trans youth who are more likely to make it to the clinic at a young age, thus deprioritizing trans youth of colour.

My point here is not just that marginalized trans youth simply are not yet benefiting from these options, and that some form of trickle down social justice (Spade, 2009) will ensure they eventually do. My point is that the discourses that work *for* more privileged trans youth are in some cases working *against* marginalized trans youth to produce them as “others.” The pervasive presence of autism in interview discourse, however, paired with the persistent absence of race in the same interviews, indicates that this happens differently in each case. Autistic youth, evidently present in clinicians’ minds as difficult cases, are present but produced as unintelligible given their lack of match with the expected narrative and their perceived failure to keep chrononormative time. Racialized youth, absent from discourse about trans youth care, are produced as unseen others – a silence in which, as Roderick Ferguson notes, “an ideology has gathered” (p.5). The absence of trans youth of colour in the gender clinic is then pondered

through this ideology, as a displacement of transphobia onto racialized families and communities, who are then said to not support trans youth or not caught up to the times.

The discourses that speed access for some trans youth then, are some of the crowning features of an affirming approach to trans youth care. Yet while making early transition possible for some, these discourses make transition difficult, slow, or impossible for others. The ability to translate the crisis trans youth may feel at puberty and convey this in the temporal terms of urgency that others can understand, is an achievement. Yet this discursive practice does not function to make available care for trans youth of colour operating in a different time zone – Berlant’s (2011) “crisis-ordinary.” The ability to depathologize trans youth and to convincingly portray them as doing well with support, more functional and happier post-transition, has worked to make early transition possible for some. Yet autistic trans youth, whose functionality is uniquely in question through the categories of ‘high and low functioning’, and whose emotional experiences can be illegible to others, are questionable as to whether they even *are* trans youth. In short, the conditions of possibility that make puberty suppression and early gender transition thinkable and possible for some, are the same grounds on which these futures are foreclosed for others.

Contributions of Thesis

This thesis makes contributions to a number of areas of theory and practice. The phenomenon of puberty suppression is frequently critiqued from both the right and the left political spectrums. From the right, transitioning youth can be seen to constitute an unacceptable rebellion, a violation of natural law. From the left, on the other hand,

transitioning youth can be seen to constitute an unacceptable form of conformity, said to align with the norms of a heteronormative society or those of medical science. Some social science literature critiques puberty suppression from the latter perspective, for example Castaneda (2014), who views the practice as being invested in a “disappointing fiction” of development in which physicians lead youth into normative futures (p.8). Yet trans youth themselves, as agents, as desiring subjects, can barely be seen in these critiques, while physicians, parents, and professionals, who may indeed have conservative goals, are described as having already met those goals. In contrast, my analysis critiques not the practice of young people transitioning, but the authority exercised over who is approved and on what basis. This analysis critiques instead the limited discourses through which (some) trans youth are permitted to determine their futures, and the direct impact on those who are not - in these chapters, racialized and autistic youth. While my research cannot report directly on the views or experiences of youth, it demonstrates that clinicians occupy their own position not commensurable with that of youth. Thus there is no reason to assume that youth who transition will become obediently normative, and the concern should centre on the criteria in use and the fate of youth who will not meet it.

In trans studies and in work on trans temporality, Freeman’s (2010) concept of chrononormativity – the normative uses of time imposed by institutions – has been usefully noted in the operations of the gender clinic by Cadwallader (2014) and Amin (2014). My analysis builds on these critiques to look more specifically at the “social patterning” in the expected schedule at the clinic and at the discourses that speed up the pace and those that slow it down, or gum it up entirely (Amin, 2014, p.2019). As Amin

(2014) writes, to say that something is chrononormative is not to say that it is bad (p.220) and so unlike Castaneda (2014) above, I focus specifically on what the harm of normative time will be, besides the fact that it is normative, specifically, at how this time makes insiders of some and outsiders of others, and who those others might turn out to be. Trans studies has also explored the significance of narrative in the unfolding of trans futures (Amin, 2014; Prosser, 1998; 2014). This study contributes to that work by outlining the implications of the chrononormative narrative on a specific sub-set of trans individuals – autistic trans youth. In his work-in-progress *Digital Trans*, Prosser (2014) gestures to new genres of trans life that become possible outside the confines of twentieth century autobiography that transsexuals were once reliant on to story their experiences. Though Prosser does not name those genres, this study points to autistic trans life as one form becoming more possible and that will undoubtedly continue to unfold with the proliferation of stories that follow a different time. Amin (2014) writes that non-chrononormative narratives may become critical, given the institutionalizing of some forms of trans life. By bringing together trans studies and critical autism studies, this project answers Amin's (2014) call.

In this astounding moment, there have never been more images and narratives of trans phenomena in the public realm, yet simultaneously, the documented murders of young trans women of colour are rising each year, having doubled since artist and activist Laverne Cox declared this violence an “epidemic” in 2014 (Democracy NOW, 2014; HRC, 2017). Transgender studies scholars and activists are working to make sense of this paradoxical time (Gossett, Stanley & Burton, 2017) and this study adds to those

endeavours. Drawing on queer and trans of colour scholarship on the “long-duree” of Black struggle (Snorton, 2017; Walcott, 2016) and the “chronic afterlife of racial atrocity” (Sharp, 2016), I bring this drawn-out sense of time to bear on the discourse of emergency and crisis in the gender clinic, finding that not only are there diverging futures for trans youth on the basis of race, class, and disability, but that the mechanisms opening new futures for some trans youth, are the very same foreclosing those futures for others.

While conservative critics have suggested that puberty blockers somehow switch cisgender children into trans children, I propose that the new technology of blockers has turned puberty into a “switchpoint”⁴¹ that moves more privileged trans youth onto a track toward an even more privileged future. While optimistic narrators of this moment propose blockers as, in the words of an interviewed clinician: “the single most important seminal event in trans care, ever”, I propose that the lesser seen effect of blockers is the widening of the opportunity gap in trans communities. While there has always been a gap between trans people who do and do not have the economic means for upward mobility, and while that gap has always been racialized, this study finds this gap poised to widen further through the “switchpoint” of puberty blockers. Unlike critics who critique blockers in and of themselves, or critique the entire phenomenon of trans children, I aim this critique at the specific discourses that open the door to better futures for some and not others.

To the large body of work on time and social power, from Bourdieu (1977) to Berlant (2011), I contribute the concept of the “temporality of privilege”, not previously

⁴¹ Kathryn Bond Stockton (2006) and Jasbir Puar (2011) use the term “switchpoint” in the context of gender and race, albeit differently than myself.

named as such but useful for remarking on the way privilege can determine who can effectively claim “crisis” and mobilize support for their child or themselves, and whose lives lack the material or discursive stability needed to make this claim. While the differential options available for white trans youth are often noted, this project points to a way of thinking these differences in both temporal and material terms and therefore to address these disparities in a way that does not cast blame onto racialized families and communities for not better supporting trans youth. This project proposes, I hope, a better answer to the question of why trans youth clinics are, and stay, white.

Methodologically, an interpretive repertoire analysis allowed for a detailed examination of the discourses at work in the gender clinic – discourses that structure the process of assessment and clinical decision-making that youth encounter and must pass through to get their needs met. The ability to identify variation, inconsistency, and contradiction in these clinical discourses, was a particular strength of an interpretive repertoire analysis. The method used in this study found the fractures and fissures in a discourse that often masquerades as simply the march of scientific progress. Moreover, this analysis was able to bridge the discursive and the material, to make vital connections between the discourse of puberty suppression and how those discourses bear out on actual bodies and lives, for example, on the neglect of trans youth of colour whose ongoing material circumstances do not lend themselves to the crisis-time that structures the clinic.

At the level of practice, recent progress in treatment ethics for trans children has finally resulted in the marginalization of, and in some regions, the legislative banning of, reparative or corrective therapies that sought to prevent youth from growing up to be trans

(Legislative Assembly of Ontario, 2015). An affirming model that validates all outcomes for gender non-conforming youth is now the more widespread and institutionalized approach (Ehrensaft, 2016). However, this study highlights unforeseen implications for the gender clinic's "others" – for autistic and racialized youth – and thus also highlights practices that are alterable and in need of advocacy. The practice of triage for younger pubertal age trans youth should be revisited with the knowledge that younger youth in clinics are often white and middle class. Youth gender clinics should develop methods for allocating resources that do not privilege youth who are already privileged. Additionally, the difficulty discussed for trans youth of colour, low income, and Indigenous trans youth to establish the stability required to show that one is a good candidate for treatment, indicates that this requirement must be revisited. Life stability may be more attainable for trans youth after receiving treatment, thus a harm reduction approach to transition care should be implemented with clinicians willing to work with youth in difficult living situations rather than deny them until such a time as they are stable. Further, that all assessment of trans youth is narrative-based, is in need of remedy. With the knowledge that autistic and some other trans youth do not communicate or story their identities in expected neurotypical ways, means that narrative-based assessment is not tenable without other options. A small number of clinicians discussed methods of communicating outside of narrative and these should be explored for widespread use. Moreover, with an upcoming postdoctoral fellowship focused on the intersection of autistic and trans experience, I plan to implement the last recommendation myself, which is to find ways of sharing autistic trans youth stories (perhaps via digital storytelling methods) with the goal

of making these stories more legible and thus helping to create the audience that, as Plummer (1995) notes, must be in place to hear the story.

Questions Left Open

With the limitations of this project, there were inevitably phenomena that went unexplored. For instance, there are many temporalities that might be called “strange temporalities” (Halberstam, 2005) pervading public discourse on trans youth and puberty blockers. The famed “reversibility” of blockers promises to unwind time while the so-called “irreversibility” of surgery ominously codes some bodily forms as forever and ever, amen. Among a new generation of parents who accompany their young child through transition, some can now be heard exclaiming afterwards “it’s like it never happened!”⁴², indicating that the appearance of a cisgender future may have the ability to reach into and edit a trans past. Even the image of a trans youth frozen in time on blockers while other teens develop around them, is strange for the way it seems to frustrate the meaning of the prefix “trans”, as that which is synonymous with crossing or change. I was unable to explore these temporalities within this specific project.

With the data I had available, I was not able to do an adequate exploration of questions for autistic trans youth of colour. The choice to analyze these experiences in two separate chapters (autistic trans youth and racialized trans youth) reflected the interview data available to me and not the belief that these identities are mutually exclusive. In *All the Weight of Our Dreams: On Living Racialized Autism*, Lydia Brown,

⁴² Anonymous manuscript under review, Journal of GLBT Family Studies.

E. Ashkenazy, and Morenike Giwa Onaiwu (2017) write that multiple oppressions work together to produce new forms of pernicious violence. With evidence that autistic people of colour are more likely to be incarcerated and forced into frightening and violent “treatment” regimes (Brown, Ashkenazy & Onaiwu, 2017), it is likely that autistic trans youth of colour would have significant obstacles on the path to coming out and transitioning. Their experiences are worthy of research and advocacy and the leadership of racialized, autistic, genderqueer activists like Lydia Brown should be followed.

Methodologically, with a discursive focus in this research, there were aspects of the gender clinic that were not in my view that perhaps an ethnographic study would better capture. For instance, there was some suggestion in interviews that clinicians may respond to the physical appearance of youth who present at the clinic and that questions of authenticity could originate there. In interviews, a handful of clinicians briefly mentioned the physical appearance of youth they found unintelligible or uncertain – youth who were said to confound the clinical process, for example, young trans women who did not appear feminine. These brief mentions of only youth who did not appear as expected, suggests that perhaps all youth are being evaluated on the basis of their appearance, consciously or unconsciously, and that other modes of non-discursive research methodologies could better capture these nuances within gender clinics.

Both critical disability studies/autism studies and transgender studies interrogate the concept of the human, often through theories of posthumanism (Barad, 2003) or animacy (Chen, 2012). In this project, I drew on critical autism studies to note that

autistic people are not regarded as fully human, and that one key aspect of this problem, is that they are viewed as non-rhetorical or lacking in voluntary intention (Yergeau, 2018). Yet other questions emerge that could be explored through Chen's (2012) theory of animacy – a theory that posits power as “naturalized and represented” through depictions of humans as more or less animate than one another (Chapman, 2017, p.2). In Chapter two, Gillet (2016) is the only other author who addresses both Ashley X and trans youth care, but argues that what happened to Ashley was just, because it is the same that we do for trans youth, to bring their bodies and minds into synchrony. Yet as I note, trans youth seek this “synchrony”, but for Ashley it is done against or oblivious to her will. Ashley is not depicted as animate in this discourse. In interviews, clinicians describe their satisfaction when they can help trans youth and essentially fix them and make them happy, an expression perhaps of the animate power they experience in this capacity, in opposition to other patients who they lament do not benefit from their help. In the discourse around trans youth, those parents who bring their child to the gender clinic (in this study, often white and middle class) are depicted as animate in their active capacity to support their child, while families who do not or cannot do so (in this study often racialized and poor families) are seen to be immobile or failing to act. Even left political critiques of puberty blockers use animacy/inanimacy in interesting ways to make a point. Castaneda (2014) and Wilchins (2012) describe puberty suppression as something that happens *to* trans youth, rather than at their behest. Though I was unable to explore this herein, in a postdoctoral fellowship (2018-2020) entitled “Dis/Human Others” I plan to explore animacy and power as they come together in autistic and trans futures.

Lastly, there is a potential problem with animacy/inanimacy in my own analysis as well. In analyzing primarily clinical discourses, there is a risk of making trans youth into passive patients who are subject only to the power of others. As Syrus Ware (2017) suggests about Black queers, the youth in these stories should not be viewed as only conquered by time. As Ann Fudge Schormans writes (2005), disabled youth should not be seen as victims of history, but as makers of history. I was able to report on some instances that key stakeholders shared in which racialized trans youth practiced profound mutual care for one another, however, there remain many open questions that should be answered by racialized and autistic trans youth themselves. For marginalized trans youth not able to access transition in a timely way, what creative steps do they take to make adolescence bearable? How do they compromise and strategize to get their needs met? How do they find what Ferguson (2004) called the “pleasure and alrightness” in life? (p.1). Historically, trans people shared strategies for navigating gender clinics with one another in a collaborative endeavour. Do trans youth do the same in online or other forums? How do they support one another? For those declined by the clinic, for example some autistic youth, how do they compose their identities outside of clinical space, and where does that take them? While it is possible that failure in the clinic is a devastating event, it also remains possible, as Halberstam (2011) would suggest, that there is another side to failure, and that it may offer its rewards in other ways. If Halberstam (2011) is correct, then it behooves me to ask if what lies beyond the time of clinical evaluation, testing and appointments, could ever be experienced as “escape”? (p.3). Interviews with trans youth

that I will conduct in a follow up project, with some focused on Indigenous trans youth, will query their life projects and how they find ways to make their time their own.

Final Thoughts

While there is much to celebrate in these newly available livable trans futures, this study finds that scene also augers something else. As stated, the conditions of possibility that make early transition possible for some trans youth, are the same conditions that foreclose it for others. Though there has always been an opportunity gap within trans community, and while this has always been racialized, this study finds that gap poised to widen through the “switchpoint” of puberty suppression that moves more privileged trans youth onto a track toward even greater privilege. Bringing together critical disability studies, critical autism studies, queer and trans of colour critique, sociological works on time and social power, transgender studies, and the literature of queer temporalities, I reconsider chrononormative time in the gender clinic and the unforeseen effects on autistic trans youth. Adding to scholarship on time and social power, I introduce the concept of “temporalities of privilege” to theorize the ability to claim crisis, however legitimate, and to mobilize to have one’s needs met. I make key recommendations for health and mental health practice with trans youth to help close the gaps so that all trans youth are able to see just and livable futures.

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