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Enacting Transgender: **An Ethnography of Transgender Ontology** **in a Pediatric Gender Clinic**

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This thesis is dedicated to all of the patients in the gender clinic,
all of the trans- youth who do not have access to the gender clinic,
and all of the trans- youth who are no longer with us.

Your realities are too good for this world.

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INTRODUCTION

Realities...

Interviewer: What does transitioning mean to you?

Max: I think it means that was my past, but here's the future, now.

Interviewer: What does transition mean to you?

Javier: To me, transition means finally starting the process of becoming you.

-Patients from the pediatric gender clinic

On my first day in the pediatric gender clinic,¹ I observe consultations with four trans-² patients ages thirteen to sixteen. For some, this is their first visit to the clinic. They appear nervous and excited, full of questions. The others show a comfortability with the hospital space that only comes from frequent visits. One patient uses they/them/their pronouns;³ one has purple and blue hair, and another often pushes her tight curls out from in front of her face. Two are on puberty blockers, and one has started on estrogen therapy. All of them have survived a suicide attempt.

¹ My research protocol as approved by the hospital's institutional review board does not allow me to use the pediatric gender clinic's official name. Throughout my thesis, I will call it "the gender clinic" or "the pediatric gender clinic."

² Gender and sexual identities continue to go under new names. As Valentine demonstrates in *Imagining Transgender* (2007), "transgender" has become somewhat of an umbrella term, though in the years since Valentine's book was published "trans" and "trans and gender non-conforming" have cast wider nets in their encompassing of identities. Throughout this thesis I will use "trans-" as termed by Stryker, Currah, and Moore, who coined the term in order to allow for many possible suffixes (Stryker, Currah, and Moore 2008). Alternatively, Eric Plemons employs "trans-" as an umbrella term for all of those who feel their identities are represented by adding an ending to the hyphen (Plemons 2017:1n1). I will follow Plemons in employing "trans-" as an umbrella term, but will use the theoretical work the hyphen affords us beginning in chapter one.

³ A note on pronouns: I worked to truthfully honor and represent the people who appear in this book. As such, I have employed the pronouns that they use. Many gender queer and gender non-conforming individuals use they/them/theirs pronouns.

The statistics on suicide rates in trans- youth are sparse, but we know that the rates are significant. One recent survey in Australia found that 48 percent of trans- youth have attempted suicide (Strauss et al. 2017). Three studies in the United States found that 25 percent (Grossman and D’Augelli 2007), 30 percent (Peterson et al. 2017), and 33 percent (Perez-Brumer et al. 2017) of trans- youth have attempted to take their own life. In contrast, the Center for Disease Control found that eight percent of students in grades 9-12 had attempted suicide (Center for Disease Control 2015).

More robust statistics exist for adults. In the United States, one study found that trans- and gender non-conforming individuals have a 41% chance of attempting suicide during their lifetime (Haas, Rodgers, and Herman 2014). In a separate study, 92% of trans- adults reported having attempted suicide before the age of 25 (James et al. 2016). Data from the general population show a lifetime suicide attempt rate of 3.0-5.1 percent (Nock et al. 2008).

Eve Kosofsky Sedgwick opens “Queer and Now” in *Tendencies* (1993) with the suicide statistics of the LGBTQ youth of her time. She explains that our culture has a way “of denying and despoiling queer energies and lives.” She continues: “I look at my adult friends and colleagues doing lesbian and gay work, and I feel that the survival of each is a miracle. Everyone who survived has stories about how it was done” (Sedgwick 1993:1). This thesis, in part, is an attempt to fathom the miraculous survival stories of the patients in the gender clinic. I maintain throughout these pages that despite the reality of trans- youth suicide the patients of the gender clinic are creating miraculous futures: ones that contain selves in which they can not only live, but also thrive.

Positions

Whether the ethnographer finds their field site, or the field site finds them, I have never found it coincidental the areas anthropologists explore. I am researching this clinic at this time for

very specific reasons. But like most things in this world, this thesis is born out of curiosity and opportunity.

First, curiosity. It would be impossible to write this thesis without acknowledging my own gender identity. And in this political moment—one in which the letters L, G, and B ally themselves with T, Q, I, A, and +—it would make sense to give a friendly nod to my sexuality, too. For a long time—a time I would call the most livable of my short life—I have identified as a gay man. I have used he, him, and his pronouns, and have been read as male by the outside world. However, starting at around the time ideas for this thesis began to brew in my head, I also began to think more about my own gender identity.

A year ago, after too many queer theory readings, and too few hours of sleep, I faced a crisis of gender identity. I struggled with conflicting societal and personal definitions of what it means to be a man. I didn't identify as a man and woman wasn't correct either. To complicate things, the label of "gender queer" didn't fit—though this isn't to say it won't someday. I felt lost in a sea of identities, trying to weigh which label fit me best. It wasn't until I read Maggie Nelson's description of her partner, Harry Dodge, in *The Argonauts* (2015) that I found an answer to my questions. Harry says, simply and profoundly, "I'm not on my way anywhere" (Nelson 2015:53). I have learned I don't need to be going in any specific direction: not towards gender queer or trans-. Instead, I have learned to identify—calmly, peacefully—in questioning.

I did not set out in this research to answer my own personal gender identity questions. And truthfully, this thesis has not given me clarity in that regard. But I am motivated to conduct this ethnography because, in some capacity, I identify with these children. I doubt any of them think of me as anything but a man (most of the world thinks of me this way), but I made my way to this gender clinic because I too have spent sleepless nights thinking, dreaming: curious, or anxious, or excited, like these children, about my gender identity.

Next, opportunity. Few pediatric gender clinics are found in the United States. This research would not have been possible had a large university research hospital in the Southeastern United States not opened a pediatric gender clinic during my time as an undergraduate student at Duke University. I am grateful for the opportunities the doctors of the clinic have opened for me in their commitment to furthering research. This exploration would not have been possible without them.

This thesis was conducted in hallways and exam rooms, behind work room computers and through phone calls across the South. The spaces laid out by the hospital institutional review board (IRB) allowed for observation of clinical visits, shadowing the care givers, and interviews with assenting⁴ pediatric patients with consenting adults. From September 2017 to January 2018 I attended nearly every day and half-day that the gender clinic was open. While observing clinical visits I would recruit patients over the age of nine to participate in a one-on-one interview.⁵ To protect the anonymity of the patients, I cannot disclose their exact ages (though I employ age clues such as if they are a teenager or an elementary school student). I have also given all the patients pseudonyms, which reflect their ethnic and racial backgrounds. Additionally, I conducted semi-structured interviews with the endocrinologist and clinical social worker who run the gender clinic. They have not been given pseudonyms, but only appear in this thesis named as “the doctor” or “endocrinologist,” or the “clinical social worker” or simply “the social worker.” The other health professionals (such as nurses) in the clinic have been given pseudonyms. My interviews, informal conversations, and field notes serve as the ethnographic data for my thesis.

⁴ Patients of the gender clinic who were under the age of eighteen assented—agreed—to be part of the study, but legally, parental “informed consent” also had to be obtained. If the patient was older than eighteen years old, they could legally consent without their parent’s permission.

⁵ Per my IRB, the interviews were structured; that is, I asked the same questions to each patient, though I had a modified list of questions for patients younger than 12 years of age (this age is a standard for the hospital). I was allowed to ask clarifying questions, but not follow up questions.

Patients travel from near (neighboring towns) and far (across multiple state lines) to reach the gender clinic. As the clinic is a part of a larger university research hospital, it shares clinical space with many other pediatric units. In addition, because the gender clinic is open only a couple days or half-days each week, it is fit in between the larger, busier pediatric medical units.

This is not to say the gender clinic is not busy. As of writing this thesis, over 220 patients are a part the gender clinic with an age range of 7 to 23. When I begin my fieldwork, the doctor and clinical social worker that run the clinic are booked out three months in advance.⁶ Now, new patients (and many that are scheduling follow ups) face a 5 month wait time for an appointment. As the doctor sees every patient, and the clinical social worker consults with all of the new patients and as many of the returning patients as she can, the two rarely spend time at ease.

Because the gender clinic is part of the university's children's hospital, it is not a stand-alone space. In fact, its 'space' is generally 4 consultation rooms and half of a shared workroom—the area where the doctors and nurses do paperwork and prepare for patients. Some days the gender clinic will be in workroom D (genetics' assigned space), other times, pediatric cardiology will be out for the afternoon so the gender clinic will move into workroom A. All of the work rooms are the same: rectangular with doors on each of the short ends and two long benches with four or five computers each running down the sides. Pages from coloring books—mostly shaded in crayon outside the lines—are tacked to the corkboard backslash behind the computers. Hospital staff's bags containing their lunch and files rest below the benches. In the pediatric cardiology work room, monitors displaying ultrasounds take up the space normally held by cabinets that run three feet above the benches.

⁶ The gender clinic was founded by a pediatric endocrinologist, a urologist, and a clinical social worker. The urologist was not present in the gender clinic during the five months of my fieldwork and thus does not appear in this work.

The gender clinic is only open at most one day a week. However, one afternoon can fill the pastel colored consultation rooms with plenty of life-changing prescriptions, stories of trauma, and affirmation for these trans- children. Patients detail self-harm or suicidal thoughts in jarring contrast to friendly lion and tiger wall decals. Moreover, they begin the alchemy of combining the chemicals they receive from the doctor with their own self-determination to draw a more livable future out of their own bodies.

I am usually only observing—a shadow in the corner of the doctor or clinical social worker—interacting directly with patients only to recruit them for and conduct interviews. Yet I leave each day at the clinic exhausted from the emotional weight that fills the clinical space. In contrast, the healthcare professionals of the clinic interact directly with the patients. On my third visit, the doctor turns to the social worker and suggests “counseling from a professional to decompress from our work here.” This is all to say, the gender clinic is a space filled with powerful emotions. And, as I will argue throughout this thesis, it is filled with realities of gender and transgender.⁷

Questions

Following in the work of Annemarie Mol,⁸ the framing question of my thesis is *How is transgender enacted in the pediatric gender clinic?* That is, *How do practices bring ontological realities of transgender into being?* This ontological formulation further prompts me to ask *What forms of temporality does an ontological approach to transgender enable us to understand?*

⁷ I will use the term “transgender” throughout this thesis to describe enacted realities in which what is trans-’d is gender.

⁸ (Mol 2002)

Literature Review

Pediatric. Gender. Clinic. These three words each represent a vast body of theoretical knowledge and research. They also meet in and on the trans- adolescent patients of the gender clinic this ethnography details. To understand how transgender is enacted, we must unpack each of these terms before bringing them all together.

Clinic

Like any object of medicine that has been constructed as a disease, disorder, or medical intervention, transgenderism/transsexualism has a specific history. Susan Stryker traces the genealogy of Western medicine's classification of transgender people beginning in Austria when Karl Heinrich Ulrich in 1864-1865 coined the term "urnings" to describe people like himself in his book *Researches on the Riddle of "Man-Manly" Love* (Stryker 2008:37). In Ulrich's biological theory "urnings" are "a female soul enclosed within a male body." This specific classification caused Karl Maria Kertbeny, a German born Hungarian, to term same-sex love without gender inversion, "homosexuality" (Stryker 2008:37). From Ulrich's first Western naming and classification to the medical professionals, social theorists, and every-day people who have generated common knowledge about it, the Western definition of transgenderism and gender nonconformity has continued to change (Meyerowitz 2002; Stryker 2008; Valentine 2007).

"Transsexualism" first came into widespread use when Dr. Harry Benjamin popularized the term in 1954 in San Francisco, California. Dr. Benjamin rose to fame when one of his patients, Christine Jorgensen, became an international sensation after traveling to Denmark to receive sex reassignment surgery. In 1952, the *New York Daily News* ran a cover story featuring Jorgensen upon her return to the United States. The headline above a pair of cover photos—one of Jorgensen as an army cadet, the other as a done-up woman—read: "Ex-GI Becomes Blonde Beauty" . Following the story's publication, people identifying with Jorgensen sought out Dr. Benjamin for the hormone

replacement therapy with which he had treated Jorgensen. He defined “transsexualism” as “a condition... perhaps conditioned by endocrine factors, and not amenable to psychotherapy,” thus placing transsexualism within the body (Benjamin 1954:219). However, there is no medical test to determine transsexualism. Doctors can’t test DNA, or hormone levels in the blood. Instead, to receive a “transgender” or “transsexual” diagnosis, a patient must be evaluated by a psychotherapist who will analyze the patients’ stories. These stories are about the body, but not about pain, or heat, numbness, or swelling. They are accounts of the patient’s body in particular situations—beginning puberty, choosing childhood toys and clothing, dating, at times of personal meditation (American Psychiatric Association 2013; Coleman et al. 2012). They are situations of moving through a gendered world in a gendered body. As Eric Plemons writes, “[Transsexualism] is a problem not of the body alone but of the body *in relation*”(Plemons 2010:320)

Michel Foucault offers a framework to analyze the body in its relation to the social world. In *The Birth of the Clinic* (1963), Foucault argues that the body is not an object that medicine simply discovers and explores. Rather, the “medical gaze”—the modes of seeing the body based in historical moments’ epistemologies of medicine and health—actively produces the body. In other words, our understanding of the body does not come from the body as inert material we act upon. Instead, we comprehend the body through a specific socio-medical training in how to see and interpret it. Furthermore, Foucault argues these epistemologies, these ways of seeing the body, are socially produced. Indeed, the social produces certain bodies.⁹

But what does this mean for transsexualism? Where on the body does medicine place this condition that’s only symptoms are stories? In “Envisioning the Body in Relation: Finding Sex, Changing Sex,” Eric Plemons argues that while biology may locate sex in a person’s X and Y

⁹ Bloor’s “The Ethnography of Health and Medicine” offers an overview of medical epistemology that is less focused on trans- individuals than my literature review (Bloor 2001).

chromosomes, surgeons find sex all over the body. The suite of surgeries that fall under the category of “sex reassignment surgery” go beyond genital surgeries. Jaw lines, brow bones, Adam’s apples, breast tissue/pectoral muscles, and calf implants, are all sites for surgical intervention.¹⁰ Turning to genitalia, Plemons observes that surgeons consider two outcomes in surgically creating “natural” genitals: “aesthetic and functional” (324).¹¹ Aesthetically, the genitalia that are produced must match diagrams of penises and vaginas in standard anatomy textbooks. And those that more resemble these depictions, are more “natural.” This is the “medical gaze” in action, socially creating the “natural” body.

Dissecting “functional” further reveals the body in its relation to the social world. In order to be considered “functional,” newly constructed genitalia have to meet two functions: urinary and sexual. In short, the new genitals need to allow the patient to control their bladder and release urine. However, function is also deeply cultural. “Functional” genitals are constructed to allow for female-to-male patients to urinate while standing and for male-to-female patients to urinate while seated. In other words, neo-phalluses and -vaginas are constructed to do more than just the essential, more than just bladder control. They are constructed to move through a gendered world in which the “medical gaze” sees that gender and urinating also have to do with posture. Finally, the sexual function of the genitalia should be such that the patient can participate in (hetero)sexual penetrative intercourse. Penises should be long and firm enough to enter a vagina, and constructed vaginas should have a cavity that allows for penetrative intercourse. Thus, function implies a relationality to other humans, and relations to an imagined future of sexual intercourse. Here, one finds the body to be constructed by the social precisely because the “medical gaze” locates gender and sex as

¹⁰ For an account of the suite of procedures classified as facial feminization surgery, look to Plemon’s book *The Look of a Woman* (2017). Specifically, pages 39-42 catalog each procedure part of the overall surgery.

¹¹ See also Plemons (2014).

relational—between the urinating body and the world; between people having sex; between a gendered face, or calf, or Adam’s apple, or chest and the public—all across the body.

Medicine not only has the power to apply social norms to the body—to gender it—but it also has the power to bring normative identities into being. In describing how acts become identity, Michel Foucault famously writes, “The sodomite had been a temporary aberration; the homosexual was now a species” (Foucault 1990:43). In naming “transsexualism,” Harry Benjamin not only described a new medical condition, but he also brought a new identity into being. Meyerowitz, Stryker, and Valentine, likewise, detail how actions—including naming—bring the identity of “transgender” into being (Meyerowitz 2002; Stryker 2008; Valentine 2007). Foucault is a useful framework for understanding how identities are constructed, but his work concerns how identities come to be *known*. That is, Foucault is concerned with epistemologies. My thesis is of course shaped by the epistemological tradition in social science and critical theory; however, I ask not of how objects are known, but of how they exist. Said differently, I will employ my ethnographic data to ask how ontologies of transgender *being* come into reality, rather than how to *know* transgender properly (Mol 2002:6). Foucault, though, is still very useful in understanding the clinic and the epistemological intellectual tradition situates many of the authors that study trans- medicine.

In the final chapter of *The History of Sexuality Vol. 1*, Foucault introduces the term “bio-power” to designate what “brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life” (Foucault 1990:143). Foucault aligns “bio-power” with the development of capitalism, its emergence “an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (Foucault 1990:140).¹² The modern nation-state applies these techniques of bio-power

¹² Foucault makes the point that “sexuality” isn't reducible to the development of capitalism, although capitalism was necessary to sexuality’s development.

to bring about a certain population. Foucault contrasts this with “sovereign-power,” which held a negative influence on society insofar as the sovereign claimed influence over life through their right to kill, or to let live.

Dean Spade provides an application of Foucault’s “bio-power” to trans- medicine in their work “Mutilating Gender” (2006). Spade summarizes “bio-power” as a productive force that does not simply repress and say no, but is one that produces “knowledge categories and behavior that manage and regulate behavior” (Spade 2006:318). In discussing their personal experience trying to find counseling services in order to begin the process of getting a double mastectomy, Spade reveals that medicine as an epistemology produces and reproduces a normative understanding of gender and transgender identities. For instance, Spade writes that the counselors they seek out only deem them to be a “real” transsexual if they pass as male full-time, without hesitation or remorse, so as to be sure Spade won’t regret their surgery. Performing and inhabiting a new gender identity is the primary requirement of gaining a transsexual diagnosis. The ability or “success” of inhabiting this new gender identity—what is known as “passing”—is decided by a medical or psychological practitioner, who will determine the “realness” of the patient. “Realness,” “passing,” “success” at inhabiting a gender are all evaluated against the epistemological norms of the female body as classified by the “medical gaze.” Moreover, because this “realness” hinges on the patient’s ability to perform a dimorphic gender, and is a primary regulating aspect to access to the label of “transsexual”—with its weight of medical access—the “passing imperative” allows trans- to only exist within gender norms. Spade offers us a clear example of bio-power: medicine only knows, and therefore only ‘makes live,’ trans- lives that conform with a societal ideal of dimorphic gender norms.

To further explicate medicine’s stake in bio-power, we can hold Spade’s narrative against a hypothetical one—though one we see everyday—offered in Plemons’ “Envisioning the Body in

Relation.” Plemons writes that if “Jan, a female-bodied person,” wants to enlarge her breasts to an extremely large EEE size, her breast augmentation or “‘enhancement’ (notice the positive language here)” surgery will be performed based on the patient’s desires (Plemons 2010:321). Though “Jan” looks to medicine to alter a sex characteristic, she will not have to see a psychologist to gain access to the surgery because an American/Western “appreciation for large breasts makes Jan’s desire a legitimate one that reflects the gender values of those around her” (321). However, as Spade writes, “most cosmetic surgeons won’t reduce breasts below a C-cup,” and, “breast reduction is a different procedure than the construction of a male-looking chest” (Spade 2006:324–325). Holding Jan’s hypothetical and Spade’s very real situations in comparison reveals that medicine will readily amplify sex characteristics on the body in order to exacerbate sexual dimorphism, but will put road blocks and layers of gate-keeping in front of those that wish to minimize or change the sex characteristics of their natal sex. Thus, pathology is a mode of gatekeeping. A normative *knowing* of a transgender only allows for one for a prescriptive existence. Moreover, trans- individuals’ pathologization indicates that they need to be ‘fixed’ or ‘cured’ so that they may once again fit a culturally constructed ideal for gender and sex. All of this is to say, medicine is situated within bio-power to so as to express, assert, and maintain gender ideals within bodies and the population.

Spade ends their personal journey in “Mutilating Gender” with a reflection on a trans-support group they join. Spade observes that none of the trans- individuals in the group view therapy as the space to voice doubts about transition or to speak of fears and anxieties. Instead, the patients view counseling as a means to an end: telling the correct story to receive a letter of support—the golden ticket on the way to medical transition.

Similarly, Bernice Hausman analyzes the stories presented trans- autobiographies as a tool to understand the ideal narrative of transsexualism/transgenderism in the eyes of medicine in her work “Body, Technology, and Gender in Transsexual Autobiographies” (1995). Hausman argues that

trans- autobiographies are constructed within the parameters of sex, gender identity, and sexuality laid out by medicine. Tracing the auto-biographies over time, allows the reader to understand changing ideas of sex and transsexualism. Hausman reads these autobiographies, many of which demonstrate stereotypical conceptions of gender, as reflections of medicine's requirements to receiving a diagnosis of transsexualism/transgenderism.

Though the gender clinic prides itself on “not having an agenda” in regards to patients' transitions—that is, patients do not need to transition to the binary genders of male or female—the gender clinic and medicine still have many requirements for care. Further research can take on the question of what the biopolitical stakes of these named and unnamed requirements that I name in chapter two are.

Gender

Early work of anthropologists exploring gender across cultures was concerned with the ‘exotic’ (Malinowski 1929; Mead 1935; Clastres 1969; Strathern 1988). These works aimed to show the diversity of gender across the world, and demonstrate the social constructiveness of gender. Additionally, anthropologists have described cultures that include gender non-normative or third gender individuals, further establishing a social construction theory for gender (Käng 2012; Reddy 2005; Williams 1992).

The social construction theory of gender is applied to medicine by Suzanne Kessler, who analyzes case management reports for intersex infants (Kessler 1990). She argues, “The belief that gender consists of two exclusive types is maintained and perpetuated by the medical community in the face of incontrovertible physical evidence that this is not mandated by biology” (Kessler 1990:25). Kessler reflects the feminist claim that sex is not natural, but rather culturally constructed (Rubin 2009; West and Zimmerman 1987). In my thesis, sex will traffic as an enacted reality of gender, following Judith Butler's argument that “sex, by definition [is] gender all along” (Butler

1990a:11), and Susan Stryker's description that sex is "not the foundation to gender... 'sex' is a mash-up, a story we mix about how the body means, which parts matter most, and how they register in our consciousness" (Stryker and Whittle 2006:9). Similar work to Kessler's is done by the biologist, Anne Fausto-Sterling, who's work on intersex conditions argues that sex does not lie in only two distinct categories (Fausto-Sterling 2000a; Fausto-Sterling 1993; Fausto-Sterling 1985; Fausto-Sterling 2000b). Furthermore, Martin, riffing off of Donna Haraway (Haraway 1985; Haraway 1994) and employing Rayna Rapp's work on amniocentesis (Rapp 1999), goes on to argue that scientists are constantly being affected by non-scientists, and that it is impossible to think of science as an empirical outside of culture (Martin 1998:29,26). Martin applies these insights to argue medicine and medical technology shape and are shaped by gender (Martin 2001; Martin 1991). I highlight the constructed-ness of gender and science/medicine's inseparability from 'culture' to demonstrate that the gender clinic is deeply entangled with the world outside its walls. Likewise, the gender clinic is situated in a Western epistemology of gender and the body, which, therefore, means that this work is culturally specific.

My work also engages with Judith Butler's theory of gender performativity. In her book, *Gender Trouble* (1990), Judith Butler claims that gender is constructed through a repetitive performance. Following her argument that discourse creates subject positions that the "I" will come to occupy (Butler 1990a:195)—that linguistic structures construct the self—Butler finds that the gendered subject must perform gender to inhabit it as an identity. By repetitive performance, Butler means gender is "a stylized repetition of acts... which are internally discontinuous, [so that] the appearance of substance is precisely that, a constructed identity." (Butler 1990a:192–193). In short, continued "citation" of the norm makes one a gendered subject; gender is not inherent, but rather

reproduced and learned (Butler 1993:23).¹³ For Butler, gendering is a discursive process, that calls for studies of “the pervasive and mundane acts by which gender identity is performed,” yet Butler’s work, “doesn’t actually engage in such a study” (Mol 2002:39). Consequently, this thesis can be seen as a response to the set of inquiries Butler leaves open: ‘How do people perform gender?’ And as I will ask briefly in chapter two, how does the body as a subject separate from the self fit into Butler’s theory (for instance, see the real body “thought as a nonsocial material” and the phenomenological real body that Salamon proposes (Salamon 2010:92)). While I do not employ psychoanalysis to frame my thesis, my theory of gender and transgender ontology in practice opens up a conversation on the intersubjectivity of the body.¹⁴

Child

While chapters one and two are concerned about gender and transgender in the clinic, chapter three is concerned with how the patients of the gender clinic fit into the figure of ‘the child.’ Specifically, I apply queer theory to interpret how the practices of the gender clinic affect the temporality of childhood. As chapter three reviews this body of literature before engaging it, I don’t wish to present it in full, here. Instead, I feel it is important to use this literature review to review the scholarly work on childhood.

The modern conceptualization of childhood began with enlightenment (Heywood 2017). The figure of the child is conceived as a symbol of innocence, with childhood characterized by a dependence on adults and limited mental capacity. “Adolescence,” the time between the beginning of puberty (the end of childhood) and adulthood, was later coined by G. Stanley Hall in his book by

¹³ Butler also writes, harkening back to Foucault’s biopower and work *Discipline and Punish* (1979), that the “forcible citation of a norm, one whose complex historicity is indissociable from relations of discipline, regulation, punishment” (Butler 1993a:23).

¹⁴ Plemons discusses Butler in conversation with the intersubjective body on pages 119-131 of *The Look of a Woman* (2017).

the same name (Hall 1916). Both the child and the adolescent in the gender clinic are, thus, like gender, culturally and historically specific social constructs.¹⁵

Many fields, including anthropology, developmental psychology, and psychoanalysis have come up with theories of the child, and in particular childhood development. While I don't aim to provide a comprehensive analysis of the theories, I do want to present scholarship that has bolstered the construction of the child. Early 20th century anthropologists such as Margaret Mead explored childhood cross culturally (Mead 1928). Psychologists such as Erik Erikson, Piaget, and Kohlberg have all developed theories of childhood development. Erikson argues that individuals must overcome psychosocial conflicts (Erikson 1959), Piaget suggests stages of cognitive and social development (Wood, Smith, and Grossniklaus 2001), and Kohlberg offers there are stages of moral development (Duska and Whelan 1975). Likewise, the psychoanalysts Anna and Sigmund Freud propose a theory of childhood development involving psychosexual stages (Freud, Strachey, and Richards 1977; Freud 2018). I am not exploring the field of childhood development in detail because as Kathryn Bond Stockton explains in her book *The Queer Child, or Growing Sideways in the Twentieth Century*, while these theories conflict greatly, what they all have in common is that the child always “grow up” (Stockton 2009:11). That is to say, the child is always oriented towards the future. Each of the theories and cultural assumptions of childhood and adolescence that I have presented assume a normative sequence of life events that produce a normative adult.

Many scholars argue that the figure of the child—its innocence—is exclusive to particularly Westernized, sexualized, and racialized youth (Gill-Peterson 2015a; Gill-Peterson 2015b; Gill-Peterson, Sheldon, and Stockton 2016; Stockton 2009; Stockton 2016; Zaborskis 2016; Katz 2004;

¹⁵ Julian Gill-Peterson traces the history of plasticity in the child in the field of endocrinology in “Implanting plasticity into sex and trans/gender: animal and child metaphors in the history of endocrinology” (2017). Preciado further explores the biopolitical stakes of the chemicals and rugs that run through our bodies in *Testo Junkie* (2013).

Bernstein 2011). Kathryn Bond Stockton and Julian Gill-Peterson have argued recently that contemporary youth in the United States may be challenging their place as children as they become sexualized at younger ages (Stockton 2016; Gill-Peterson 2015b). Likewise, Paul Amar has called for a de-infantilization of children, especially children in the global south, so as to take their political and social movements more seriously (Amar 2016). While race, nationality, and socioeconomic status may all challenge the assumption of who is allowed a (Western) childhood, my project positions itself to question how trans- youth experience childhood development, and how they may queer the idea of a normative childhood.

My Contribution

Having surveyed the literature that situates my thesis, we can now explore the contribution my thesis makes to the field. This thesis is first and foremost an ethnography; however, my work positions itself in conversation with not only anthropology, but also gender, sexuality, and feminist studies; science and technology studies; queer theory; and trans- studies. The central argument to my thesis is that *gender and transgender ontologies are enacted through practice. Moreover, the varied ways both human and nonhuman actors do gender and transgender in the gender clinic bring multiple realities of their objects into being. As such, transgender and gender being multiplies.* Inseparable from my ontological claim, is also an exploration of temporality. That is, throughout my thesis *I examine how enactments of gender and transgender rupture, sequence, and drag time, ultimately arguing that in these queer temporalities the patients of the gender clinic construct more livable futures for themselves.*

In chapter one, *Transgender in Practice*, I lay the foundation for my ontological claim. I argue that gender and transgender are enacted in the relation of patients with caregivers, other people in their lives, objects, and infrastructures. I categorize these gender enactments into bodily, linguistic, material, stylistic, and structural practices. Transgender, then, comes into being in the conflict of

gender enactments. Often, enactments of mis/gender¹⁶ from the past appear to haunt the patient in the present, rupturing time to challenge temporally present enactments of the patient's gender identity. Likewise, future enactments of the patient's gender identity can appear in the present as a referential that current enactments of gender are held against. Yet transgender is not an epistemological misunderstanding of gender between male and female or the botching of gender. Instead, I maintain that transgender is enacted as a reality beyond or greater than the dissonant gender enactments that cross the patient's body.

I employ an understanding of gender and transgender as enacted ontologies in chapter two *Enactments in Relation, Transition in Sequence*, to posit that the relationalities between these enactments creates a normative sequence of transition in the gender clinic. I classify the relationalities of the clinic as predicative, obstructive, and justifying. Predicative relations—when certain enactments must precede others—set up the normative sequence of transition in the gender clinic. Obstructive relations foreclose other realities of gender and transgender from coming into being, slowing the sequence of transition. On the other hand, justifying relations bring about enactments earlier than normatively allowed, thus accelerating the gender clinic's normative sequence. This analysis of temporal sequencing allows us to understand that transgender can be enacted both in the alignment and rupture of the normative sequence of transition. Furthermore, the normative sequence reveals a morbid irony of the gender clinic. Namely, the clinic positions itself to alleviate violence against trans- youth, but the gender clinic can only help those trans- children and adolescents who already have the most support. This irony is intimately tied to the original predicate of the gender clinic: the only trans- youth who can access the gender clinic are those with supportive parents. In other

¹⁶ Misgendering means to refer to someone, especially a trans- individual, by the wrong gender. This is often done by using incorrect pronouns or names. I will use “mis/gender” to highlight that these acts (sometimes violently) enact a gender not inline with the trans- individual's gender identity.

words, supportive parents must predicate the gender clinic's medical intervention. This analysis of violence leads me to explore how Judith Butler's performative theory of gender can be applied in the gender clinic. In brief, I engage a discursive understanding of gender to argue for an intersubjective theory of the body and how gender crosses it.

Finally, in chapter three, *Queer Time, Queer Futures*, I move my focus from thinking about the temporalities of the gender clinic to the temporalities of childhood. Specifically, I employ scholarship in queer time and temporality to argue patients transitioning in the gender clinic both queer the chrononormative sequence of childhood, and are queered by their treatment. My work makes a valuable contribution to this body of literature, as I ground it in ethnographic data. In engaging my theory of transgender, transition, and gender as ontology, I demonstrate that the chrononormative sequence of childhood development is similarly enacted through practice. Moreover, I maintain that while queering trans- youth can be a form of violence, following Muñoz, the patients catch glimpses of their futures, the “not-yet-here,” when they lean into queer temporalities (Muñoz 2009:12). In doing so, the patients of the gender clinic construct more livable futures for themselves.¹⁷

¹⁷ Judith Butler discusses the “livable life” in *Undoing Gender* (2004).

ONE

Transgender in Practice

“And here, around the lumen, this first layer of cells, that’s the intima. It’s thick. Oh, wow, isn’t it thick! It goes all the way from here, to there. Look. Now there’s your atherosclerosis. That’s it. A thickening of the intima. That’s really what it is.”
And then he adds, after a little pause: “Under a microscope”
- Annemarie Mol, *The Body Multiple*, (2002)

Each clinical visit at the Gender Clinic begins with three knocks. After a sharp rap on the closed door, the doctor pushes the handle with confidence, entering the consultation room without hesitation. From there, a world of possibilities opens.

The stories within this thesis detail the many worlds that each of these three knocks opens. They tell of chemicals and needles, techniques and technologies, doctors and children, clothing and names. And together, they lend themselves to a theoretical argument, that *transgender as ontology is enacted in practice*. As Annemarie Mol writes, holding the practices of medicine as central to their objects engenders a multitude of realities (Mol 2002:5). When our focus is placed on practice rather than perspective, objects no longer passively wait to be seen by many points of view. Instead, “objects come into being—and disappear—with the practices in which they are manipulated” (Mol 2002:5). In short, they are enacted by practice.

In *The Body Multiple* (2002), Mol traces atherosclerosis and its many ontologies through a Dutch hospital. Here, I want to explore how transgender is *done* in the gender clinic. Transgender in the clinic is enacted differently by (and with) doctors, social workers, families, schools, everyday objects, and the children themselves. And in turn, the reality of transgender—ontology, what transgender *is*—multiplies.

But transgender as ontology is also unruly. Its multiple realities—the multiple ways of enacting transgender—sometimes align, but often conflict or take precedence over one another.¹⁸ And for a child in transition, the sociomaterial practices of the clinic, as well as the ways the child moves through the gendered world outside of the clinic, offer many modes in which transgender can be done and undone. While epistemology tells us how to *know* objects correctly, I argue that the ontologies of transgender are not accounted for in the order of things. Rather, they are brought into being, or permitted to fade away through practice.

However, to understand the multiple ontologies of transgender, we must also consider the realities of gender and the practices that realize their being. This is essential, of course, because gender is what is being trans-d in transgender.¹⁹ “Trans-” as a prefix means “on or to the other side of,” “across,” and “beyond” (merriam-webster n.d.). Susan Stryker, Paisley Currah, and Lisa Jean Moore contend it is common to understand “the ‘trans-’ in ‘transgender’ as moving horizontally between two established gendered spaces, ‘man’ and ‘woman,’ or as a spectrum, or archipelago, that occupies the space between the two” (Stryker, Currah, and Moore 2008:13). These definitions rely on the “across” and “other side” definitions of “trans-.” As such, they reflect an epistemological *understanding* of transgender as a s/p(l)ace of misrecognition—neither essentially male nor female—and an answer to such misrecognition: an identity and category to be included in the order of things. I don’t use “common” here to mean incorrect, simplistic, or crass—many patients in the gender clinic know transgender to mean a horizontal between or across—but in thinking transgender as ontology, I will argue “beyond” as a central definition to the “trans-” in transgender.

¹⁸ Conflicting enactments of transgender will be explored in further detail in the “obstruction” section of chapter two.

¹⁹ Susan Stryker, Paisley Currah, and Lisa Jean Moore call for thinking “trans-” as a verb similar to “queer” in the introduction to inspire scholarship in thinking of trans- as a prefix not solely sutured to gender.

I will employ “beyond” as my analytic because it nods to hope and a future, and references a *somewherenotthere*. Significantly, “beyond” does not indicate fixity or a permanent and definite destination. “Beyond” could be anywhere and may never be reached. This is critical for my argument because in this chapter I argue transgender is brought into being in the conflict of gender enactments.²⁰ However, the object brought into being—transgender—is not a botched gender, or a failure to fit into the order of things. Rather, transgender appears in the conflict of gender enactments as something greater than the dissonant gender enactments. Put another way, trans-ing gender creates an object that is more than just gender. The hyphen in “trans-” points beyond.

To begin our understanding of the many realities of transgender in the child’s body, and for me to further lay out the chapter, we must go back to three knocks and the opening of a door:

Three short knocks and the doctor strides into the last consult of her day. Khalif, a young child dressed in baggy jeans and an orange t-shirt layered over a dark, muted yellow long sleeve t-shirt, is just climbing off of the exam table. The white paper across its beige leather crinkles as the endocrinologist asks if it’s okay if I observe the clinical visit. When Khalif’s mom nods and says, “Yeah, of course,” we take our positions: the endocrinologist sits at the computer, Khalif’s mom stays seated against the wall, I take the chair in the corner, and Khalif climbs back onto the exam table—now sitting up, dangling his legs off the edge.

“How are we doing today?” the doctor asks, both as a pleasantry and a coded way to ask ‘what brings you in?’

“We’re doing well,” the mom replies, “Khalif came into his kindergarten socially transitioned.”²¹ He wears boy clothes and likes his hair cut as a Mohawk.”

²⁰ Conflict, here, and throughout the thesis does not mean a conflict necessarily between male and female. Rather, the conflict takes place between a patient’s enactment of their gender identity and misgender enactments. For some, this means that the conflict is between male and female, but this is not the case for all patients.

²¹ Due to HIPAA (the Health Insurance Portability and Accountability Act of 1996) I cannot reveal any of the patients’ ages. However, Khalif was in kindergarten when he came into the Gender Clinic.

The doctor turns from the files pulled up on her computer to Khalif and asks, “And Khalif, what pronouns do you use?”

“He,” Khalif answers quietly, lowering his gaze sheepishly to his swinging feet.

“Well I use she, her, hers,” the doctor says kindly. “How has school been?”

“Good,” Khalif again says quietly.

“Good,” Khalif’s mom says, “All of the teachers know and are supportive. They use his correct name and his pronouns. We haven’t had any problems with any of the other kids.” As the endocrinologist gets up and starts washing her hands, the mom goes on: “I’m in an online support group for parents with trans kids and I wanted to come in today because I want to know a timeline of when we should start Khalif on blockers²² and T²³.”

The doctor has finished washing her hands and begins the routine of her normal check-up: moving her stethoscope along the child’s chest and back as he breathes, shining a light into his eyes, ears, and mouth. She explains that she starts her patients on blockers when the child begins puberty. Hormone replacement therapy^{24,25} [HRT] normally starts at 16 years old at the earliest, but if the patient has been on blockers for a long time, “and we know the child is trans-, we can start hormones earlier.”

Khalif’s mom and I both sit silently as the doctor continues with her exam. She checks Khalif’s armpits for hair, and his chest for any breast tissue growth. Then, she has Khalif lay back on the exam table. She unfolds a small blue sheet and places it over Khalif’s torso and legs. She asks him to pull down his pants. I look away. “Yep, they’re there!” the doctor exclaims in regards to his genitals. After Khalif pulls his pants back up, the doctor turns to Khalif’s

²² “Blockers” is the colloquial term for “Hormone Blockers” or “Puberty Blockers,” which stop puberty from beginning, or stops puberty if it has already begun.

²³ “T” is short for Testosterone, the androgen hormone that encourages the body to exhibit male sex characteristics.

²⁴ Hormone replacement therapy provides estrogen (the hormone that produces female sex characteristics) or Testosterone (the androgen hormone that produces male sex characteristics) to patients to help them medically transition.

²⁵ The endocrinologist refers to hormone replacement therapy sometimes as “hormone affirming therapy”

mom and explains that blockers can be administered via injections or as a pill, and even as a patch (though the endocrinologist doesn't recommend this because the dosing is difficult).

Khalif squirms when he hears the word injection. "He doesn't like shots," his mom says.

"Yeah, but I'll do the shots for blockers," Khalif says in his high pitched voice, turning to his mom.

The endocrinologist explains that the decision about which method used for blockers is often determined by insurance coverage.

"Is it possible that he's intersex?" Khalif's mom asks, explaining she read Khalif could be androgen insensitive²⁶ on her online support group.

The doctor answers that genetics testing isn't a part of the regular set of tests she gives all of her patients, but that they would figure out if Khalif was androgen insensitive when they started to give him testosterone. With an open palm and fingers splayed, she moves her hand in a circular motion in the direction of Khalif's body. "This would be very normal for androgen insensitivity."

To end the consult, the endocrinologist tells Khalif and his mom to come back in a year or if they start to see any signs of puberty. "Look for breast tissue development first. And that would start at around age nine."

Transgenderism is done in many different ways in this consultation. Khalif's male identity is enacted as wearing boy clothes and a Mohawk haircut. The doctor might describe it as breast development and armpit hair (or lack there-of). Or genitalia. Then there are also names and pronouns, signifiers part of some social contract.²⁷ In the clinic, these instances of boyhood—of "male"—when held next to the "F" that lies on Khalif's birth certificate and in his medical record,²⁸ as well as the doctor's regard for his female-sexed body produce transgenderism. But the objects

²⁶ Androgen insensitivity syndrome occurs in XY individuals who are resistant to androgens (what medicine would call 'male' hormones) causing these individuals to have female physical traits (though these individuals have internal testes instead of ovaries and a uterus).

²⁷ Butler (1990)

²⁸ I did not have access to medical records as an undergraduate researcher, but the category "sex" does appear there.

here—male gender and transgenderism—are also done in the interactions of Khalif using “he” pronouns, and when the endocrinologist checks for signs of female puberty, or when she recommends blockers to stop future female corporeal development.

Who—or what—then, does transgenderism? In Khalif’s case, we see his gender is done by people: his mom, and teachers, Khalif himself, and the doctor in the clinic. As well as words. In telling his mom, or his teacher, or his classmates, or his doctor that he is a boy, Khalif calls his maleness into being where “girl” once was. It is a speech-act.²⁹ The clinical space also takes part—its rooms and exam tables. And there is the paperwork that designates his sex and gender identity, Khalif’s pronouns and chosen and legal names. Also X and Y chromosomes. And the chemicals that may enter his body in the future, plus the insurance system that regulates this.

But I argue Khalif’s male gender and his transgenderism are multiple because pronouns are not a lack of breast tissue, which are also not haircuts. Yet gender *is* all of these things. This is what it means to hold Khalif’s male gender as multiple. Transgender materializes when Khalif’s gender enactments are held against one another. When an “F” stands next to “he” and when the doctor discusses chemicals that will foreclose a particular form of bodily development. So transgender is multiple, too. This is what I will explore. How gender and transgender reality multiply. And how these multiple ontologies relate and conflict and manage to hang together.³⁰

Because I will be tracing the socio-material practices of gender that cross the child’s body and the gender clinic, it is tempting to organize this chapter categorically by modes of gender enactments. And as we will see, these enactments do fall into categories: stylistic, linguistic, bodily, structural, and material. However, the patients of the gender clinic live complex lives in which they contemporaneously enact gender and transgender in multiple ways. Moreover, I will argue that

²⁹ Butler (1990)

³⁰ “Hang together” comes from Mol (2002:55).

transgender is always enacted in relation.³¹ Of course, relation includes the conflict of gender enactments, but it also refers to an interaction with other actors and objects in the world, as well as a relation to the past and/or the future. For the patients of the gender clinic, past enactments of gender continue to haunt their present. The present often ruptures, allowing the past to touch the present and conflict with current realities. Likewise, the future often appears in the present, the hope of future enactments acting as a referential for the present.³² On the whole, such intricate and entangled lives don't lend themselves to neat separations. Consequently, though categories of enactments track throughout my thesis, I organize this chapter around an emic separation of "social" and "medical."³³ First, I track "social" enactments, those that the gender clinic holds occur outside of the gender clinic. I next argue the gender clinic problematizes the antipodal distinction between "medical" and "social" even in its continued use of these terms. And finally, I unpack the "medical" enactments the gender clinic's intervention aims to affect.

Now that I have stated my claim, we will need to unpack it one step at a time. It is hard to know where to start; like I've said, transgender is unruly. It's messy and convoluted. But why don't we start where I begin all of my field notes: an outward description.

The Social

When I'm first introduced to Max he's quiet. We're in a consultation room with jungle decals on the walls. Lions and monkeys smile at us from all directions. Yet, despite these happy figures, Max seems intimidated by the

³¹ Plemons (2010)

³² Chapter three will be a deeper interpretation of these temporal ruptures and the importance of futurity in the gender clinic.

³³ Here, it may be tempting to analogize medical and social with nature and nurture. However, the nature/nurture debate implies an etiology that doesn't openly or commonly traffic through the clinic. Instead, distinctions are made between social transitions and medical ones, social (non-clinical) spaces and medical ones, etc.

space. Hospitals are scary to many children; I had the same fear as a child. But I also remember that Max is on blockers, so he has been coming to hospitals for a while now. Maybe it's my presence that is making him shy.

Max and has fairly straight, light brown hair, the kind that may have been blonde when he was younger and will continue to get darker. Max's hair is cut short with a swoop of hair on his forehead. He touches it, arranging and rearranging it, constantly. Pulling it across his forehead and out of his eyes. At this clinical visit he's wearing grey sweat pants and a blue long-sleeve t-shirt with a Ninja Turtles graphic on the front. To build rapport, the doctor says that she, too, likes the Ninja Turtles and that Max's shirt is "pretty cool." This gets a smile out of Max.

He smiles again when, after complaining that his mom gave him too long of a haircut, the endocrinologist says it looks great. She even turns to me as the only other non-family member (i.e. unbiased bystander) in the room to back her up. "I like it," I say, thinking it looks like a haircut many elementary school boys have.

I want to pay close attention to what Max is *doing* in the consultation room. Max *does* "boy" through his haircut and through the clothes he chooses to wear. For Max, one way of being a boy *is* having a short haircut and wearing clothing with Ninja Turtles. These are social norms and stylistic enactments that indicate his gender to the world and to himself. Even in this small example, we see that gender *is* clothing and gender *is* a haircut. However, the transitive property does not apply here: clothing is not the same thing as a haircut. Yet gender happens *to be* both of these things.

What's queer about this situation, though, is that Max was once a girl. In fact, legally, he is still female. When I interviewed him,³⁴ for legal/IRB³⁵ purposes, I had to take down his legal, female name. In the clinic, an "F" stands in Max's medical record to denote this. When the structural enactment of female gender in the "F" is held against a speech act like 'I am a boy,' or choosing

³⁴ With his mom present. All patients under the age of twelve had to have a parent present. Those twelve and older could participate in the interview one-on-one with their parent/guardian's consent.

³⁵ Institutional Review Board, the committee within a hospital that monitors the ethics of studies and approves the methods proposed for research

“boy’s” clothing or a “boy” haircut, “transgender” begins to appear.³⁶ However, Max has not chosen to enact female or girl with the “F” that marks his medical record. In fact, I would guess he would rather leave that “F” behind. Yet the “F” that landed on his birth certificate and medical record when Max was born with female genitalia continues to haunt the present. Notably, it is not the genitalia themselves that enact female in this scene. The doctor has not done a genital examination in this clinical visit. Rather, gender enacted in state and medical institutions and infrastructures as read on Max’s medical record ruptures the present to bring the past event—“It’s a girl”—in contact with Max’s present enactments of male gender. Only then does transgender solidify into an object. Transgender does not exist on its own. Transgender comes into being, here, when Max *does* male, yet a past enactment of female appears—and continues to appear—to haunt the present. In the conflict of these gender enactments, transgender arises.

Let’s look at part of Max’s interview:

Max is much more energetic in the interview than when I saw him at the clinic. He’s happy to be doing the interview and well-spoken for his age. I’m grateful that his mom is in the room with him because she sometimes gives background that Max has forgotten.

Midway through our conversation I ask Max, “what does transitioning from a girl to a boy mean to you?”

Max responds, “I think it means that was my past, but here’s the future now. And, like, I changed.”

Max’s mom cuts in before I can respond, “what does it mean that you made your transition for your trans-versary? What did you do?”

“Oh! I got my hair cut all the way off and [my parents] bought me boys clothes. I have boy toys and I have like, boy bikes and scooters and I play with Army stuff, and (short pause) I play with Nerf guns. And I like Legos.

³⁶ I am not suggesting that shopping from the men’s section or having a short haircut makes everyone assigned female at birth trans-, real world examples—for instance, “butch” identifying/presenting women—demonstrate this is false.

And tool sets and cars,” Max says excitedly in his sing-song voice. “We also used my [male] name and my class knows my pronouns are ‘he, him, his.’”

“There’s also the bathroom, thing,” his mother adds at the end. This in reference to an arrangement that was made about bathrooms at the school, but I never got the details.

Again, Max repeats his emphasis on cutting his hair and wearing clothes for the boy’s section as stylistic ways he enacts boyhood. But Max also describes bikes and scooters and toys that he deems make him male or masculine in his interaction with them. He didn’t start playing with these objects on his “trans-versary”—the day he came out as trans- at school—but they are ways that he *does* boy gender. Max enacts boyhood using materials outside of his body, but transgender is done when these material enactments are related to a past. Max’s “trans-versary” marks a relation between the present and the past. Enacting girl stylistically and material with long hair and ‘girl toys’ is replaced by enactments of male. It is in comparing Max’s gender identity in the present to past enactments of gender that transgender—and a trans-versary—come into being. Here, another reality of transgender is added, both in new enactments of gender and in how the past is related to the present.

A similar multiplication of gender’s ontologies happens in Max’s use of male pronouns and a male name. These linguistic enactments of Max’s gender identity are done in a register that requires others to enact gender with him. ‘My name is Max,’ and, ‘I use he, him, his pronouns,’ are both speech-acts, but they gain meaning through interpersonal relations. Alone, they mean very little, but in their sociality, they demand a social enactment of one’s gender identity. This is clear to see for linguistic enactments of gender, but is also true for all of the other modes of gendered enactment. As Wittgenstein notes, a private language has no meaning; in fact, it is no language at all (Plemons 2010b). Rather, Max’s enactments of gender gain their significance through a culturally shared language around gender. This is true of all of the enactments in this thesis. Doing gender and

transgender mean intersubjectivity and sociality. Max can only do “boy” through toys if others understand the practice of interacting with those toys to be masculine, too. Max then enacts a reality of transgender when these current realities of gender are held against his birth certificate or the past—that is, what people used to call him and what pronouns they used.

The stakes are high surrounding the linguistic enactments of gender—pronouns and names—for many trans- people. For most of the patients in the gender clinic, these linguistic enactments are a first step in coming out as, becoming, doing, being transgender. I asked in my interviews with patients, “What did you do after you came to the realization you were trans-?” To which Javier, a “trans-masc/trans-male” teenage patient in the clinic, explained:

“At first, it was a little bit of me trying to figure out if this was what it really was, and I talked to my friends about it and they helped me by asking, ‘Oh, well, would you rather be ‘they’ or ‘he?’” So I started off with ‘they’ and then we did ‘he.’ And I felt a lot better as ‘he’ and ‘they’ than ‘she.’ And my friends helped me find a name that would be more masculine, because my birth name was very feminine. We decided on my name, and I talked my mom about it... We picked out a couple of names that we liked and we settled on my name as a group: my friends and my mom.”

Names and pronouns, linguistic objects with significant gendered values, are ways that Javier creates his trans-masc/trans-male identity *with* his friends and family. Transgender and gender come into being via the socio-relation acts of using male and/or gender neutral pronouns and (re)naming.

Troubling the Social vs. the Medical

The gender clinic may seem outside of the social. Within the walls of a hospital, its purview may appear to be only the body. However, medical anthropologists have continually shown that the clinical setting and the body are both highly social and that the world outside of the hospital seeps

into the clinic.³⁷ While the gender clinic has no such isolationist fantasy, it does employ a language of “social” versus “medical” transitions. That is to say, the gender clinic understands its intervention to be both a medical and a social one, thus opening pores in the distinction between these terms. Yet as part of a Western medical tradition the gender clinic continues to use the language of dyadic social and medical opposition.

In its name, the *gender* clinic already breaks the sex/gender framework that assigns sex to biology and medicine, and gender to culture, psychology, and sociology.³⁸ Moreover, the gender clinic describes itself as “multidisciplinary,” meaning that it assembles a holistic care team for each of its patients. If a patient is in need or so desires, they can be referred to a nutritionist or a spiritual care provider as well as voice coaches and transition specialists.³⁹ The gender clinic also has close ties to trans-friendly OB-GYNs, plastic surgeons, psychologists/psychiatrists, and family medicine doctors in the region whom patients can be referred to. In this way, the gender clinic views transgenderism and transition as not solely an endocrine intervention. Many other facets of medicine are involved. However, in the everyday of the clinic, what “multidisciplinary” means is that nearly all of the patients are seen by a clinical social worker as well as the endocrinologist, and that these two work closely together.

A crass divide could be made in which the social and the medical are separated between the clinical social worker and the endocrinologist, respectively. And while the endocrinologist is the only one that can order labs or write a prescription, and the social worker asks more in-depth questions about mental health, home life, and bullying, both caregivers understand their care as inherently

³⁷ Bloor 2001

³⁸ See the literature review, especially all of Anne Fausto-Sterling’s work.

³⁹ Transition specialists are not associated with the hospital network the gender clinic is a part of. They are private “coaches” that help patients train their voices and alter their mannerisms to present in a more masculine or feminine manner.

both social and medical. In describing beginning hormones, the social worker tells me, “it doesn’t mean that their social transition has ended when they start hormones, but [it] augments their efforts.” Similarly, the doctor describes that the clinic aims to treat misalignment, “the fact that their identity doesn’t match their body.” It may not be that the social and the medical are one in the same; however, for the gender clinic, they are too entangled to separate.

In truth, when I began this project, I wanted to find a medical/social distinction. It seemed so simple: the (medical) doctor works with a medical transition, and the social worker with the social transition. It’s even in their job titles! But as this work demonstrates, transgender is messy. It seems to almost fight against classification. Its enactments hang together at the nexus of the social and the medical. In this way, transgender is a perfect object to argue that its ontologies are more than one (both social and medical) but less than many (not fractured or separated).⁴⁰ That is, though transgender *is* many things, transgender does not become obscure to the patients or the gender clinic in its multiplication. Transgender as both social and medical offers a social-medical divide as too porous to authentically make.

To understand how permeable this divide really is, as well as how the social permeates into the medical space, and how transgender and gender are enacted, let’s follow two scenes for a moment—one of a new patient, the other of the workroom.

When a patient enters the hospital, they go up a floor and head to the check in desk the gender clinic shares with other pediatric clinics. There, knowing that this would be the first place the patient would interface with the clinic, the social worker trained the front desk staff to ask about chosen names and pronouns. The social worker also placed a small sign at each check-in station that reads “We value diversity, please tell us your pronouns.” Signs in a similar

⁴⁰ Mol (2002)

vein adorn the doors to the bathrooms and consultation rooms. When the patient checks in, their chosen name (if it hasn't been legally changed) is entered into the medical record under "preferred name" and their pronouns are noted.

One morning, both the endocrinologist and the clinical social worker are running late. "I've paged 'em, but I don't know where they are," Erin, one of the regular nurses in the gender clinic, says in her Irish accent. I don't often get a chance to observe the nurses because I spend so much time shadowing the doctors and social workers, so I welcome the doctor and social worker's unusual tardiness. Erin hesitates when writing the first patient's name on the whiteboard that serves as a schedule for the day. "I can't tell which is his legal name," she says out loud, though I'm not sure if this is for me or if she's just talking to herself. "It doesn't say his gender." I note her use of male pronouns, even though she's not sure of the patient's gender, in my field notebook.

No matter the workroom—whether the Gender Clinic is placed in workroom A with genetics or is moved to workroom D when pediatric cardiology has an afternoon off—the nurses draw the same table on the whiteboard near the entrance and under the clock. In fact, all of the nurses in each clinic (cardiology, genetics, etc.) write the same table. "Appointment time, patient's name, room number, initial"⁴¹ are written across the top of the board, and the appointments are written chronologically down the board. The gender clinic is anomalous in its schedule because the nurses sketch out the schedule for the day, but also add the columns: "preferred name, pronouns, gender identity." Gender is transcribed as "M" or "F" under the gender identity column, and "He/him/his," "She/her/hers," or "They/them/theirs" lie under pronouns.

Just as Erin finishes the table on the whiteboard and writes "Fri-yay", the endocrinologist walks in. "Mr. J is ready and in room four," Erin says to the doctor. Then she asks, "This is his real name, right?" pointing at the folder in her hand and then the whiteboard schedule.

⁴¹ "Initial" stands for the nurses initials, which they sign when the patient has filled out their intake forms and is ready in their room.

These two scenes demonstrate how transgender is transcribed in the clinic, how it is enacted in techniques and modes outside of the body, how it leaves a material mark, and how it co-opts existing structures. On the whiteboard gender is enacted as preferred name, gender identity, and pronouns. Transgender ontologies emerge in the contrast of the patient's preferred name, gender identity, and pronoun enactments and the "sex" that also appears prominently in the files Erin reads from when constructing the table. Transgender as a conflict of enactments makes itself apparent in Erin's question of what a patient's name *is*, a coded way to ask what the patient's gender *is*. This transcription of transgender, an enacted ontology, excludes many other realities of gender and transgender: it is not haircuts or toys played with, and it is not genitals or developing breasts. Instead, gender is done with the materials of whiteboard and marker, with transgender appearing as these enactments are held against "sex" rearing its head in the present. These tables are wiped away at the end of each day, but transgender manages to coopt the existing structure of the pediatric clinics in the form of the daily schedule.

Likewise, transgender makes its way into the medical records. Though a patient's name cannot be changed in the medical record without legal documents, patients are able to enact their gender as preferred name in the (digital) medical space. Finally, in the first field note gender is enacted by pronouns and inclusive signs, transcribing itself onto the physical space of the clinic. Gender suddenly becomes something located not in chromosomes, hormones, bodily tissue, or even the mind—the classic western medical understanding of gender (and gender as sex). Rather, gender in the medical space takes the form of posters, whiteboards, and polite questions around pronouns. Transgender, in turn, is enacted when the staff that work the front desks only ask patients what pronouns they use if a conflict of enactment arises, making patients appear trans-. That is, patients become trans- in the linguistic and structural interaction of a patient's pronouns and their sex

assigned at birth, or in conflicting bodily and stylistic enactments of gender. Only when disagreeing gender enactments are held together does transgender appear and pronouns are asked for.

These field notes show that in the gender clinic, gender is not solely located in the body. The skin does not limit the s/p(l)ace for its enactment. However, gender as “social”—that is, something located outside of the clinical space—also appears in the clinic. Gender enactments that occur outside the clinic’s walls manage to breach the medical/social border. To understand this, we can continue to follow a hypothetical new patient where we left off at the reception desk.

Once the patient has checked in, they also receive an intake packet. Actually, two packets: one for the parent/guardian and one for the child. They are thick and take a long time to complete. Though the packet is supposed to be filled out before the doctor or clinical social worker see the patient, on busy days (of which there are many) the patient and their parent are sometimes unable to fill the paperwork out before the doctor or social worker must see the patient to stay on schedule. Though I have never completed the intake packet, it is good fodder for conversations when the patient’s parent and I are momentarily kicked out of the exam room while private examinations are done.

The clinical social worker collects these packets and analyzes them to “learn where [the patients] feel they are on the spectrum of gender” (as well as, if the patients have mental illness). At the time of my fieldwork, the questionnaires and scales the clinical social worker are using are in flux: some are being replaced by newer, less gender binary scales. However, in the hectic world of the gender clinic, patients are sometimes given the non-updated packet. Between the former and new packets, scales are used to measure body image, gender dysphoria, pediatric stigma, recalled childhood gender dysphoria, recalled childhood gender identity experience, and gender queer identity.

Transgender, or at least some of its realities, arises from the pages of these packets. Questions such as “have you ever felt uncertain about your gender?”⁴² that ask the patient to circle

⁴² (Deogracias et al. 2007; Johnson et al. 2004)

their satisfaction with different body parts⁴³—those that are considered secondary sex characteristics⁴⁴—or that have the patient agree/disagree with statements such as “I feel unhappy if someone calls me a boy”⁴⁵ allow the patient to enact transgender. This is to say, when the patient marks X’s that “agree completely” to wanting to be treated as a boy, or they circle 5s that indicate dissatisfaction for breasts or facial hair, the patient indicates realities of gender being done or undone (or unable to be done). In the consequent comparison of present, future, and past enactments of gender, transgender comes into being. In addition, through the technology of the intake packet, the patient’s “social” life—or at least stories of them⁴⁶—is brought into the clinic and into a quantifiable measure. Gender and transgender enactments located in the “social” cross into the “medical.”

However, transgender does not appear independently out of these pages. Alone, the packet does not *do* transgender. Transgender and gender do not exist in blank documents. While the technology of these scales may be a tool for medicine and psychology to *know* the object of transgender—an epistemology—transgender cannot be done, cannot exist, without a patient to fill out the survey. A patient must participate, recall, mark, circle, describe. The social worker must later calculate, note, interpret, and analyze. Foregrounding practice it becomes clear that only together—a patient, a packet of questionnaires, and a clinical social worker—does transgender materialize. In concert, these three—two people and one technology—enact transgender as a set of scales, measures, and surveys.

These measures are far away from injecting a hormone into the body. But they bring the outside world into the clinic. Moreover, they are necessary to predicate medical treatment. All of the

⁴³ (Webb 2015)

⁴⁴ Sex-differentiated characteristics that arise during puberty. For instance, facial hair.

⁴⁵ (Schneider et al. 2016)

⁴⁶ Plemons (2010) and Spade (2006) describe the stories of gender told in psychotherapeutic sessions

patients in the clinic have a diagnosis of gender dysphoria by the time they receive treatment. This is not a coincidence, but rather a requirement of the World Professional Association for Transgender Health (WPATH)⁴⁷ for patients to begin hormone replacement therapy or blockers. While gender is enacted by surveys and in the the clinical social worker’s evaluation, patients must also have a “letter of support” from a psychotherapist to begin their medical transition. Many of the patients in the clinic have mental health problems that, as the clinical social worker describes, “sit adjacent to their transgender identity.” For instance, many patients suffer from anxiety and depression, sometimes caused by bullying. This letter serves to confirm the patient is mentally healthy enough to begin a medical transition,⁴⁸ that they have a professional to turn to for counseling as they begin a medical transition, and that the patient (truly) identifies as a gender that does not associate with their natal sex.⁴⁹ Transgender is thus imported into the clinic from the office of a psychotherapist. In this way, the patient does transgender by recounting stories. These stories span across time and space, and, as I describe in the introduction, are stories in relation to a gendered world.⁵⁰ Their prominence in medical care for the patient also shows the object(s) of interest—transgender, and gender dysphoria to a secondary degree—travels from the patient’s life, into the psychotherapist’s office, and then via a letter to the gender clinic. In its multiple enactments (we can see all of the categories, here), transgender moves across spaces and temporalities from the “social” into the “medical.”

One reason patients must have a diagnosis of gender dysphoria before receiving treatment is that gender dysphoria is an object of the gender clinic’s medical intervention.

⁴⁷ (Coleman et al. 2012)

⁴⁸ This does not mean that patients cannot have mental illness(es) before beginning a medical transition, but that their transition won’t exacerbate their mental illness(es).

⁴⁹ I explore “knowing” a patient’s gender identity in chapter two.

⁵⁰ Plemons (2010)

Interviewer: “What is this clinic directly treating? What I mean by that is that transgenderism is not a disease. It is not in a pathology textbook. So what would you say you are treating?”

Endocrinologist: “So really what I’m treating is people’s dysphoria about their gender. And the fact that their identity doesn’t match their body. And you know, some people who are transgender don’t need medical treatment, but some people do. And my goal is to relieve any dysphoria they have.”

More than just a requirement from the WPATH’s standards of care, treatment of gender dysphoria is part of the clinic’s logic of care. However, gender dysphoria is a mental health diagnosis. To diagnose it, a psychotherapist uses the Diagnostic and Statistical Manual of Mental Disorders (DSM–5).⁵¹ Yet an endocrinologist, a doctor concerned with hormone levels in the body and whose other clinics involve treating children with diabetes and thyroid problems, offers treatment. Gender dysphoria, then, is both a problem of the mind and the body. And because gender dysphoria is medicine/psychology’s epistemological understanding of transgenderism, it becomes clear that transgender’s multiple ontologies exist both in the mind and on/in the body.

The gender clinic’s doctor believes she is treating a mental health condition, so I ask the clinical social worker the same question: “what is the clinic treating?”

“Gender dysphoria being part of what one might consider we are treating. [That is,] the condition of distress, by helping one to align. The other thing that we are treating... we are treating a hormonal imbalance. And we do this with kids with differences in sex development, with diabetes, with lack of certain hormones because they don’t produce them.”

In the clinic, transgender is gender dysphoria, ‘misalignment’ and its consequent distress, but transgender is also enacted as a hormonal imbalance. However, because a psychotherapist’s letter of support is necessary before a medical transition can begin, in the clinic, an enactment of transgender

⁵¹ (American Psychiatric Association 2013)

as mental distress must predicate an enactment of transgender a hormonal imbalance. I will further explore this predicative relationship in chapter two, but I bring it up here to point out that transgender moves from the “social” to the psychotherapist’s office, through a letter into the clinic, and then into the patient’s body. In the psychotherapist’s letter, the measures on the intake packet, and the consultation with the clinical social worker, transgender and gender are enacted with knowledge. “Gender dysphoria” is written down as the finding. To get there the social worker and the psychotherapist probe with questions; they learn, they judge. The product of their findings—a diagnosis—is a representation of an object—transgender—which can be written in a medical record or on a letter. It is data that can be calculated, translated, and can travel. Transgender *is* many different things in this schema, and it moves fairly easily across the distinction between “social” and “medical.”

The Medical

A medical intervention, on the other hand, enacts its object through altering it. Interventions don’t try to know their objects better, but aim to improve their condition. While diagnosis uses communication (talking, writing, filling out forms) to know its object, therapy seeks material changes. And because there is no psychological treatment—intervention—for gender dysphoria, the body becomes the avenue for intervention. In the clinic, the caregivers make this switch seamlessly.

Imani is tall and seems to glow with positive energy. Her dad is with her at the consultation. They’ve just moved about 2 hours away from the clinic from California, where Imani recently started HRT—estrogen therapy, in her case—after having been on blockers.

“Well, we’ve gotten all of your files and labs transferred over to us,” the doctor says looking down at her file, “I see you’ve got your letter of support.”

The doctor leafs through the intake packet as Imani explains she's "really excited to have some breast growth." Turning to me, Imani exclaims, "I know they're small right now, but it's just so exciting!" Her tight curls spring up and down as Imani herself bounces, sitting on the exam table.

"Your labs look good. I see your taking estrogen every other week. Where are you injecting it?"

Imani points to her thighs. "On the front of my legs. Right here."

After washing her hands, the doctor conducts the physical exam. Imani's father and I step out of the room where he tells me he played football for some college I've never heard of as the doctor completes the final parts of the physical: the genital and the breast exams. In sum, the doctor has checked the patient's ears, nose, and mouth, her reflexes, her stomach, her lungs, and her heart. She also checked for any facial hair growth, penile and testicular growth, breast development, and body hair. Everything checks out. There's been no penile or teste growth because of the estrogen. Likewise, for the facial hair. As Imani noted, she has had some breast development and will continue to see growth there as the estrogen continues.

The doctor tells Imani and her father that the clinical social worker will be in soon to see them and that they should schedule a follow up appointment for four months.

In this scene from Imani's visit, gender is the growth of breasts (and lack of growth in the penis and testes). Gender is also estrogen levels. When holding these bodily enactments against the letter from a psychologist and the intake packet, transgender is enacted. The endocrinologist flips between reading a blood test that shows estrogen and testosterone levels, to palpating a breast and checking for testicular growth. But hormones are not tissue. And tissue is certainly not a psychological diagnosis of gender dysphoria. Yet transgender is enacted by all three of these things. The doctor shifts between these enactments of transgender, some bodily, some structural, and in doing so, we see these multiple realities manage to hang together.

One way to think about the alignment of enactments—their movement towards singularity—is to understand how they communicate gender. From Imani, we see that in the cultural

language of gender, breasts are read as female. This leads Imani to appreciate her recent growth of breast tissue, while other patients wear bras (possibly with implants) to enact female as breasts. Still others will go on to have “top surgery” when they are eighteen to augment their breast tissue. All of these enactments aim to engender the same result: breasts. Yet they go about it through different means. This convergence can be seen in other bodily enactments of gender: binding and top surgery (breast removal), tucking and bottom surgery⁵² (vaginoplasty), voice training and testosterone (for deepening of the voice), etc. All of these enactments are different, some are stylistic, some are bodily. Many blend the border between the two. Yet, they lead to similar results. This pattern can be further extrapolated to all of the gender and transgender enactments in this chapter. Stylistic, linguistic, bodily, structural, and material enactments of gender are all different, yet their object hangs together at the nexus of these realities.

In the gender clinic, gender is enacted corporeally as the growth, loss, suppression of the material body, but this enactment cannot be done without technologies and objects outside of the body. Transgender and gender are relational because they exist in the clinic only when a caregiver and a patient (and possibly the patient’s guardian) come together. But even then, these actors are not always enough to engender certain ontologies of gender and transgender. They need something more. A technique. A tool. A method. And while analyzing these technologies reveals how medicine knows its objects—gender and transgender (in/on body)—gender and transgender as ontology do not materialize until an action occurs. Until the patient, the doctor, and the technology come together to *do*.

Turning back to scenes from the clinic, this field note elucidates how gender and transgender emerge in the (active) relationship between technology, the patient, and the caregiver.

⁵² Bottom surgery for both phallic and vaginal construction is often called sex reassignment surgery (SRS).

A few days during my fieldwork at the clinic, a family medicine resident sees patients and trains under the endocrinologist. I'm surprised at first when I see her. I hadn't realized residents train with this clinic. But the resident is interested in LGBTQ+ health and has devoted a significant amount of her training to working in the gender clinic.

I follow her into a consult with a young teenage patient, Sofia, who is seeking medical assistance in transitioning from male to female. The Sofia's mother is with her, and seems fairly supportive, though voices that she would like some more information. After asking the standard medical history questions, and having a conversation about what the patient desires, the resident has Sofia sit on the exam table. The two then begin the choreography of a physical exam. The resident leads. She tells Sofia to open her mouth, say "ahh," "can you follow my finger with your eyes?" and Sofia follows in (metaphorical) step. This isn't Sofia's first visit to a doctor and she knows the script of a physical fairly well. The resident's "This will be a quick tap with my stethoscope to check your reflexes," "I'm just going to check your heart beat," "Three deep breaths," and "Can you lift your arm for me?" move the physical exam along. Finally, the resident asks, "Can you lie down here?" patting her hand where she'd like Sofia to lay her head on the exam table. "I'm just going to take a quick look at your genitals," the resident says. Sofia knows to lie flat and still. The resident pulls up on Sofia's waistband.

When we get back to the workroom, the resident says she thinks Sofia is "tanner two, or maybe three." She explains to me that there are five tanner stages—tanner one being pre-adolescent, and tanner five being post-pubescent—and that they're important because blockers are only effective on tanner two (sometimes three) or lower patients. She has some hesitancy though about Sofia's tanner stage. "I didn't palpate the testes. I just visually inspected them." The fellow also training with the endocrinologist that day then pulls out what looks like a necklace of green beads from her bag. "Here, you can use these," the fellow says. Each bead associates with the teste size of each tanner stage.

Sofia demonstrates that gender cannot be done in the clinic without technology. Testes enact puberty in their size only when they are referenced against tanner beads. Likewise, chromosomes can only enact gender (as sex) as XX and XY (or the many intersex permutations) through genetic

screenings, hormone levels can only be a reality of gender through a blood test, and the endocrinologist must employ the technology of the patch, the pill, the implant, or the injection. In short, “medical” realities of gender only come into being through the use of technologies, tools, and methods.

Hormones offer a special case of bodily gender enactments. They are obviously central to the endocrinologists intervention, but they also have a dualistic property of acting as a technology or tool for change, and also an enactment of gender themselves.

Interviewer: “When you’re thinking about, for instance, a male to female patient, what are you trying to do medically for them?”

Doctor: “As the endocrinologist what I’m trying to do is to help their bodies aligned more with their gender identity. So for that specific group I would try to decrease the amount of their own hormone, so testosterone, so that that wouldn’t be interfering and continue to masculinize them. And I would give them estrogen to feminize them... The goal is to take them within the normal female range... We want them to totally align as much as they can with their gender identity both physically and emotionally.”

Interviewer: “And again for a male to female patient, what do you want these hormones to do in the body?”

Doctor: “So the estrogen we really want to do (short pause). The goal is to give more feminine features including fat distribution that’s more in the hips and the breast rather in the abdomen. Softer skin, less hair growth especially in the face. We would like for softer facial features, less muscle mass. Breast development of course, that would be key.”

For the doctor, gender dysphoria is the *reason* to intervene (medically), but corporeal changes—in muscles mass, body fat distribution, breast growth (or lack thereof), genital growth (or lack thereof), facial hair growth (or lack thereof), voice change (or lack thereof), larynx/Adam’s apple growth (or lack thereof), hand and foot growth (or lack thereof), (stopping) menstruation, facial features/softened skin, and hairline—are the *objectives* of her medical intervention. This is a

discordance. ‘Misalignment’ and a suite of bodily loci offer a different object diagnosed than the object that is treated. Hormones act as the link between these two objects

The doctor explains, “the changes that we are talking about are physical changes that happen with the tool, hormones.” But, as the clinical social worker notes, for the trans- child hormones are also “‘imbalanced;” they are something to be brought into, what the doctor describes as, a “target range.” Hormones are both a technology, a method towards a target of corporeal modification, and a locus of change, themselves. Estrogen is what the doctor “would give [the patients] to feminize them, to allow more feminine features to develop, and for them to feel more feminine,” *and* hormones are “parts of sex that [we are] trying to match with gender.”

There is an incompatibility because transgender and gender are multiple. In the clinic, they are not enacted as singular realities. Transgender and gender are done as bodily transformation, as hormone levels, as gender dysphoria. It is all three of these realities. But it is not all of them at once. Clothing does not show up on the lab test alongside a patient’s estrogen and testosterone levels. Likewise, a syringe, patch, or pill is not necessary for a patient to be addressed by their pronouns and chosen name.

However, transgender and gender are not fragmented. Their multiplication is not grotesque; their proliferation does not obscure. In foregrounding practice, we see that gender’s enactments are multiply over different spaces and are done with different technologies by and with different people. Yet they still hang together at the nexus of these multiple realities under one name. When these gender enactments come into conflict, transgender as ontology arises. I have offered five categories of enactments—stylistic, linguistic, bodily, structural, and material—that track throughout this chapter. They are found both in the realms of the “social” and the “medical,” and prove the distinction between these s/places to be porous. Moreover, transgender appears as an object in relation, not only to the actors and objects that populate gender enactments, but also in temporal

relation to the past and the future. Gender enactments rupture the present to haunt from the past or act as a referential from the future. In their opposition to current enactments of gender, transgender ontology is enacted.

TWO

Enactments in Relation, Transition in Sequence

What I'm trying to do is to help their bodies align more with their gender identity.
- The Endocrinologist

Coordination into singularity doesn't depend on the possibility to refer to a preexisting object.
It is a task. This is what designing treatment entails.
- Annemarie Mol, *The Body Multiple*, 2002

If chapter one lays the basis for my claim that transgender as ontology is a specific bodily/material experience that arises from conflicting enactments of gender, chapter two is a deeper exploration of the relationships of these enactments. In chapter one, foregrounding the practices of the gender clinic reveals that gender comes into being in socio-material practices that cross the body. Transgender ontology, in turn, is *done* as these practices are held against past enactments of gender that continue to haunt the present and future, referential enactments of gender. Chapter two stays in the temporal present, but asks where, when, and how enactments of gender and transgender interact in the gender clinic.

As many readers may have picked up on by now, the gender clinic is as much about gender identity as it is about development. About change over, through, athwart time.⁵³ This would make logical sense to most of the actors in the clinic: gender transitions do not happen over night. They are processes. Longer for some. Shorter for others. But maybe long and short are not useful ways of

⁵³ I borrow the word “athwart” from the foreword to Eve Kosofsky Sedgwick’s *Tendencies* (Sedgwick 1993:xii)

thinking about a transition, because who is to say when a transition begins? Some would argue a social transition begins before a medical one. But when does that social transition begin? When the child comes out to their parents? When they cut their hair? Or did it begin when the child was young and always wanted to wear dresses, or wrestle with their older brothers?⁵⁴ Alternatively, could the transition have started even before then? Does its origin lie in genes, epigenetic markers, and fetal hormones?⁵⁵ Are we not back to the medical, then? Is it in fact the medical that begins first?

What about the analog: when does a transition end? Judith Butler would not want us to forget that we all continually cite (or fail to cite) gender norms (Butler 1990b). That is, gender never stops being done. And as Harry Dodge demonstrates in *The Argonauts* (2015), it is limiting to some to think of transition as even having a beginning or an end. Stryker, Currah, and Moore add the hyphen in “trans-” to indicate where we “might begin to enact and materialize new social ontologies” (Stryker, Currah, and Moore 2008:14). There does not need to be a goal, or a destination, or an end to a transition. It can just be going.

In analyzing the relationalities of gender and transgender enactments in the clinic, it has become clear to me that there are certain epistemological assumptions as to the definition of transition in relation to time. While theory (as cited in the previous two paragraphs) has challenged such epistemological (medical) knowledge, a logic of gender, transition, and time still exists in the gender clinic. There still exists a normative understanding of the time(line) of gender and transition.

Both this chapter and the next will focus on this temporality. However, as I expressed previously, where chapter one offers a near harmony of enactments—an alignment disrupted only by gender enactments from temporal haunting and future reference—this chapter explores the

⁵⁴ Anne Fausto-Sterling critiques John Money’s famous John/Joan case, that explored the origins of gender, to demonstrate the complexity of sex and gender in *Sex/Gender* (2012:10-11).

⁵⁵ For an in depth understanding of the origins of ‘sex’ turn to Fausto-Sterling (2000a)

messiness of gender and transgender enactments. To unpack this unruliness of enactments, we must also think about temporality. Specifically, in chapter two I explore the sequence of transition. Let me rephrase: the sequences. For there is more than one transition going on in the clinic. Gender and transgender are multiple, don't forget. The relationalities of enactments reveal sequences (normative, non-normative, "medical," "social," in agreement and disagreement, those proceeding and those stalled). Sequences which themselves interact, but which all are different realities of transition. In other words, transition *is* sequence. And in order to understand transgender as ontology, we must add transition as another object to our study. It is in the interaction of these three: gender, transgender, and transition, that we can come to fully understand how transgender is enacted in the clinic.

Again, I am not trying to understand transition from multiple perspectives (from mom, from dad, from the patient, the doctor, the social worker, the therapist, etc.). Instead, I am foregrounding practice so as to explore how transition as an object comes into being, how it is done in practice. It is because transition—sequence—is handled differently by these many actors that reality multiplies. And in the relations of its multiple enactments, transgender arises.

This chapter tracks relationalities of gender enactments as they relate to transition. Certain enactments of gender are necessary for the sequence to proceed, others block the sequence from advancing, and still others move the sequence along at a faster rate than the 'normal' trans subject or the 'normal' sequence. I will call these relationalities predication, obstruction, and justification, respectively.

Predication is that relationship in which an enactment must be done, must be present, for a sequence to proceed. For instance, a letter of support from a psychotherapist is required to predicate a medical intervention. The enactment of gender as a letter must precede enactments such as gender

as hormone levels, breast development, or voice deepening. This relation is the foundation of the sequence. It can be thought of as a check point, a necessary step.

Obstruction is the relationality of enactments that foreclose other enactments from coming into being or completely shield them from view. These enactments inhibit the sequence from proceeding, block transitions, and thus occlude certain enactments of gender and transgender from coming into being. The relationality of obstruction will be especially useful in helping think through practices and spaces that give preference to certain realities, and actors beyond the trans patient, who enact mis/gender or refuse to enact gender. These competing enactments reveal contesting sequences of transition—some of which are the absence of a transition—and where these enactments can produce violence against transgender *being*.

Lastly, justification as a relationality is an accelerant. In contrast to obstructions, which hamper or terminate a transition, these enactments bring others into being—pull them into the sequence—before they would normally occur. As I explain in the opening field note of chapter one, the endocrinologist “normally” begins hormone replacement therapy at sixteen years old, but if the gender clinic “knows the child is trans-” hormones can be administered starting at fifteen. The enactment of the gender clinic *knowing* a patient is transgender, knowing them as their gender identity, allows the patient to enact gender as hormones and changing body fat distribution (and...) earlier than sixteen, earlier than normal. Transgender enacted as *knowing* accelerates the sequence.

These relationalities—predication, obstruction, and justification—are an organizing schema, but they are not meant to imply there is no grey area or overlap between them. It is possible that enactments of gender and transgender may fall into multiple categories or somewhere in between. For instance, a letter of support predicates other (medical) enactments; however, the lack of a letter is a form of obstruction. Likewise, the opposite of many obstructions may sometimes (often when combined en masse) act as accelerants to a transition.

To parallel categorizing the relationalities of enactments into predication, obstruction, justification, I have organized the chapter into three respective sections. Another way to think about these sections is what these relationalities mean for sequence. Thus, one can also read this chapter as, normative sequence, dissonance within the sequence, and accelerants to the sequence.

Predication

Predication as a relationality was already mentioned in the previous chapter. However, the enactments I describe in chapter one can often be temporally unregimented and diverse. That is, a patient does not need to legally change their name—or go by a chosen name at all—before the patient injects a hormone into their leg. This can likewise be said of altering one’s hairstyle, or wearing binders or makeup. In the gender clinic, there is not a strict temporal linearity—sequence—to these events. However, a letter of support from a mental health provider must predicate any medical intervention from the clinic. In requiring this predicative relationality between the enactments of gender as a letter of support and as changing levels of chemicals in one’s blood, a sequence emerges.

Logan is in his mid-teens when I meet him. His hair is colored a mélange of blue, grey and purple. No, he and his parents wouldn’t mind if I observe his consultation with the clinical social worker. When the social worker tells Logan he’s now ready for testosterone, a smile arches across his face that will stay with him for the rest of the visit. “We do need a letter of support, though,” the social worker says. “How are your therapy sessions going?” she then asks.

“They’re good. I don’t like the group sessions much, but I can go to more of the group therapy if that means I can get a letter of support,” Logan replies, not letting this roadblock temper his excitement.

“Who’s your mental health provider, again?” the clinical social worker asks rhetorically as she looks down at her notes. “Ah! Well, I can also give you a referral to one of the gender friendly mental health providers we recommend.

I do want you to keep going to group therapy, but we need that letter before we can start you on T. I'll tell you what, though, let me go talk to the doctor and we can probably send you the prescription for T once we get that letter, so you don't have to wait until your next visit."

This scene of acquiring a letter of support in order to begin medical treatment at the gender clinic happens often, but with many permutations. One mother tries to get her son's psychologist on the phone while she and her son are still in the clinical consult. Another patient completed a round of therapy to come to terms with their gender identity before they came to the gender clinic, but learn they need to return to a psychotherapist in order to obtain a letter of support. Many patients don't know of the requirement, and learn at their first visit that they will need to find a therapist to receive treatment.⁵⁶ This scene from Logan's consultation with the clinical social worker and the role of the psychotherapist's letter of support in many other scenes reveals its necessary predication to medical treatment. Moreover, one observes a normative sequence unfolding. First a letter, then hormones. To enact gender as hormones or blockers—the lack of hormones—gender identity and transgender done as a diagnosis of gender dysphoria must come first in the sequence.

The gender clinic premises its medical intervention on the letter of support to meet the medical standards of care set by the World Professional Association for Transgender Health (WPATH).⁵⁷ One of the criteria for a “physical intervention” in the WPATH's *Standards of Care* (2011) is that “The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed)” (19).⁵⁸ This standard is in place to make sure the medical apparatus does not complete a “physical intervention” when in fact a

⁵⁶ It should be noted, here, that, as I mentioned in chapter one, many of the patients have mental health issues—such as anxiety, depression, and obsessive compulsive disorder—that are a product of, or interact with their gender dysphoria. Consequently, all of the patients are required to have a therapist.

⁵⁷ (Coleman et al. 2012)

⁵⁸ Adolescent is categorized as the developmental stage beginning at puberty.

patient does not desire a “physical intervention.” However, this same safety, or check, is not applied to many of the other patients in the hospital, nor even in the endocrinologists other pediatric endocrinology clinic. For instance, the doctor once describes a cis-gender patient in her general pediatric endocrinology clinic who is frustrated he has not begun puberty. It turns out that he has some hormonal issue in which he is not producing (or not producing enough) sex hormones. Consequently, the endocrinologist prescribes him testosterone. What is important to note, here, is that this patient did not need a letter of support from a mental health professional verifying his distress in order to receive medical care.

Of course, this cis-male patient in the doctor’s general endocrinology practice had to give informed consent with his parents, a standard of ethics in western medicine. And so do the patients in the gender clinic. However, the requirement of trans- patients to acquire a letter of support in addition to their consent before a medical intervention reveals a socio-medical doubt of their (trans) existence. That is, trans- patients are required to obtain a letter of support in order to *prove* their identity, their trans-ness, their being. Cis-patients do not need to prove their distress or their being, their cis-ness. Additionally, they are not required to acquire a psychological acknowledgement that a lack of medical care will maintain their suffering. They are taken at face value. They have nothing to prove.

The necessary predication of a letter of support to the clinic’s intervention reveals that that the patient must socio-medically prove their transgender identity in order to become legible to the medical system. Part of this legibility is falling into the normative sequence of transition medicine has not only come to know, but has also come to enforce. Said differently, these predicative relationalities—the letter before the intervention—ground and construct the normative sequence. In the gender clinic, many enactments of gender are unimportant to medicine’s sequence—legal name

change, how one cuts one's hair, wearing a binder—but the predicative relationality of enactments bring a sequence into being.

Holding the cis- and trans- patients against one another, it is clear the patients of the gender clinic bring their transgenderism into being via the letter of support (the argument I made in the previous chapter). However, in comparing the cis- and trans- patients, we also see the letter enacts transgender because there is doubt. Or it enacts transgender in the face of doubt. These two readings of the letter's enactment, though, are not mutually exclusive. Transgender is enacted in the letter by a patient, a psychotherapist, and the clinician who requires the letter. This is done because of the high epistemological stakes of gender in societal systems such as biomedicine, the law, the household, etc. Transgenderism is held as an epistemological challenge to the gender binary, and thus is doubted and regulated. However, the gender clinic also requires a letter of support in the face of this doubt. The endocrinologist and clinical social worker are invested in and committed to the trans- community. In interviewing the clinical social worker she stresses to me that she knows “that medicine has not always been kind to that entire population, not just trans-, but to LGBT together. But trans- people especially are even more marginalized... And so with such a marginalized population, I could understand how hard it would be to gain their trust. And trust was really important to us, because once you gain their trust you don't want to fail them... especially with minors, which is very new, very controversial concept and treatment.” Thus, in requiring a letter of support, the clinic is also ensuring that medical care is provided to these trans children. In the face of societal doubt around trans- existence and the high stakes of providing medical care for trans- children, the clinic ensures it never fails its patients by follow all of the international standards of care. Doubt engenders predication, but an insistence on predication keeps the clinic open and providing medical care in the face of societal doubt.

While the predication of medical care on a psychotherapist's letter of support uncovers another actor—societal doubt—the sequence of a letter of support and medical intervention also reflects the logic of care in the clinic. One of the doctor's stated goals of treatment is to align the body and mind. This alignment fits the western medicine's epistemological understanding of transgenderism in which sex is the body and gender is the mind.⁵⁹ Alignment acts as a technique to create “singularity” between the many enactments of transgender (Mol 2002). That is, linearity combines gender dysphoria diagnosis as a psychotherapist with the enactment of transgender as “a hormonal imbalance.” In the linearity of the normal sequence, gender can be established in the mind, and the body can then be “aligned.” As such, Logan must enact his mind as male before a medical intervention can begin. Thus, the linearity of predication produces, seeks after, constructs, and insists upon singularity. Multiple enactments are added together in a particular sequence in order to ensure a singular object: transgender.

I argue this coordination towards singularity is ontological because transgender does not reference a pre-existing object. That is, transgender does not sit in waiting, an essential essence to be discovered. Instead, transgender is done. Transgender is enacted in multiple ways that must be coordinated in order to produce a singular object. Predication is a tactic of fusion. It is the temporally linear addition of multiple realities of transgender into a composite object.

Other relations of predication beyond the letter of support construct a normative sequence within the gender clinic. For example, a patient must begin puberty before they can receive blockers.⁶⁰

⁵⁹ (Plemons 2010; Fausto-Sterling 2000a; Valentine 2007; Meyerowitz 2002; Spade 2006)

⁶⁰ However, as I demonstrate in my analysis of the Tanner beads, if puberty is too far along, blockers will not have any effect and are therefore not prescribed.

It's immediately clear that Eric is shy when I follow the endocrinologist into her first consult of her afternoon clinic. Eric slouches in his chair, shrugging deeply so that his shoulders nearly reach the pink tips to his short brown hair in response to many questions.

I never learn his age, but I assume Eric is in late elementary or early middle school. His mother reports to the doctor that Eric started feeling pain in one of his nipples, so they went to their family doctor who confirmed breast development was beginning.

It becomes clear that this is not the first time Eric has been at the clinic. In fact, he and his mother have been thinking about what to do when (female) puberty did begin. "After the pediatrician said it was the beginning of puberty, we made the appointment with you." Eric's mom says. "You told us to come in if we saw any signs of puberty."

"How long ago did this start, Eric?" the endocrinologist asks. Eric just shrugs, but his mom answers, "Two months."

"Do you want to stop breast development?" the doctor asks. Again, Eric shrugs and I'm not certain if he's paying attention to the questions.

"Honey, you have to voice up and let us know what you want," Eric's mom tells him.

*"I don't want to do anything you don't want to do," the doctor says, scrubbing in for the physical exam. "Do you want to have your breasts continue to grow?" the doctor finally asks *pointe blanc*.*

"No, I don't want my breasts to continue growing," Eric answers before returning to his shy shell of shrugs for the rest of the visit.

After the physical exam in which the endocrinologist confirms that breast development—female puberty—has begun, she tells Eric and his mom, "Well if we don't want the breast development to proceed, with blockers we have a plan. We can do injections, shots, or we can do the implant."

"Remember that implant we saw at our last visit?" Eric's Mom asks him. He nods a yes, and says he'd rather do the implant than the shots.

After our goodbyes, the doctor and I return to the workroom where she orders labs for Eric and a referral for the implant to be put in. She begins dictating her notes with, "Patient is tanner 2, so we can begin puberty suppression."

In Eric's case we see that breast development, a bodily enactment of female, must predicate a medical intervention to stop such bodily enactments.⁶¹ In fact, like the letter of support from the psychotherapist, the gender clinic establishes the predicative relationship of mis/gendered puberty and blockers to dispel doubt. The endocrinologist references "cognition" as the reasoning behind requiring patients to begin a puberty they do not want to go through before they can begin blockers. This "cognition" signifies a confirmation of the patient's gender identity, that, in fact, the patient does not want to go through their natal sexed puberty. The doctor explains that there is no physiological necessity to wait for puberty to begin, but that the mis/gendered puberty is a tool that confirms the patient's trans- and gender identities. Thus, though Eric may have wanted to begin blockers at previous visits, he was told to return once he (or his mom) saw the first signs of female puberty.

Transgender comes into being in this predicative relation between mis/gendered puberty and blockers. The bodily enactment of female gender as breast tissue, and the enactment of blockers as the absence of this reality, or of a "minimally gendered" or pre-gendered body are practices that cross Erik's body.^{62,63} As I argue in the previous chapter, a reality of transgender is enacted as these practices are held in conflict. Moreover, "transition" is enacted in their sequencing. Erik transitions *from female to male* (his gender identity) when these enactments are done in order, in sequence. This

⁶¹ I discuss blockers as obstruction in the obstruction section of this chapter.

⁶² I discuss the implications of the doctor's conception of blockers enacting a "minimally gendered" body in chapter three.

⁶³ Of note, the early bodily changes in puberty will recede if blockers are administered early in puberty.

begs the question: if blockers had been administered before female puberty began in Erik's body, would a transition still occur? All of the actors in the clinic—the doctors, social workers, nurses, parents, patients—would all argue yes. I would agree with them, too. As I describe in chapter one, there were previous enactments of one gender (genitals, birth certificates) and now there exist enactments of a different gender (linguistic, stylistic, whatever they may be). In Western culture and medicine, this signifies a gender transition. Transition is done in holding together and in temporal—sequential—order those past mis/gendered enactments, a patient's current enactments of gender, and future enactments that match their gender identity. However, the predicative relation between misgendered puberty and blockers does not need to reference a past enactment. Rather, it employs a temporally present enactment of gender—breast tissue growth—as its referent to establish transition. These are two different realities of transition, two different ways of doing sequence.

Yet the gender clinic requires that all patients who receive blockers have begun mis/gendered puberty. There are no exceptions to this rule. My question of administering blockers before puberty is only a hypothetical. Consequently, one can see the normative sequence establishing itself out of predicative relationalities. In the clinic, a letter of support always predicates medical intervention, and a mis/gendered puberty always predicates blockers.

Kalif, the youngest trans- patient I meet in the clinic and the one whose field note appears in the opening of chapter one, is not considered for blockers during his visit because he has not started (female) puberty. Logan must obtain a letter of support before the endocrinologist will prescribe him hormones. Eric begins blockers only now that he has had some breast tissue growth. Imani had to wait until she was sixteen to start HRT, and she will have to wait until she is eighteen and obtain a second letter of support in order to undergo any form of gender affirming surgery. All of these patients must fall into the normative sequence of the gender clinic. A sequence that is enacted through predicative relationalities between the multiple ontologies of gender.

Obstruction

Up until this point, the enactments of transgender that I have laid out have, for the most part, aligned. That is, though they have been multiple they have not come into conflict with one another. One reality of transgender has not foreclosed another's enactment nor shielded another from view. However, in the gender clinic, the various enactments of transgender sometimes conflict. One enactment may obstruct another reality of gender or transgender from being enacted. Or one reality may take preference in certain spaces, obstructing another from view.

The simplest instances of obstruction in the clinic occur when the patients have their blood drawn to test their hormones levels. Vial(s) of blood are taken to a lab, a space outside of the consultation- and work-rooms of the clinic, where they are analyzed. The vials of blood do not return to the clinic; instead, concentrations of hormones are sent back as test results. When looking at these hormones levels on her computer screen (all of the tests are reported digitally in the electronic medical health record), the doctor does not see a patient's social transition. Haircuts and clothing, pronouns and binders do not appear in the blood test. Nor can the doctor interpret these hormones to understand a patient's social transition. Through the technique of blood drawing and analysis, gender as results of a hormone test obstruct many other enactments of gender from view.

Now, of course, this can be done in reverse and across many other enactments of gender. The clinical social worker's intake packet tells nothing of a patient's chromosomes. In the psychotherapist's office, gender enacted as hormone levels is likewise obscured. These tools—the measures of the packets, the psychologist's interview—obstruct things the clinic would call “medical” like genes and sex hormones from being seen. In fact, all of the techniques of ‘knowing’ the transgender subject—the intake packet, the psychotherapist's evaluation, the blood draw, the

genetics test, the physical examination—bring preferential realities of gender into being while obstructing others from view.

But there are also times in which certain enactments of gender don't simply obstruct another enactment from view, but rather preclude other enactments from occurring, preventing other realities from coming into being. This obstructive relationship reveals the multiple sequences present in the patient's transition, and, moreover, how certain enactments can inhibit sequences from proceeding. To understand this, we can turn to the clinic for an example:

I meet Lily, a cheery middle schooler, at their first appointment at the gender clinic. They have a soft spoken nature, a high pitched voice, and cross their legs tightly when sitting on the exam table. Lily identifies as gender fluid and use they/ them/ theirs pronouns; however, they tell the doctor they would like to “transition to female” and use she/ her/ hers pronouns in the future. This desire is why they are at the clinic, now.

The doctor is the first to see Lily. The consult begins with doctor asking Lily about her gender identity and why she has come to the clinic. She then asks questions that are couched both as ways to build rapport and gain an understanding of the Lily's life and gender expression outside the clinic. “How is school?” the doctor asks Lily.

“Um... Alright, I guess. I've got some friends, but I get teased,” Lily says sitting on top of the exam table.

“The school isn't great,” Lily's mom adds from her spot sitting on a chair in the corner. “They're not very supportive. Lily can't use the bathroom she would like, and the teachers and administration don't do enough to stop the bullying. The teachers still call Lily by their male name and don't use the right pronouns.”

“And are you out at school?” the doctor asks.

“No. We talked to the school about using my name and pronouns, but they weren't supportive,” Lily responds in their high pitched voice.

“Lily and I have talked about this and we decided it will be best for them to wait to transition and come-out at school until they go to high school,” Lily's mom says.

“And how do you feel about that, Lily?” the doctor asks, “Is that ok for you?”

“Mmm-yeah,” Lily answers.

The doctor turns from Lily for a moment to write this in her notes on the computer. The doctor then asks, “And how are things at home?”

Lily and their mom explain that Lily’s father is “not on board.” That he thinks Lily’s transgender identity will “turn Lily’s younger sister trans, too.” That he won’t use Lily’s chosen name, or the gender neutral nickname the family came up with. Lily’s mother is supportive: she’s brought Lily to the clinic and always uses Lily’s pronouns and chosen name, but she feels torn between her husband and her child.

When we leave the consultation room and return to the workroom, the doctor briefs the clinical social worker on the consult. She reports Lily’s name and pronouns, goes over some of their medical history and the medical exam—that they have started puberty, but are still in the early stages, so blockers will still be effective—and recounts Lily’s experience at home and at school. The doctor ends by saying, “They’re a good candidate except for their dad.”

The enactment of gender in Lily’s case, and in the case of those patients with unsupportive parents, is a failed enactment. In not recognizing Lily’s chosen name and pronouns, Lily’s father is blocking—obstructing—a relational linguistic enactment of Lily’s gender fluidity (and femininity). Moreover, in continuing to use Lily’s male name and male pronouns, Lily’s father linguistically enacts maleness with regards to Lily. Because Lily’s father is unwilling to enact gender fluidity or femininity with Lily, and because he has legal power over them, Lily is at risk for not being able to medically enact gender. The enactment of male between Lily’s father and them—put a different way: the absence of female or gender fluid enactments—obstructs medical enactments of gender from coming into being. And so we hear, “They’re a good candidate except for their dad.” Ontologies of medical gender in and on, running through, Lily’s body are foreclosed because another reality of Lily’s gender obstructs their becoming.

Lily's father's enactment of male—with the power of legal authority behind it—also inhibits the normative sequence of a medical transition. It is a practice that continues to preferentially enact a mis/gendered sequence of male on and in Lily (as well as between Lily and the social world) that places a hold on the sequence of gender affirming bodily enactments the gender clinic can provide for its patients. In fact, it is possible that if Lily cannot access these gender affirming enactments from the clinic, their body will further corporally enact maleness as puberty progresses. Thus, Lily's father's use of incorrect pronouns and names upholds its own sequence, one antithetical to Lily's gender identity, but one that, because it is endowed with power, has the ability to obstruct the enactment of other sequences.

Luckily for Lily, only one parent is required to provide consent for blockers. In turn, she is given a prescription for blockers and told to return in four months to monitor her hormone levels. It is not out right discussed between the clinical social worker and the doctor, but I'm sure the decision would have been different if Lily were older and wanted to begin hormone replacement therapy. The benefit of blockers in Lily's case is that they have no positive effects. Blockers will only stop puberty from beginning rather than provide the “feminizing effects” estrogen does. I suspect the conversation would be different if Lily were old enough to begin estrogen therapy because Lily's feminization, rather than their obstruction of puberty, could put Lily in danger. In such cases, the clinic, especially the clinical social worker, would work with the family until it was safe for Lily to begin hormones. However, in this scenario, still, we see the enactment of Lily's gender as a familial relation obstructing medical realities of Lily's gender fluid or female gender from being done. Moreover, though this obstruction may not foreclose the sequence of a medical transition from ever occurring, it would certainly slow the sequence or pause it as Lily's obstructive relationship with their father was resolved.

A similar situation is happening in regards to Lily's school's refusal to recognize Lily as gender fluid or female. Enacting gender as names and pronouns requires at least two actors: Lily and a teacher or the school administration. In refusing to participate in the linguistic enactments of Lily's gender as gender fluid or female, the school forecloses relational and social realities of gender fluid or female from being enacted. Moreover, every time the school engages in the practices of using Lily's male name that appears on school rosters and male third-person pronouns, the school is perpetuating the enactment of Lily as male.

However, we see in the case of Lily's school that a medical sequence would not necessarily be obstructed by the school's enactments. The school does not have the same power over Lily as their father does. In fact, while the gender clinic would never begin a medical transition if it thought doing so would put the patient in harm's way, the the gender clinic applies its normative sequence so as to alleviate the violence a patient receives from society. The clinical social worker explains to me that the gender clinic is treating an incongruence between the patient's "body not matching their inside," but also "society saying that you're not normal." That is, the clinic understands that in some social spaces—such as schools—enacting gender that aligns with one's gender identity but not one's natal sex (i.e. body), makes a child or adolescent at risk of violence.⁶⁴ Consequently, the gender clinic offers bodily enactments of gender with the logic of care that aligning the body with one's gender identity and expression lessens one's risk of violence.

The comparison of the possible violence of Lily's family and Lily's school leads me to a critical point. The normative sequence of the gender clinic imagines a normative trans- subject, but it also expresses an assumption about where violence occurs: in society. However, Lily demonstrates

⁶⁴ While there are numerous high-profile cases of such violence, the recent work of Gayle Salamon, *The Life and Death of Latisha King: A Critical Phenomenology of Transphobia* (2018), offers in-depth scholarly coverage of one such case.

that while violence can be societal, it is also intimate. That is, violence can come from—it does come from—one’s own family. And this is a violence that the normative sequence of the gender clinic cannot account for. It’s an intimate violence of obstruction that causes a break, a pause, a block, a rupture in a child or adolescent’s transition. The morbid irony of the gender clinic’s sequence is that a parent’s support is necessary for a patient to enter the space of the clinic and for the sequence to even begin. Though the gender clinic aims to alleviate violence against trans- youth, it’s normative sequence precludes those most at risk of violence from accessing its services.

Lily’s story is accordingly not like the majority of patients’ in the clinic. Most have two supportive parents; an (at least mostly) accepting relationship between parent and child is what brings the patient to the gender clinic in the first place. Minors cannot make doctor’s appointments without their parent’s support, nor can they gain give consent.⁶⁵ Thus, Lily’s case reveals the original predicative relation of the gender clinic: the cooperation of parent and child must predicate the gender clinic’s sequence from beginning. Lily allow us to see the genesis and the morbid irony of the gender clinic’s sequence.

However, Lily’s story does not only tell of obstruction of Lily’s gender identity. The blockers themselves are a form of obstruction, a relationality that enacts Lily’s identity as gender fluid and (sometime in the future) female. The endocrinologist explains that “puberty blockers are hormones that, or they are really medications that mimic hormones, that both act as an agonist and an antagonist... So at the very beginning it actually positively stimulates the hypothalamus and the pituitary, and actually increases, briefly, the amount of testosterone and estrogen that is made. But as the medication stays in a system it actually locks on and doesn't allow those to be stimulated

⁶⁵ A court order can supersede a parent’s lack of consent. This happens in the clinic when the caretakers believe the patient is at risk of suicide if the patient does not receive medical assistance to their transition.

anymore.” In binding to the receptors on the hypothalamus and the pituitary gland, blockers obstruct other stimulating hormones from binding. This subsequently blocks testosterone and estrogen—the hormones medicine epistemologically knows as gender in the body (Martin 2001:51–52)—from being produced. For Lily, the short period of stimulation of the hypothalamus and pituitary gland and their consequent closure, obstructs a male gendered reality from being enacted as puberty. It obstructs male sequence from proceeding. Thus, puberty blockers do not so much enact gender as they enact a foreclosure of bodily gender and a foreclosure of sequence. They obstruct testosterone from being produced, and more critically for Lily, they obstruct puberty as a bodily enactment of maleness from coming into being.

In holding blockers’ enactment of (lack of) gender in reference to the enactments of male both in Lily’s past (their birth certificate, the “F” that marks their sex in their medical record) and in their presumed future (the presumed male puberty and the physiological changes medicine epistemologically knows that entails), Lily and the endocrinologist enact transgender. Said differently, in the obstructive relationship between blockers and gendered pasts and (assumed) futures a reality of transgender comes into being.

Lily’s case offers us examples of how “social” sequences and enactments of gender (occurring outside the walls of the clinic) can obstruct “medical” sequences and enactments (one’s that medicine considers part of physiology and/or its intervention, happening generally inside the clinic or inside the body). And how puberty blockers—a key medical intervention the clinic offers—are an enactment with the express purpose of creating an obstructive relationship to a future gendered sequence. But to further explore the relationality of obstruction in the clinic, namely, when the body obstructs other enactments, we must to visit another example. Let’s turn to the interview I did with Liam:

When Liam agrees to do an interview with me, I have to ask him if he is over 18. (He's not). He's in his mid-teens but carries himself with maturity beyond his years. His deep voice and shaggy blonde hair make his age hard to place.

Liam is very fond of the gender clinic, but he is actually at his last visit when I meet him. He is moving soon with his mom. Many of the patients travel long distances to get to the clinic—Liam does, too; he lives out of state—but he'll be moving closer to another pediatric gender clinic that can manage his care. When the appointment ends he and the doctor share a tight hug before she leaves the room to see other patients. I stay after the “goodbye’s” and “good luck’s” to get informed consent with Liam and his mom.

When I ask Liam what motivated him to come to the clinic and why he wanted testosterone, one of his answers is that testosterone makes him “pass⁶⁶ better in public,” and that on T he is “accepted by cis-men around me.” Liam describes that before starting HRT he had changed his “clothing, hairstyle, just even little things like changing the color of my room from purple [to blue].” Despite all of this, he says, “once I was twelve or thirteen I realized I wasn’t on par [developmentally] with guys my age, so I really wanted to change that.”

It's once Liam begins HRT that he starts “a new life.” With testosterone, Liam finds that “even if it was just the change in hairline, or face shape,” testosterone’s effects fulfill his goal of passing and being accepted by the guys his age.

Liam provides us with a view of the desires of many of the trans- patients in the clinic. Which, in short, is to “pass,” to *be perceived as* any other cis- person their age.⁶⁷ Throughout my field work, I was profoundly moved by the ways in which the patients of the gender clinic find an acceptance for their appearance, yet also yearned for a different body. They deeply desired to enact

⁶⁶ Passing generally connotes a trans- individual being perceived as cis-gendered.

⁶⁷ In my thesis of transgender as ontology, passing is one way of enacting gender, but it is not coveted by every patient in the gender clinic. Additionally, I find patients’ pride in their trans-identity is not linked to a desire to pass. For instance, Liam is very proud of his trans-ness, yet desires to pass.

their gender identity through the materiality of their body. Many found additional—if not sometimes more significant—drive in the evasion of violence such corporeal enactments could bring about.

Liam expresses this in his desire at age 12 or 13 for the developmental changes the boys his age were going through. He tells me, “They were having these different changes, and I wanted those, but I couldn’t have them.” In fact, Liam’s body was beginning female puberty, initiating a sequence of enactments antithetical to his desire to enact maleness with his body. Despite Liam’s clothing, hairstyle, and color of his room, as well as his desire for male development, his body was obstructing male enactments from being done by enacting femaleness via puberty. Despite all of Liam’s efforts to do male, at puberty, his material body began to betray him.

From a very young age, Liam tells me he tried to express maleness, to enact it, but the materiality of his body begins to obstruct this when puberty brings about changes that are enacting female despite Liam’s desires. Of course, the body, here, as it is throughout this thesis, is intersubjective. The body is not just material. It is also highly social, relational (Plemons 2010). Body parts such as breasts and hips have significance and are epistemologically known as female. It is the socio-material growth of the body that enacts femaleness when Liam begins puberty. And it is this socio-material enactment that comes into being in, across, and through Liam’s body that obstructs his maleness.

In his clinical visit, Javier, the trans-masculine patient I introduced in chapter one, mentions a friend who turned out to be trans-, though Javier didn’t know of his trans- identity. Javier says to the doctor, “I just hope I can pass as well as him someday. I’m just nervous my hips and my large chest will stop me from passing.” Javier invokes his friend to explain that the substitute teacher who bullied Javier, telling him, “what you’re doing is a sin,” was clued to Javier’s trans- identity by his self described “hourglass,” “feminine,” figure. To Javier, his passing trans- friend would not have experienced this bullying because he passes. His passing offers a body that is protected from the

violence inflicted by others. In our interview when I ask Javier what he wants testosterone to do for him, he answers, “For me it’s going to help with the figure problem.” Testosterone will remove the hourglass figure that enacts femininity and which is the source of violence against Javier.

The clinical social worker explains all of this to me as well:

Some patients will get to this point with their social transition: they’ve changed their clothes, cut their hair, and their wearing a binder, or they’re tucking, and they’re using bras with some implants, and shave their legs, and they’ve done everything they can socially to help align their bodies with their gender identity so that people will see them as they want to be seen and as they see themselves. But they come to a point where that’s as far as they can go with that. There’s only so much they can do. At that point they say “I need... I need a physical change. I’m being misgendered because of this facial hair. And no matter how much I shave it off I can’t get it all.” Or maybe, “I’m getting misgendered because I have this feminine face. Or have these hips or whatever.” And it’s like they’re wanting something they can’t do, either to masculinize or feminize themselves, and that’s where the hormones come in.

Let me be clear that a social transition does not just build, and then rupture, with medicine consequently taking over—the clinical social worker goes on to say medicine “augments their efforts;” it does not supplant them. Both Liam and Javier tell me that they do not necessarily need medical assistance in their transition to be themselves. For them and many (though not all) of the patients in the gender clinic, the socio-material realities of gender that their bodies enact (generally beginning around puberty) in a sequence beyond their control obstruct all of the other “social” (as the clinical social worker would call it) realities of their gender identity they are enacting.⁶⁸ This

⁶⁸ This is not to say that in a hypothetical, genderless world, Javier would not like to get rid of his hourglass figure and Liam would not want the face-shape- and hairline-changing effects of testosterone. They very well could. But imagining what transgender would be in a world without gender is a hypothetical that seems out of scope from the lives of the children in the gender clinic.

obstructive relation can lead to psychic pain—labeled gender dysphoria—and can put these trans-adolescents at risk of violence.

Liam, Javier, and Lily all offer a theory of the body (and gender and transgender on the body) that Eric Plemons writes is “irreducibly social and intersubjective” (Plemons 2017:124). Performative theories of gender, like psychoanalytic and phenomenological understandings of subject formation, hold that bodies gain meaning through discursive practices (Butler 1990b; Butler 1993b; Butler 2004; Salamon 2010). For Butler, this means continued “citation of a norm” (Butler 1993a:23). And while Butler has spent multiple books defending what she argues are misreadings of her performative theory of gender as a theory of performance—that gender can be taken off and put on like the clothing in one’s closet—(Butler 1993; Butler 2004) still, others have argued that Butler’s theory does not fully account for the body (Prosser 1998:chap. 1). These “(dis)embodiment” critiques posit that the body can be “a drag on signification,” as well as, “a limit on potential” (Prosser 1998:69; Martin 1994:110, 119). I believe that Liam, Javier, and Lily offer an answer to this question of the body that Butler leaves open. They all demonstrate that the intersubjective body may enact gender, citing a discursive norm, without their consent.

For Javier and Liam, gender is something that they do. They subscribe to this theory, painting their rooms and cutting their hair. But their bodies are intersubjective. Thus, even if Javier can personally re-signify his “hourglass figure,” because the body is social and read relationally it enacts female gender anyways. And despite how much much Javier may want to cite a gender (whether that be male or something else)—a *doing*, in a sense—his body does not allow him to do it correctly. Or at least not the way he wants it to, the way that would be relationally recognizable and would alleviate violence. Instead, he experiences his hips and his chest to limit his ability to *do* his gender because others who read his body cite it against a female norm. The body can thus fail the

trans- child. In its relationality, it can continue to enact mis/gender despite the subject's desires and other practices.

Lily demonstrates this intersubjectivity further as their father has a relational stake in their gender. His lack of joining in enacting Lily's gender, as well as his continued mis/gendering enactments, have material effects on Lily's body—had Lily's mother not been supportive their body would have begun a male puberty. All of this is not to say that gender identity as a performative act is not an important enactment. Rather, Lily's father's relational (non)acknowledgement of gender has power despite Lily's enactments of gender fluid or female because, again to reference Wittgenstein, a private language is no language at all (2009: §243). Lily needs their father's acceptance for their relational citation to gain meaning. Lily, Liam, and Javier demonstrate that the body, and gender that crosses it, exists not only in a discursive register, but also between people.

Justification

So far in this chapter, the relationality of predication between enactments of gender has established the normative sequence of the gender clinic. Further, obstruction has demonstrated how enactments can (permanently) forestall both sequences and other enactments from coming into existence or being seen. Justification has a converse effect on the normative sequence to obstruction. That is, enactments with a justifying relationality to the normative sequence accelerate its process.

I want to focus on one point in the sequence that's set up by predicative relationalities: beginning hormone replacement therapy. This is the only point in the grounding of the sequence—those predicative enactments that are absolutely required—that has at least some temporal ambiguity. Said another way, beginning hormone therapy is the only 'checkpoint' with wiggle room.

A patient must have a parent or guardian's cooperation to access the clinic,⁶⁹ a letter of support must predicate any medical intervention from the gender clinic, a second one must be obtained if the patient wishes to have surgeries, patients must begin puberty before they can begin taking blockers, patients in the United States must be 18 before they can receive sex reassignment surgeries, patients must also have twelve months of hormone therapy and live twelve months openly as their gender identity before they can have sex reassignment surgeries (Coleman et al. 2012). These are all set in stone. However, the requirement that patients be at least sixteen years old before they receive hormone therapy is one that has variability.

Certain patients are allowed to accelerate their transition. They do not need to wait until they are sixteen years old for the sequence to take a step forward, but instead can begin hormones at the age of fifteen years old. Some outside factor, some other enactment of gender, allows the patient to enact gender as hormone levels and all of its consequent corporeal enactments sooner. Hormones produce some permanent changes. Consequently, the gender clinic follows the Endocrine Society guidelines, which state patients should only receive hormone treatment before they are sixteen years old if they have "sufficient mental capacity to give informed consent" (Hembree et al. 2017:3870). The logic of accelerating the path to hormone therapy, though, does not track in the gender clinic solely as a "mental capacity to give informed consent." Rather, the doctor will prescribe hormones when a patient is fifteen if she and the clinical social worker also "*know*" the patient is trans-. This relation is labeled justification because the patient or an outside event must validate this *knowing*

⁶⁹ I want to temper this statement somewhat, in that there is one patient in the clinic whose parent's do not support her gender identity nor a gender transition. She is a patient at the gender clinic because she went to the emergency room (likely having a panic attack) after secretly injecting herself with estrogen she bought illegally online. There, she was obliged to come out to her parents to explain herself. She was then referred from the emergency department to the gender clinic, where she now receives supervised care. However, this patient is an anomalous case, and did not willingly seek out the gender clinic.

against doubt of the patient's trans-identity. That is, the patient must prove they will not, as the social worker tells me, "desist from their cross-gender identification" to justify beginning hormone therapy early. In the political climate around transgender children, desisting could become negative publicity for the gender clinic, causing it to limit its activity or even shut it down. As such, knowing becomes the justification for acceleration so as to continue providing care for the most trans-children and adolescents rather than accelerating all of their sequences.

This logic of *knowing* is expressed in many of the clinical visits. In her consultation with Kalif—the first patient I mention in chapter one—the doctor tells Kalif's mom that hormone replacement therapy normally starts at 16 years old at the earliest, but if "we *know* the child is trans-, we can start hormones earlier" (emphasis mine). Similarly, when the doctor goes in to see Sofia (who was also introduced in chapter one), in laying out the long term plan for treatment (i.e. the normative sequence), she tells Sofia and her mother, "We begin patients on gender affirming therapy [HRT] at 16, but it's possible to begin estrogen before 16 when we really *know*" (emphasis mine).

However, the logic of "knowing" is not given much of a logic at all. There is no rubric or scale by which the clinic can measure the trans-ness of its patients. Nor does the clinic attempt to measure such an identity. Numerous times, the doctor and the clinical social worker stressed to me—and also demonstrated with their actions—that they do not have an agenda for what a transition should look like, where it should end, or how a patient should identify and express themselves. I argue the sequence of the gender clinic imagines and constructs a normative patient, but this normativity does not relate to trans-ness. Patients do not need to be more or less trans- (whatever that would mean) to access care.⁷⁰

⁷⁰ Some patients told me that before they first visited the gender clinic they assumed they would have to perform gender. Consequently, they did act to mimic stereotypes of gender, but quickly learned that trans-normativity in the clinic does not mean fulfilling the gender binary.

Instead the logic of knowing is left amorphous. Because this knowing is related to risk and doubt, “knowing” does not refer to an image of the subject, but rather to a trust between the patient and the gender clinic. Though not explicitly stated, this trust is founded upon compliance and consensus. Compliance insofar as the patient must be a ‘good patient,’ one who makes their appointments, has their letter of recommendation, goes to therapy, etc.⁷¹ And consensus meaning that the patient’s therapist believes they are a good candidate for hormone therapy and do not need more time to sort out their gender identity, their parents are supportive and believe their child’s gender identity, the clinical social worker feels the patient is “in a good spot”—secure in their gender identity and with a good support system—and the doctor believes the patient understands the risks and benefits of hormone therapy and does not doubt their gender identity. When all of the parties agree, when the gender clinic “knows” the patient is trans-, the sequence can be accelerated so a medical transition can begin. Once the socially valuable status of gender has been settled through “knowing” the patient’s gender and transgender identities, a medical transition can “align” the body to meet what the gender clinic knows the patient’s gender to be. The gender clinic can intervene to socio-materially enact gender identity through, in, and on the patient.

Most of the clinical encounters that I observe in which “knowing” cumulates into beginning hormone therapy at age 15 rather than 16 are characterized by pure joy from the patients. They beam, ecstatic that a dream of theirs is coming true, and that a year of waiting has disappeared.⁷² Yet I have no field notes describing the calculus of “knowing,” the summation of compliance and

⁷¹ Racial and ethnic differences in compliance has been shown for various treatments, but it is unclear “whether they are due to differences in the way patients are treated or advised, in the cultural background of each patient, or in other factors” (National Research Council Committee on Population 2004).

⁷² I will explore the temporality of this waiting in chapter three.

consensus that leads to acceleration. The trust the doctor and the clinical social worker have in their patient is more of a feeling, a visceral connection.

However, we can find contrapositive evidence of “knowing” in the patients that the doctor and social worker feel should not begin hormone therapy early. Most of the patients begin hormone therapy at sixteen because the normative sequence of dictates this timeline. However, there are a few patients whom the doctors feel *must* wait, who do not have the consensus or compliance that indicates knowing. There are not many instances of this, but they in part reveal the logic of “knowing.” Aaron offers us one example of a patient who must wait.

Both Aaron and his mom are eccentric. She wears large round glasses and jewelry with chunky, colorful beads. He has grey-blond hair and braces. Generally, he's fairly shy. I meet Aaron when I observe his clinical visit, but he comes in again the next week because the clinical social worker did not have time to see him. This sometimes happens when a particularly complicated patient consumes the social worker's time.

When Aaron returns the next week, I am with the endocrinologist in another consult during the clinical social worker's time with Aaron. When we all reconvene in the workroom, the clinical social worker asks in regards to Aaron, “Taking testosterone increases your risk of stroke, right? Both his father and his grandfather died young because of stroke. So I asked him, ‘how are you going to deal with that risk?’ Aaron said that he would eat healthy and exercise, but then I asked him, ‘didn't your dad also eat healthy and exercise?’”

By the end of their discussion, both the doctor and the clinical social worker agree that Aaron “is a patient we should really wait until 16 with. He may not have the maturity to understand the risk of taking these hormones and we need to wait until he understands the risks more.”

A training clinical social worker then asks the clinical social worker, “Is the patient immature?”

The clinical social worker replies, “Aaron isn't immature for a natal male, but he is immature for a natal female.”

Aaron exhibits a case in which not only his lineage—interpreted as a medical history—obstructs an acceleration of the sequence, but also his “maturity.” The doctor and the clinical social worker are not convinced that he understands the medical intervention he wishes the clinic to provide him. All of the staff of the gender clinic address Aaron by his male name and use he/him/his pronouns—the ones he told them he uses. In short, they accept him as trans-. But they are unsure if he can make an informed decision. They don’t know if they can trust his maturity.

The clinical social worker and the doctor agree that Aaron does not “get the risk” of taking hormones. That is, they believe he’s not mature enough to give informed consent. However, the clinical social worker also states natal females at Aaron’s age should be mature whereas natal males are immature. In a sense, Aaron’s immaturity should enact male, then. He is meeting medicine’s epistemological understanding of maturity, and development, for the male sex. However, the conclusion the gender clinic reaches is because Aaron’s assigned sex at birth is female, and because he is not mature, he is developmentally behind and cannot give consent. In employing Aaron’s natal sex to establish his maturity, the clinical social worker and doctor are continuing to enact femaleness in Aaron. Part of him—whether that be his sex, or his chromosomes, or some part of his brain—is still female. The caregivers are identifying that his female sex assigned at birth is still present and is the epistemological rubric that he should be held against. This enactment of female breaks consensus. Not every actor is enacting maleness with Aaron. There is still some doubt with female still being done, still present. Therefore, in the language of maturity and informed consent, the gender clinic does not fully “know” at this moment that Aaron is trans-.

I want to be clear that the caretakers of the gender clinic would never explicitly doubt Aaron’s gender and transgender identities. Never would they say (or even overtly think), “I’m not sure if he’s really male,” or “Maybe he’s lying to us.” However, they do subscribe to Western medicine’s epistemological understanding of sex and gender in which gender is located in the mind

and sex in the body. This is why a central logic of care in the clinic is to “align the body with the mind.” Aaron’s body, having been identified as female at birth, must become aligned with his male mind. In claiming that “Aaron isn’t immature for a natal male, but he is immature for a natal female,” and grounding the decision to not accelerate Aaron’s transition in such immaturity, the caretakers are enacting female. They are implicitly implying doubt.

It is this doubt that stops the caretakers from fully “knowing” Aaron as trans-. And without “knowing” the sequence of Aaron’s medical transition cannot be accelerated. One can observe from Aaron’s case contrapositive evidence for “knowing” as justification in the gender clinic. Doubt is thus anti-knowing, an obstruction to acceleration. Doubt, in fact, justifies not accelerating the sequence. And Aaron demonstrates to us that centrality of consensus to “knowing.”

With the final piece of evidence for the relationality of justification, I want to explore how events outside of the clinic can accelerate the sequence of transition in the clinic. Specifically, I want to turn to June.

June has always been a special patient at the clinic. She was one of the first patients in the clinic gender and before her consult, the doctor told me June was one of the patients she wanted me to meet. I first observe June’s visit with the family medicine resident, who is training under the endocrinologist. June expresses that she’s been frustrated that her hair isn’t growing longer and she also asks about facial feminization surgery. The resident finishes the physical exam and begins explaining that surgeries will have to wait until the patient is at least eighteen years old and that June may also be happy with how estrogen affects her facial features and the fat distribution in her face. Just as the resident is finishing, the clinical social worker walks in. June is obviously excited to see her, smiling and laughing at the jokes the clinical social worker makes. Doctors and social workers are not often in the same consult, so it’s a small surprise that everyone is in the same room. The resident steps out to find the endocrinologist and consult with her. In the meantime, the clinical social worker will conduct her check-up.

No, June remarks, there isn't much to update the social worker on. Everything is going well. She just can't wait to start hormones. The clinical social worker makes June blush and giggle when she mentions a pamphlet for the gender clinic that has June on the cover. The social worker says, "You look so beautiful! We're so proud you're doing well." June waves her hand, saying "Stop it!" before covering her face as she laughs with delight.

The resident returns with the endocrinologist and the small consultation room becomes a little crowded. June's father tells the doctor, "As you know, June competes in trampoline gymnastics⁷³ and she may qualify for the youth national championships this year. June's coach asked the national association if June would be able to compete in the women's competition. After discussing it, the national association has actually made new rules because of June. They say that her testosterone levels just need to be below the Olympic standards for testosterone. We were hoping we could get those tests done today."

After congratulations from the caretakers in the room, the doctor pulls up June's previous lab tests. "Now, these tests are from a while ago, but you're right on the border. I would suspect that the spironolactone⁷⁴ you've been taking should be keeping your testosterone levels low. These tests are from right when we started spironolactone, so to make sure you're under that testosterone level, how about we start estrogen on your next visit? We just need to get baseline labs and we can check your current testosterone levels now. How do mom and dad feel about that?"

Both of June's parents smile and confirm they approve of June starting estrogen before 16. June covers her mouth with both her hands in astonishment and then throws them out in celebration. "I'm so excited," she keeps saying, "I'm so excited."

June's story demonstrates an outside event—the national trampoline competition—accelerating the normative sequence of events in the gender clinic. The Olympic standard's

⁷³ Note: this sport is the only detail I have changed in this thesis so as to protect the identity of the patient.

⁷⁴ Spironolactone is used to decrease testosterone levels in patients who are too old to begin blockers but too young to begin estrogen therapy. Spironolactone is then used in conjunction with estrogen to maintain its inhibitory effects on testosterone production.

requirement that June enact gender as a certain hormone level justifies beginning estrogen therapy before June is 16 years of age. June, of course, has great compliance—taking her spironolactone as prescribed—and she has consensus of buy-in to her gender identity and transition. Her parents are supportive, and both the clinical social worker and endocrinologist have affection for her. With all of this in place, the national trampoline competition serves as a spark to accelerate June’s transition and a justification against any risk the gender clinic is acquiring in beginning hormone treatment before 16.

“Knowing” is present in June’s clinical visit, though the word is never said. “Knowing” occurs in the affection the doctor and clinical social worker show for June and in their recommendation for me to meet her. Likewise, the caregivers also view June as a compliant patient in her regular use of spironolactone. But “knowing” also appears in the national trampoline association’s understanding of gender as hormone levels. If the consensus of June’s gender from this outside actor is founded on certain hormone levels, and the gender clinic “knows” June as trans-, then extending this “knowledge” justifies beginning estrogen therapy. The “knowing” of June’s gender is spread into further social networks, continuing to enact June’s gendered ontological status among more actors.

In sum, Aaron and June’s stories, as well as snapshots from Kalif and Sofia’s visits, demonstrate the relationality of justification accelerates the normative sequence of the clinic. This acceleration is unobtainable to Aaron and other patients for whom consensus of “knowing” cannot be reached, or for those who are considered non-compliant patients. Acceleration takes advantage of the changing recommendations of when to begin hormone therapy, but it must be justified because the clinic is betting against patients “desisting from their cross-gender identification.” In turn, for the sequence to accelerate, the clinic must “know” a patient is trans- to justify prescribing HRT before the age of sixteen.

Conclusion

In chapter two I analyze the relationalities of gender and transgender enactments that form the sequence of the gender clinic. The predicative relationship sets up the normative sequence of the gender clinic in its linear ordering; that is, which enactments *must* come before others. These predicative relationalities serve as checkpoints that ground the sequence of transition offered by the gender clinic. In Lily's case, it becomes clear that there is also an original predicate to the gender clinic: the patients must have their parent's support to access the gender clinic. This predicate, in turn, reveals a morbid irony of the clinic—though the gender clinic aims to alleviate violence against trans- youth, those children who experience the intimate violence of unsupportive parents do not have access to the resources of gender clinic.

Obstruction is the relationality that slows the normative sequence of the gender clinic. They occlude transitions, and future enactments of gender and transgender from occurring. Obstruction can both be a location of violence (as depicted by Lily's father), and the logic of care, for instance with blockers. I employ a discussion of the body's obstruction of the trans- child's ability to enact their gender identity, as well as the interpersonal relationality of enactments, to argue for a social and intersubjective understanding of the body. I pose this understanding against Butler's theory of performativity, not as a complete refusal of citation as a form of enactment, but to challenge the theory to account for the body's failure of the trans- child and the relationality of gender enactments.

Lastly, justification is the relationality of enacting transgender as knowledge between multiple parties. This "knowing" is employed against doubt—in other words, against the possibility of "desisting"—to accelerate the normative sequence of the gender clinic by administering HRT at fifteen rather than sixteen.

THREE

Queer Time, Queer Futures

Queer is a continuing moment, movement, motive—recurrent, eddying, troublant. The word “queer” itself means across—it comes from the Indo-European root *-twerkw*, which also yields the German *quer* (transverse), Latin *torquere* (to twist), English *athwart*.
- Eve Kosofsky Sedgwick, *Tendencies*, 1993

Queerness is utopian and there is something queer about the utopian.
- José Esteban Muñoz, *Cruising Utopia*, 2009

In chapter three I wish to continue the exploration of temporality in the gender clinic that I began in chapter two. Chapter two focuses on the relationalities of gendered and transgender enactments in the gender clinic that establish the clinic’s normative sequence. It also explores relationalities that cause rupture and dissonance in the temporal linearity of the normative sequence. Chapter three, then, is where we move from the temporality within the gender clinic to the temporality of a life that extends beyond that space. Said differently, I explore how the patients of the gender clinic queer the temporal order of childhood and adolescence.⁷⁵ This happens in the moments when, as Elizabeth Freeman writes, “an established temporal order gets interrupted and new encounters consequently take place” (Freeman 2010:xxii). Moreover, I ask: in queering temporality and creating “new encounters,” how do the patients of the gender clinic open new futures?

⁷⁵ Here, I use “queer” as a verb to mean to make something non-normative. The “queer” in “queer theory” means the opposite of normative; however, this academic definition of the word, and especially its use as a verb, does not track through the gender clinic. Instead, “queer” is used to mean “gender queer” (not fitting the gender binary, so non-normative), or as an umbrella term for the long list of LGBTQIA+ identities.

Central to my argument around queer time is Elizabeth Freeman’s term “chrononormativity,” which Freeman coined to express the heteronormative temporal schema that constrain everyday life (Freeman 2010:xxii). I wish to expand Freeman’s definition to encompass cis-normative time, especially in regards to childhood and adolescent development. I do so to argue that the developmental timelines of the patients in the gender clinic queer the chrononormative sequence of childhood and adolescent development. For instance, injections, age limits for medical procedures, and long-term puberty suppression mark the development of the trans- child, creating a non-normative chronology of development. I hold this queer development in contrast to a chrononormative sequence to demonstrate how, like the trans- normative sequence of the gender clinic, the chrononormative sequence is also enacted through practice. Additionally, I argue the moments that mark queer time in the clinic, that form ruptures in chrononormativity, are “impasses.” I borrow the “impasse” from Lauren Berlant to name those times in the development of the trans- child in which delay—what Berlant calls “dithering”—queers chrononormativity (Berlant 2011:4). The impasse is especially useful in understanding the prolonged pre-pubescent and pre-gendered state caused by blockers, and the periods of waiting patients experience in anticipation of medical treatment and/or a second puberty. I employ Elizabeth Freeman’s term, “temporal drag” in my discussion of the impasse caused by blockers to argue blockers *drag* the temporal present into the future (Freeman 2010). Furthermore, I explore the dualistic nature of this prolonged present of the impasse caused by blockers; that is, how it is both troubling to the trans- patient and also a desired state.

Finally, I wish to employ queer time to think about future making. I opened this thesis with an account of the many patients in the gender clinic who have attempted to take their own life. In *Tendencies* (1993), Eve Sedgwick writes that many parts of society are adept at “denying and despoiling queer energies and lives;” consequently, the “survival of each [queer person to adulthood]

is a miracle” (Sedgwick 1993:1). This seems apparent in the gender clinic: an alternative future for these patients could have been death. It is queer time that opens new futures for these patients. As Halberstam writes, queer temporalities allow “participants to believe that their futures can be imagined according to logics that lie outside of those paradigmatic markers of life experience” (Halberstam 2005:2). Thus, the survival of the trans- patients in the gender clinic is not just a miracle, but rather comes from inhabiting queer temporalities. And the patients learn more than to just survive into adulthood, but rather bring into reality futures that are, for them, more “livable lives” (Butler 2004). Drawing on the concept of “growing sideways” from Kathryn Bond Stockton and expanding on my discussion of Elizabeth Freeman’s “temporal drag,” I maintain that the patients of the gender clinic enact these futures which appear in the present as glimpses of José Muñoz’s “utopia” (Stockton 2009; Freeman 2010; Muñoz 2009).

Queer Time and Chrononormativity

In chapter two, I named the standard progression of a transition in the gender clinic the “normative sequence.” This is the epistemological ‘normal’ for the gender clinic. What it *knows* should be the sequence of transition. An analogous timeline for childhood and adolescent development exists both outside and inside of the gender clinic. This epistemological normal is what I call Elizabeth Freeman’s “chrononormative.” In her book *Time Binds* (2010), Freeman does not delve into childhood development, but rather focuses on how schemas of time related to heterosexual domestic life enforce a chrononormativity. Writing about three works from lesbian authors, Freeman argues chrononormativity works in the texts as “an enforced synchronicity that seems at once to suffocate [the] female characters and to offer queer possibilities” (Freeman 2010:39). Though the source material for Freeman’s analysis varies greatly from my ethnographic data, abstraction of Freeman’s theory proves useful for my analysis. Instead of thinking in terms of

heteronormative chrononormativity (temporal movement towards reproduction), we can apply Freeman's theory to encompass cis-normativity in childhood development. That is, while Freeman's work reveals temporal schemas oriented towards successful reproduction, the gender clinic elucidates the normative temporality of gendered child and adolescent development. When thinking of children, this "enforced synchronicity"—chrononormativity—can be seen in the regular hours of the school day, and the frequency of scheduled medical check-ups. In other words, I employ chrononormativity to denote the various stages and checkpoints that define a Western epistemological understandings of 'growth' and 'development.'⁷⁶

One can discern this chrononormativity in the gender clinic, too; for instance, when I observe a clinical visit with Andrés.

Andrés is a female to male patient. He's short and skinny, and has a great confidence in himself and his gender identity. Andrés knows what he likes and how he feels, and isn't afraid to tell anyone.

Andrés is having his first visit at the gender clinic, but he previously began testosterone therapy with another clinician before moving to the area. Specifically, he's come to the gender clinic because he wants to adjust his dosage of testosterone. Though he's been taking testosterone for about a year, he's still experiencing periods. Changing the dosage and/or frequency of testosterone should stop his "cycles," as the doctor calls them.

While a dosage adjustment would normally be a routine visit, because Andrés is new to the clinic, he must fill out the intake packets. Additionally, the fellow conducting the consultation has to do a full physical examination. After all of the introductions ("Hi! I'm a fellow training with the endocrinologist. I use she pronouns. What pronouns do you use?") and the looking, listening, touching, and tapping of the physical exam, the fellow moves to the computer and pulls up Andrés' charts that have been transferred from his former doctor. When the fellow gets to the growth chart, she turns the monitor to face Andrés and his mother. "I'm sorry this is only the female growth chart," the fellow

⁷⁶ The literature review has a review of some of these understandings of childhood growth.

says, “the electronic medical record system automatically pulls up the growth chart based on sex.” Andrés’ growth appears as a green sigmoidal line moving across the graph with age marking the x-axis and height in inches marking the y-axis. It intersects points on the graph indicating Andrés’ height taken at previous appointments. Reference lines in blue follow similar sigmoidal curves above and below Andrés’ line, each marking the 25th and 75th percentiles. A third blue line runs just below Andrés’, denoting the 50th percentile. “If you’d like, I can print out a male growth chart with the points transferred over,” the fellow says, “but it looks like you’ve had very healthy growth for a female, and though you’re on the shorter side for a man, you’re still in a healthy range.”

Andrés’ clinical visit offers an example of a chrononormativity. The gender clinic’s electronic health system—one used by the hospital system the gender clinic is a part of—only recognizes Andrés’ sex assigned at birth, plotting his expected growth over time based on this data and data collected at previous doctor’s visits. This growth chart marks the chrononormative height development of children and adolescents.⁷⁷ In fact, the practice of marking height on gendered growth charts enacts chrononormativity, bringing it into being. Thinking back to Aaron, one can imagine a similar chrononormative understanding of growth with regards to maturity versus age (likewise mediated by sex). However, in identifying as a trans- male, Andrés queers the chrononormative assumption of height development related to his sex assigned at birth. His transition interrupts the chrononormative growth(chart) of the child. In fact, the fellow tells Andrés that “taking testosterone may even give [him] an extra two or three inches” because his growth plates may not have closed before he started taking testosterone. Thus, Andrés’ transition not only upsets which graph his growth chart should be placed upon, but his possible hormonal height also

⁷⁷ These growth charts also demonstrate that height can be an enactment of gender. Lily asks in their visit what their height will be after their transition, and that they would like to be 5’ 2”, a height they feel will enact femininity.

disrupts the epistemological understanding of childhood growth. In short, Andrés' bodily development is not accounted for in the chrononormative order of things.

Time itself also changes due to Andrés' transition. Time becomes marked not just by when sex hormones *began* to flood Andrés' blood—puberty—but also by when Andrés *introduces* them to his system—injecting himself with exogenous testosterone. Andrés explains to the fellow that he administers T to himself “on the second of every month.” That is, on the second of every month, Andrés takes the small glass vial of testosterone he keeps at the back of his family's refrigerator, locates the needle and syringe that he got from the pharmacy, and draws up his monthly dose of the drug. He flicks the syringe and pushes out the small air bubbles in the needle like the nurses taught him. Andrés then wipes his thigh down with rubbing alcohol and pushes the subcutaneous needle into his leg. Whereas in the chrononormative sequence (female) puberty *happens to* Andrés, enacted by a bodily actor (perhaps the pituitary gland or ovaries), here, we see Andrés does the enacting. *He* is offered control of the sequence, and in doing so queers time.

Time becomes marked by this ritual. And at this visit—because it is Andrés' first appointment at the gender clinic—the fellow will double check when Andrés gave himself his last injection because “we need to know when your last dose was so that we can read the labs correctly.” Moreover, the fellow and the endocrinologist will adjust the frequency by which Andrés takes testosterone—now half his current dose, but once every two weeks—to hopefully stop Andrés' periods.⁷⁸ Time for Andrés and the patients of the gender clinic is therefore intimately delineated by the frequency of treatments. One patient explains that he “craves T” the days before his next injection. “I'm in a bad mood. I'm not myself,” he says. Others remark that they “look forward” to their next dose, and that they “would never miss a day” or “never miss a dose.” Javier tells me in an

⁷⁸ The more constant level of testosterone in the body should suppress Andrés' periods.

interview, “What with hormone replacement you have to go through a second puberty.” Treatment builds a temporal landscape outside of chrononormativity. New temporal markers gain significance, and the temporal order can be queered with repeated puberties. One patient, Nolan, who recently started HRT, explains to me, “T means going through a second puberty because I hadn’t taken blockers... It’s kind of terrifying and exhilarating at the same time because I have no idea what the end result will be.” I will unpack Nolan’s turn to the future later in this chapter, but it’s clear that, all in all, the patients and the gender clinic build a queer time unrecognizable to chrononormativity. Moreover, this queer time has, as Halberstam writes, “the potential to open up new life narratives and alternative relations to time and space” (Halberstam 2005:2).

The Impasse and Temporal Drag in the Gender Clinic

While Andrés demonstrates to us a queer temporality mediated by hormone replacement therapy, puberty blockers also cause rupture in the chrononormative temporal order of childhood development. Blockers’ express purpose in the gender clinic is to disrupt the timeline of gendered growth. This is why blockers appears as an example of “obstruction” in chapter two. It binds to the hypothalamus and pituitary and quite literally obstructs their stimulation, thus obstructing gendered corporeal maturation. But rather than rehash my previous claim, I want to think about the temporal consequences of blockers and their obstruction. To understand this, we will have to appreciate why blockers are used in the clinic in the first place.

When the endocrinologist prescribes blockers, she has two logics of care in mind. One is to keep the patient “at a minimally gendered state.” The other is to “buy time.” By “minimally gendered” the doctor means that the patient has not developed secondary sex characteristics. That

is, they have not gone through any of the bodily changes that come about during puberty.⁷⁹ This “minimally gendered” state can be achieved because when blockers are administered within the earliest stages of puberty, the pubertal bodily changes will recede to their pre-pubescent states.⁸⁰ By “buying time,” the doctor refers to the extension of the period of time the patient will live as “minimally gendered” before they go through puberty. Blockers push off puberty. And in doing so, they extend the period in which the material body of the child does not enact gender. This is why before puberty “tomboy” girls may be mistaken for young boys, and boys with long hair and who wear pink might be mistaken for a girl. At this age, gender is primarily enacted as adornment to the material body and how one carries that body through the gendered world (for instance, bodies that roughhouse enact masculinity).⁸¹ This delay of puberty ‘buys time’ for the patient to “further explore their gender identity” and possibly “desist from their cross-gender identity” before the patient would begin HRT at sixteen (or fifteen). The doctor tells me this is “rare”—a patient in her clinic who stops identifying as trans-. The doctor tells me research shows pre-pubescent patients who come to the gender clinic are the most likely to “desist.” On the other hand, patients who come to the clinic at the early stages of puberty, during puberty, or after puberty are “highly likely to persist forever as identifying as transgender.”⁸² The doctor theorizes this difference is caused by a natural exploration of gender and gender identity in childhood, whereas by puberty children have a more solidified understanding of their gender identity. Why and how does this crystallization happen? The doctor doesn’t know. But this is why patients must wait until they begin puberty to start puberty blockers. It’s a test that proves the patients don’t want to go through the puberty associated with their natal

⁷⁹ These bodily enactments of gender are discussed in chapter one.

⁸⁰ Eric, introduced in chapter two, offers a good example of this. His enlarged nipple (the beginning of breasts) will return to its prepubescent size when he begins blockers.

⁸¹ Pages 7-10 of Fausto-Sterling’s *Sex/Gender* (2012) offers an overview of childhood play.

⁸² Steensma et al. (2011), Steensma et al. (2013), as well as Wallien and Cohen-Kettenis (2008) all examine this trend.

sex, and it stops a clinical intervention in patients who are more likely to “desist.” The gender clinic is thus accounting for the high societal stakes of gender and especially gender transitions in children. Blockers are a palatable treatment (it is reversible and has no positive effects) that will ‘buy time’ for the child to better understand their gender before they are sixteen and can begin a positive medical transition.

But what does this bought time mean for the trans- child? Patients begin blockers once they begin puberty. In fact, if blockers are started at the earliest stages of puberty, the secondary sex characteristics associated with puberty will dissipate. This is the case for patients like Eric and Max. For patients who are a little farther along in puberty (but not so far along that blockers will not be effective) such as Lily, puberty’s effects will be halted and kept at a minimum. There is a large age range for when puberty normally begins,⁸³ but many patients I observe in the gender clinic are beginning blockers (and therefore beginning puberty) at age nine or ten. With the minimum age for HRT set at sixteen (fifteen in special cases), these patients will wait around six years to begin puberty. They will be kept “minimally gendered” for an extended period of time in comparison to the chrononormative timeline of development.

This delay in puberty is difficult for many of the patients who are on blockers. Their peers are going through puberty at a ‘normal’ age, while the patients must go through middle school and half of high school before beginning puberty. At one of my early visits to the gender clinic the doctor describes to me one patient I did not meet, who began blockers at a very young age and continued them until they were sixteen. The doctor tells me he “was skilled at social projection of gender and age.” Specifically, she explains that this female to male patient would apply makeup to

⁸³ For girls, this is age 10 to 14, and for boys, age 11 to 15 (Kail and Cavanaugh 2010:296). However, the age range for when puberty starts is changing (Euling et al. 2008; Walvoord 2010).

contour his face and also give him a hint of a beard-shadow. In short, he tried to enact his gendered age through makeup. No more baby fat. Now he looked like an adolescent/young man.

This discomfort with the extension of the temporal period of being “minimally gendered” appeared often in my discussions with patients, for example, in my interview with Liam.

Liam tells me he began blockers at age twelve or thirteen. Not only did Liam begin puberty at that age, but he was also seeing changes in his cis-male peers that he wanted, yet “could not have.” When I ask Liam, “what do blockers mean to you?” he responds, “I just think that [blockers] kind of stopped everything that I didn’t want from the beginning. So that was kind of a relief. But still kind of depressing, because it didn’t really do anything physically.” Liam goes on to clarify this means he feels blockers had no positive effects.

I follow up by asking, “And how did blockers affect your transition?”

Liam replies, “I mean it definitely helped getting prepared to do HRT. But it didn’t, didn’t really do anything. It was just another point of my transition. It was just another curve in the road that I had to get over to be where I am now.”

Liam, like the patient who performed age alongside gender, is queered by the treatment offered by the gender clinic. Liam also queers the chrononormative sequence of childhood development by taking blockers, while contemporaneously expressing a desire to fit the chrononormative timeline. He tells me at another point in his interview that he initially wanted HRT, but his first treatment was “blockers because that was something that [the gender clinic] could do then and there.” Liam desired to follow a male chrononormative development, but because his sex assigned at birth is female, and because his only treatment option was blockers, he dually queered time and was queered by the normative temporal sequence of the gender clinic.

Both Liam and the patient who performed gendered age/aged gender (I’m not sure if the two are separable or which is the adjective), demonstrate what Elizabeth Freeman calls “temporal drag.” She writes that “temporal drag” signifies “all the associations that the word ‘drag’ has with

retrogression, delay, and the pull of the past on the present” and a “corollary to the queenier kind” (Freeman 2010:62). In the patient the doctor tells me about, we see drag as performance. Like a drag queen performing a gender, the patient presents age through makeup.⁸⁴ Alternatively, in Liam, we see Freeman’s first definition. But instead of the pull of the past on the present, I want to argue Liam is dragging the present into the future.

Liam begins blockers at age twelve or thirteen—the beginning of his female puberty—and in doing so *drags* the developmental state of his body through the future until he stops taking the blockers. That is, his present (state of development) will continue until either he begins HRT at sixteen (or fifteen), or he ‘desists from his cross-gender identity.’ With each of his monthly blocker injections, Liam is delaying. Delaying not his present via his past, but delaying a future via his present. Thus, when Liam injects blockers he, rewording Freeman, pulls the present on the future. For Liam in a constant state of “minimally gendered” existence is not a past, pre-pubescent Liam pulling on the present Liam, but rather Liam at the precipice of puberty pulling on the future. With each injection, Liam is determining his future as a continuation of the present. This only ends when he stops blockers and begins HRT.

The stuck-ness of blockers—of Liam in the present—can also be described as an “impasse.” Lauren Berlant writes, “[A]n ‘impasse’ designates a time of dithering from which someone or some situation cannot move forward.” And furthermore: “the impasse is a stretch of time in which one moves around with a sense that the world is at once intensely present” (Berlant 2011:4). Many of the patients in the gender clinic live in this impasse, even those past the age for blockers. For instance, some patients have come to the gender clinic too late in their puberty to begin blockers, yet they are younger than sixteen and therefore cannot begin HRT. Others have already begun HRT but are

⁸⁴ He also presents the question: Can age be enacted, brought into being? Is age a reality we can dictate or is it wholly dictated by chronological time?

waiting to turn eighteen so that they can undergo one or more surgeries. These patients are left in a state of waiting, of delay, and of want. In short, they are at an impasse.

Liam, likewise, demonstrates existing in an impasse. Liam's drag of the present into and through the future can also be described as a state of non-motion. Liam "cannot move forward." With his transition. With puberty. With a chrononormative timeline. And he knows so. He compares himself to his cis-male peers and is "depressed" by existing "intensely present" rather than developing at a chrononormative pace.⁸⁵ Here, it seems Liam feels left behind by his peers, that blockers obstruct him from becoming his future self. Yet Liam is kept in this impasse so that he should dither. Or rather, come to a conclusion of his dithering, resolve vacillation between female and his male gender identity. Liam is held in an impasse so as to decide if he will "desist" or persist in his "cross-gender identification." And this is done for years—from the earliest signs of puberty until sixteen (or fifteen)—pushing Liam off the chrononormative timeline for development. Consequently, Liam is in an impasse that temporally queers him.

Yet Liam has chosen this impasse. He is an actor. He seeks out the gender clinic, consents to treatment, injects himself with medication. So Liam is also queering chrononormativity. Thus, we see blockers are dualistic in nature—they cause the patient to be the object and the subject of queering. Moreover, a dualism exists in blocker's desirability and their inability to fulfill the deep desire for transition. Blockers obstruct patient's unwanted puberty but consequently halt *all* puberty—even a desired one—from proceeding. As a central intervention to the gender clinic's treatment of early pubescent trans- youth, blockers "buy time." But bought time is time the patients are not actively transitioning. Liam expresses blockers are "a relief" from an unwanted puberty, "but

⁸⁵ "Intensely present" is Berlant's phrase, not Liam's.

still kind of depressing.” That is, they don’t provide the material bodily changes he desires—“they didn’t do anything physically.”

Many of the patients have completed extensive research into the care options the gender clinic can provide them—including blockers—before their first visit. When the doctor lists the methods by which Lily can take blockers—by implant, injection, or patch—Lily answers so quickly with injection that they nearly interrupt the doctor. Lily explains that they have been doing research online and believe injections to be the most effective method of administering blockers. This clearly demonstrates that blockers and the impasse they enact are coveted. Yet blockers, and specifically how they are administered in relation to the requirement that HRT can only begin at age sixteen, obstruct a patient’s bodily enactment of their gender identity. Accordingly, the trans- patient on blockers queers the sequence of childhood development, but in turn is queered by the impasse. This impasse is still desirable to its alternative (a misgendered puberty); however, it is an impasse that bars the positive medical transition patients who seek out the gender clinic truly desire.

Future Making, Future Tense

What viscerally strikes me most completing my fieldwork in the gender clinic is the ability for the patients to build futures for themselves in the face of a society whose opposition to their existence has led many of them to attempt suicide. In turn, this last section of my thesis has been the hardest for me to write. I want to recognize the gravity of the decision for trans- children and adolescents to end their life, while I also want to honor their enactment of a new one. Writing this section has furthermore been challenging because, per my IRB approval, these are topics I do not directly talk to the patients about. However, they are topics that cross the gender clinic often. Each consult with the clinical social worker involves one-on-one time with the patient, during which she asks the patient if they have had suicidal thoughts or desires to hurt themselves. On the other hand,

a large part of the clinical social worker's intervention is, as she tells me in an interview, "just getting [the patients] into the future tense. Because they are making a big decision about the direction of their lives." She wants the patients to "think about that future self. What is that future self going to think about this? What is that future self going to encounter and think about?" With the future so heavily stressed in each clinical visit—the possibility for its reality or its termination—I find it important that the future tense makes it into this thesis.

Specifically, I find throughout my research that the future is often enacted when the patients lean into the queer temporalities of the gender clinic. For instance, Liam tells me in his interview one of the best things the gender clinic did for him during his first visit was that "they gave me a diagnosis." And even though he started treatment with blockers rather than the hormones he wanted, something that frustrated him, the gender clinic, "also gave me a plan of what I can do now, [and] what I can do in the future." Even though Liam is placed in an impasse via blockers, he is able to see a future for himself. In this way, Liam and the patients of the gender clinic challenge what Lauren Berlant calls "cruel optimism." Berlant writes, "optimism is cruel when the object/scene that ignites a sense of possibility actually makes it impossible to attain the expansive transformation for which a person or a people risks striving" (Berlant 2011:2). I have argued that the impasse can produce harm against trans- youth, but in the queer temporalities of the gender clinic, the patients find futures. In the end, the blockers act as a step in the sequence and do not limit the patients' ultimate becoming.

The impasse, however, can often be described as a time when children are not allowed to grow up. They are placed in a pre-pubescent, and thus pre-adolescent, temporal state until they are allowed to begin puberty (or a second puberty if the patient is not on blockers). Kathryn Bond Stockton argues that "children grow sideways... because they cannot, according to our concepts, advance to adulthood until we say it's time" (Stockton 2009:6). In other words, in a culture in which

childhood and adolescent development is associated with vertical movement—growing up “toward full stature, marriage, work, reproduction, and the loss of childishness”—those children that are not allowed to grow vertically, “grow sideways” (Stockton 2009:4). In the gender clinic the patients grow sideways away from a chrononormative timeline of development and into queer time. Patients put themselves in an impasse engendered by blockers; they go through a second puberty or puberty at a non-normative age; and due to hormone treatment, patients choose to give up the ability to have biological children.⁸⁶ Stockton writes, “The child who by reigning cultural definitions can’t ‘grow up’ grows to the side of cultural ideals” (Stockton 2009:13). And for the patients in the gender clinic, this growing to the side of cultural ideals means existing in queer time and constructing a future.

For instance, Nolan explains that, to him, “T means going through a second puberty because I hadn’t taken blockers... It’s kind of terrifying and exhilarating at the same time because I have no idea what the end result will be.” Nolan is growing sideways, into queer time. Moreover, in doing so, he is turning towards a future. One which is frightening and ecstatic in its unknown promise. José Muñoz argues that queer is always oriented towards the future, and that “Queerness as utopian formation is a formation based on an economy of desire and desiring. This desire is always directed at that thing which is not yet here, objects and moments that burn with anticipation and promise” (Muñoz 2007:455). Nolan seeks out the gender clinic because he yearns for the “not yet here,” the future self that lies on the horizon. Testosterone promises a future that is more livable for Nolan, but what that future will be is still unknown. We see that the patients’ turn to the future further aligns with Muñoz’s claim because Muñoz argues “A queer utopian hermeneutic... [not only] look[s] for queer relational formations within the social... It is [also] the work of not settling for the

⁸⁶ Some patients will have sperm or eggs frozen before they begin hormone therapy (if they have not taken blockers). Additionally, trans- people who have uteruses can sometimes become pregnant, but must not be taking testosterone at the time to do so.

present, for asking and looking beyond the here and now” (Muñoz 2007:457). As I maintain throughout this thesis, Nolan enacts transgender and his gender identity relationally; only in sociality do their practices call realities into being. Thus, we see Nolan bringing about a future in his queer relational enactments.

Other theories of temporality in queer theory are founded on an “anti-social thesis,” the most important to Muñoz’s work (in its opposition) is Lee Edelman’s *No Future* (2004). Edelman rejects looking towards futurity as he believes it promotes a reproductive heteronormativity.^{87,88} Yet the gender clinic challenges this assertion. It has no stake in reproduction, but rather engenders anti-chrononormative realities. Nolan, like all of the patients, seeks out the gender clinic because the future promises a reality that cannot be offered in the present. In this desire, we see that the gender clinic’s intervention and queerness are turned towards the future.

Liam offers another example of the turn to the future. He explains that the gender clinic’s treatment, especially HRT, “meant, like, a new life. That I can start from the beginning and have this perfect, perfect self that I envisioned for myself.” Though this self really comes about when Liam starts HRT, while he is taking blockers, he is given a diagnosis that gives him hope, which, along with “futurity,” is a primary quality of queerness for Muñoz (Muñoz 2009:11). Another patient tells me that for him, “[T offers] all the physical aspects: it will lower my voice it will change the shape of my body, it will give me facial hair, make me look more masculine. But really it’s just the fact that I

⁸⁷ For further understanding of the basis of anti-social queer theories, turn to Leo Bersani’s *Homos* (1996) and “Is the Rectum a Grave?” (1987). Halberstam offers an overview in “The anti-social turn in queer studies” (2008). To understand the debate between the anti-social thesis and queer utopia. turn to Caserio, Edelman, Halberstam, Muñoz, and Dean in “The antisocial thesis in queer theory” (2006).

⁸⁸ In *No Future* (2004) Edelman is also concerned with the child, but believes that the future is dictated by the figure of the child produced by the heteronormative couple. Muñoz disagrees with Edelman, writing, “I respond to Edelman’s assertion that the future is the province of the child and therefore not for the queers by arguing that queerness is primarily about futurity and hope” (Muñoz 2009:11).

am taking a step forward. I'm moving towards [my] final goal... So T is a step in the right direction. And it's a constant. It's a reason to shake off the feeling that I'm standing still." This patient has not started taking testosterone yet—his parents are wary of any permanent changes—but even the idea of the T provides him with hope. Treatment, or even its future promise, therefore acts as an object of anticipation and optimism, which allows the patients of the clinic to “envision” their new futures and their new selves. In growing sideways and existing in queer temporalities of the gender clinic, futures are found.

Other scholarship on queer temporality has come to similar conclusions that leaning into queer time allows people to visualize and catch glimpses of the future. For example, Elizabeth Freeman argues temporal drag is “a way of forcing the present to touch its own disavowed past or seemingly outlandish possible future” (Freeman 2010:78). And these futures can seem outlandishly unattainable to the patients at the gender clinic, especially when they first visit the clinic. When the clinical social worker asks Javier at his first consultation if he has had suicidal thoughts, Javier responds that although he does not want to kill or hurt himself, he sometimes feels “it would be easier, be less stressful, if I wasn't alive.” The future seems so inaccessible or outside the realm of possibility in the present that Javier feels he will never reach it. Yet when I interview him after he has talked with the doctor and been given a timeline for beginning T, he tells me he feels testosterone treatment “is kind of like the process of the caterpillar becoming a butterfly. Even though as this person [pre-transition] you felt that something was wrong most of your life... you have to become that person that you want to be, eventually. And you're going to be a happier person, and you're just going to feel a whole lot better and have a different outlook on life.” Because Javier is too young, he won't start T for many years. The present will drag into the future. But Javier exemplifies Freeman's argument: temporal drag allows one to see an unknown future, at least in glimpses, at least in hope. Javier has already gone through a female puberty and now must wait in an impasse until he is sixteen

to begin testosterone treatment. He is dragging his present through his future until he can begin HRT. But in this temporal drag he is seeing a future. One in which he flourishes and feels proud in his existence.

José Esteban Muñoz would call this a glimpse of something utopic. He believes, “the utopian can be glimpsed in utopian bonds, affiliations, designs, and gestures that exist within the present moment” (Muñoz 2007:453). What Javier is exactly binding to, affiliating with, designing, or gesturing to, is difficult to perceive or at least concretely describe. But in his relation to his body, his past, the gender clinic, the care providers, his family, and the medical treatments, he is catching glimpses of a utopian future. When we consider this glimpse in connection with Muñoz’s idea that “queerness in its utopian connotations promises a human that is Not- Yet- Here,” we see that for Javier, and the patients of the clinic, the “Not- Yet- Here” is one’s future self(Muñoz 2007:455). And as this entire chapter argues, the patients and their futures simultaneously queer chrononormativity and are queered by temporality to reach these future selves. The patients break down the epistemological knowledge of what it means to grow up, and the definitions of child, adolescent, and development. In inhabiting queer time, the patients have “the potential to open up new life narratives” and “[see] through the present to a future elsewhere” (Halberstam 2005:2, 77). They move into the future tense, making new futures.

CONCLUSION

... Miracles

Interviewer: What does trans- mean to you, then?
Liam: A pivotal point in my life that changed for the better.

I have argued throughout the chapters of this thesis that gender and transgender are enacted. That is, they do not exist in a presupposed space for one to discover or come to know. Instead, I maintain they are ontological realities that are brought into being through practice. As such, the varied ways actors (both human and nonhuman) *do* gender and transgender in the gender clinic enact multiple realities of their objects. Gender *is*, and transgender *is*, multiple.

In chapter one, *Transgender in Practice*, I lay the basis for this claim. From my ethnographic data in the pediatric gender clinic I ask, How is gender done? How is transgender enacted? Moreover, who or what enacts gender and transgender? I argue that gender and transgender cannot be enacted alone; they always exist in relation. The doctor cannot practice a transition without a patient who also participates. A child cannot state their pronouns without anyone to listen. Likewise, gender is done not just with the body or linguistically, but also with materials (the toys one plays with), styles (how one adorns and presents one's self), and structurally (how gender is transcribed through infrastructures such as bio-medical and government records). Transgender comes into being when competing enactments of gender are held against one another. Often times, this happens through temporal ruptures in which past enactments of mis/gender appear in the present, haunting and challenging temporally present realities of gender. Or when the patient's future self and their desire to enact gender is employed as a referential in the present against current gender enactments.

However, transgender is not epistemological between-ness; it is not the gap between male and female. Transgender is brought into reality as something beyond or greater than its constitutive dissonant gender enactments.

I further explore enactments of gender and transgender in chapter two, *Enactments in Relation, Transition in Sequence*, but posit their relationalities construct a trans- normativity in the gender clinic. Specifically, the relationality of predication sets up a normative sequence of transition, while the relationalities of obstruction and justification slow and accelerate the gender clinic's sequence of transition, respectively. The analysis of how transitions in the gender clinic are done in practice allows us to understand transgender as ontology better. Namely, that transgender can be brought into being both in the alignment and rupture of temporal sequencing. The sequences of transition also reveal an original predicate—that the patients of the gender clinic must have their parents' support to access its resources—an assumption of the location of violence, and in turn, a morbid irony. The gender clinic aims to mitigate violence against trans- youth by providing affirming medical care; however, the original predicate forecloses access to the gender clinic's resources to those trans- children experiencing the most intimate of violence.

Employing my ontological approach of gender and transgender to my ethnographic data from the gender clinic, especially around violence, leads me to engage Judith Butler's performative theory of gender. In the debate of the body's role in Butler's performative thesis, I argue that the patients of the gender clinic demonstrate that the intersubjectively gendered body has the ability to mis/gender the trans- child. That is, parents of trans- youth have the ability to relationally enact mis/gender on the child, while the child's own body can enact mis/gender in its intersubjective signification. This is to say, trans- youth may be citing a norm of their gender identity, but they often experience the relationality of the body and its gender citation as constraining their ability to *do* their gender identity.

In chapter three, *Queer Time, Queer Futures*, I move from focusing on the time of the clinic, to the time of the child. Accordingly, chapter three is the space in which I place transitioning in the gender clinic in conversation with scholarship on queer time and temporalities. Throughout the chapter I maintain that the patients of the gender clinic are both queered by their transitions, yet also concurrently queer the chrononormative sequence of childhood. Moreover, I employ my theory of transgender, transition, and gender as ontology, to reveal how the chrononormative sequence of childhood development is likewise enacted through practice. In this way, my work makes a valuable contribution to a body of literature by grounding it in the lives of the trans- patients of the gender clinic, dramatizing the particular versus the general to ask, “What is normative? What is queer?”⁸⁹ I argue that while the queering of trans- youth can be a form of violence in itself, when the patients lean into the queer temporalities of their transition they are able to catch glimpses of their futures. As such, the patients of the gender clinic construct futures for themselves, enacting more livable lives.⁹⁰

The exceptionality of futures for these patients cannot be understated. I open this thesis describing the pervasiveness of former attempted suicides in the gender clinic. It does not strike me as coincidental that I argue the patients of the gender clinic enact realities of gender, yet many of them have come so close to permanently ending their realities of life. There is something profound in the patients of the gender clinic continually enacting their identities into reality, bringing futures into being, where so easily there could have been no future.

Of course, the reality of a future is not true for all trans- children. This is the obvious methodological shortcoming of my thesis, one based on the morbid irony and original predicate of

⁸⁹ A further question staged in this tension might be: How do we appreciate the unique, queer child, yet also integrate them so as to alleviate violence? Is integration the method to do this? Or is there another way, one in which queering is not reciprocal?

⁹⁰ (Butler 2004)

the gender clinic. Not only did the IRB prohibit me from asking about suicide or depression in my interviews, but in the grand scheme of things, these children are the fortunate ones. The luckiest of the living trans- children are the only ones who populate my field site. Even if their parents may not wear rainbow pins or unabashedly celebrate their child's identity, the patients of the gender clinic have parents and guardians who support them enough (and have the resources) to bring them to a pediatric gender clinic. This methodological shortcoming in itself, though, demonstrates my claim that the ontology of transgender is multiple. Some trans- children will enact a reality that involves medical assistance, while many more will find it nearly impossible to enact that reality into being. Still others will end their realities of living altogether.⁹¹ Future scholarship, though it may be methodologically difficult, can employ an ontology-as-practice approach to further engage how gender and transgender are done, undone, or obstructed from being done in this population.

In my claim for ontological multiplicity—that gender, transgender, transition, future, reality is multiple—an ethical question consequently arises. We must ask, as Annemarie Mol writes, “What reality should we live with?” (Mol 2002:165). This is not a question my thesis undertakes. But it is one I believe this thesis can be used answer in part. This thesis tells us that transgender *is* many things. In fact, there are countless realities of gender, transgender, and transition that did not make it into this thesis. Moreover, as time goes by, socio-material practices will bring new ontologies into existence while others will fade in their neglect. Asking, then, “What *is* transgender?” or “How can we *know* transgender?” becomes unhelpful. Instead, we might ask, “Is this practice[, is this reality,] good for the subjects (human or otherwise) involved in it?” (Mol 2002:165). To answer my first

⁹¹ Employing Wittgenstein, anthropologist Angela Garcia thinks about suicide as a form of life in *The Pastoral Clinic* (2010). Future scholarship, could additionally think about the point many trans- children come to in which death arrives either in the form of suicide or one's former gender identity (for instance, in the use of “dead name” to refer to a trans- individual's pre-transition, mis/gendered name).

question, then, we should live with realities, practices, existences (whatever one might call them) that bring “goodness” into the world.

Does the gender clinic practice such a virtue? Yes, I believe so. But I also believe there is more to be done, and that medicine will need to grapple with the question, ‘are its practices bringing the “most good” into the world?’ The clinical social worker explains to me in an interview that the gender clinic has three goals: “The first is patient care that is integrated and holistic. The second part is training the future providers,” and the third is to build “community support and a safety net.” The gender clinic is still young and is overwhelmed by a five-month waitlist for new patients, but these goals demonstrate that the mission of the gender clinic is to help all trans- youth, not just those who can access its resources. Consequently, the gender clinic must contend with its relationship to structural violence as a filter and predicate to entering its doors. This may be an intractable problem for clinicians, but the clinic prides itself on its “multidisciplinary” nature. Thinking about the open-ended “relationality” of the hyphen in “trans-”, a coalition of actors both within and outside the walls of the hospital, might be the “beyond” the gender clinic needs to realize its goal (Stryker, Currah, and Moore 2008).⁹²

...

When Eve Kosofsky Sedgwick was diagnosed with the breast cancer that would eventually end her life, she began a period in her career in which she cultivated positive relationships with her objects of study. In “Queer and Now,” noting how “everyone who does gay and lesbian studies is haunted by the suicides of adolescents,” she wrote the “survival” of her queer friends was “a miracle” (Sedgwick 1993:1). My thesis attempts to understand some of these miraculous survival

⁹² Stryker, Currah, and Moore employ an open-ended relationality of the hyphen to resist a permanent tie of “trans” to any suffix; that is, to call for trans- theory that is not just trans- gender, but also trans- “-national, -racial, -generational, -genic, -species” etc. (Stryker, Currah, and Moore 2008:11).

stories. Like queer theory's growth out of the death of sexually non-normative people during the AIDS crisis, this thesis is inescapably grounded in the reality of trans- youth suicide.⁹³ However, like Sedgwick, I have attempted to turn towards the positive. That is, in the shadow of trans- death, my project has been to imbue the pages of this thesis with life.

In "White Glasses," reflecting on memorializing her friend, Michael Lynch, Sedgwick writes, "My own real dread has never been about dying young but about losing the people who make me want to live" (Sedgwick 1993:264). I've had a short life so far. One which has been filled with many people who make me want to live. The patients of the gender clinic—the profundity of their lives and their futures—are some of those people.

⁹³ The profound sense of mortality and mourning during the AIDS crisis required a new way of thinking about the stakes of life and death in the world, running from the scale of the personal to the biopolitical. Further research in the area of trans- youth can explore the biopolitical consequences of 'making live' and 'letting die' for this population.

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