Two classes of trans kids are emerging – those who have access to puberty blockers, and those who don't

4 May 2021, by Travers

For people who have never thought about it before, it might sound reasonable to require trans kids to wait until they're adults before they can receive certain forms of care known as gender-affirming treatment—which is what legislation that just passed in Arkansas does.

But this type of legislation actually prevents kids from accessing treatment before and during a crucial period of development: puberty.

When I was researching my book "The Trans Generation: How Trans Kids and Their Parents are Creating a Gender Revolution," I observed how not all trans kids can access the care they want or need during this critical stage of life. This unequal access to gender-affirming health care, which occurs across state lines and socioeconomic divides, could cause two "classes" of transgender people in the United States to emerge—those who are able to take hormone blockers, and those who aren't able to do so.

Those in the latter group can endure more financial hardship, physical pain and mental anguish later in life, while becoming much more vulnerable to discrimination and violence.

A paradigm shift in trans treatment

For decades, kids who didn't conform to the gender expected of them were forced to endure treatments designed to "cure" their gender nonconformity. This form of therapy, called "reparative" or "corrective," typically involved instructing parents—and sometimes teachers—to subject children to constant surveillance and correction. If a child acted in ways that didn't align with gender-expected behaviors, psychologists told caregivers to withhold affection and mete out punishments.

For example, in the 1970s, a boy with the pseudonym Kraig was a patient at UCLA's "feminine boy project," a government-funded experiment that sought to evaluate ways to reverse feminine behavior in boys.

Kraig was subjected to shame-inducing treatments, with therapists counseling his father to beat Kraig when he failed to conform to masculine norms.

He ended up committing suicide as an adult.

In recent years, however, there has been what transgender studies scholar Jake Pyne has called "a paradigm shift" in treatment. An ever-expanding body of research shows that family support, social acceptance and access to supportive health care produce the best outcomes for transgender kids.

In 2011, the World Professional Association for Transgender Health took a position against gender-reparative therapy, stating that any therapy that seeks to change the gender identity of a patient is unethical. Changes to the law have followed suit. For example, in 2014, California passed the Student Success and Opportunity Act to ban reparative therapy and require schools to permit transgender children to participate in activities and to access spaces and facilities according to their self-determined gender categories.

Buying time

As corrective or reparative programs have lost legitimacy, publicly and privately funded gender clinics featuring affirming models of treatment for trans kids have sprung up across the U.S.

Affirming treatment focuses on enabling kids' families to embrace their child's gender identity, and supporting them in dealing with any resulting

discrimination or mental health issues.

This treatment model doesn't steer patients toward any particular gender identity. However, if a child makes the decision to transition to another gender, a number of medical interventions are available.

According to the clinical literature surrounding gender-affirming practice, the first goal of medical treatment is to buy time for the child or young person.

This is done through puberty-suppression therapy, via hormone blockers. The thinking goes that by delaying the onset of puberty, gender-nonconforming kids won't be rushed into a decision before they experience the irreversible development of secondary sex characteristics.

The second goal is a more "normal" and satisfactory appearance.

To accomplish both goals, access to hormone blockers is crucial.

For example, most children who have been assigned female at birth and take hormone blockers will not need top surgery. Meanwhile, children who have been assigned male at birth and take hormone blockers won't need to later mitigate or reverse characteristics spurred by puberty: a deeper voice, facial hair, and a visible Adam's apple and other results of male puberty that cannot be reversed.

Having the opportunity to take hormone blockers has been linked to reduced mental health vulnerability in transgender adults.

Children who are taking hormone blockers can decide to stop doing so at any time. They will then go through puberty consistent with their assigned sex at birth.

A divide emerges

Transitioning is possible after going through puberty, but it's much more difficult for trans people to look the way they want to look. It's also a lot more expensive.

This is where the divide opens up. Not everyone has supportive parents, good health insurance or doctors who are able to provide puberty-suppression therapy. Nor does everyone live in a state with progressive legislation.

When conducting research for my book, access was a big theme that emerged.

At the age of 16, Nathan, for example, hated his post-pubescent body so much that he engaged in self-harm. (The names used in my book are pseudonyms, as required by research protocol.) The top surgery he so desperately needed was out of reach because his family simply couldn't afford it. His mom, Nora, describes being terrified that Nathan would kill himself because of this lack of access.

"It's all because of this damn top surgery," she told me. "And I am literally terrified, because I know for a fact that once he gets this done he's going to be a totally different child. And it kills me that I can't do anything."

Seven-year-old Esme, on the other hand, knew very clearly from a young age that male puberty was not what she wanted and felt able to communicate this to her parents. And because of her parents' support and access to affirming health care, she told me she's planning to take hormone blockers when she's old enough. Later, she'll take cross-sex hormones, which will result in the development of secondary sex characteristics consistent with her self-defined gender identity.

Whether Esme chooses to be openly transgender or not as an adult will be mostly up to her; her physical appearance won't mark her as trans.

Then there are the ways poverty and race are intertwined. Because Black, Native American and Latino trans kids are disproportionately likely to be living in poverty, they're less likely to have access to crucial treatments at a young age that will make it easier to be a transgender adult.

And trans kids who are nonbinary—meaning they don't feel like they're strictly male or female—also face challenges in accessing affirming health care.

Many medical professionals continue to see trans health care within a binary model: Patients are transitioning to either male or female.

For example, Stef, who's 14 years old and nonbinary, told me they had a far easier time accessing puberty blockers when they were asserting that they were a girl than when they subsequently adopted a nonbinary identity.

A matter of life or death

Ultimately, these disparities in access have repercussions.

For example, research indicates a significant improvement in quality of life among adult transgender women who have undergone facial feminization surgery, which involves surgically altering facial bones and soft tissue to conform to female gender norms.

However, this is an expensive and painful procedure that transgender girls can forgo by simply undergoing puberty suppression treatment. Of course, some trans people don't understand themselves to be trans early enough to advocate for themselves. And that's OK. But the majority of transgender children remain invisible—unable to articulate their feelings and longings because of unwelcoming and unsupportive environments.

Now, the availability of gender-affirming health care for teens is under threat in ways that go beyond insurance, cost and familial support.

In states like Arkansas, it's a societal rejection of treatment that is, for some trans teens, a matter of life or death.

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