

The Endocrinologist's Office—Puberty Suppression: Saving Children from a Natural Disaster?

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Abstract In the past few years, the introduction and rapid acceptance of puberty suppression has transformed the clinical treatment of children diagnosed with Gender Identity Disorder. This essay analyzes the narratives used by some advocates of this treatment, particularly the elements of saving children from the looming disaster of puberty and from future abject lives of violence and suicide as transgender adults. It briefly addresses the potential implications of this account for the well being of the children brought under clinical purview.

Keywords Children · Puberty suppression · Transgender · Gender identity disorder · Queer health · Narrative

During the past few years, the introduction and rapid acceptance of puberty suppression has transformed the clinical treatment of gender non-conforming children.¹ The popularity of this treatment has grown very quickly, accompanied by an explosion of media coverage about transgender children in the US and UK. This controversial medical treatment, which involves major bodily interventions for children who are not physically ill, has been embraced by many clinicians, parent support groups, and some adult activists as a progressive breakthrough in the clinical management of children diagnosed with Gender Identity Disorder (GID). While parents, clinicians, and activists understandably seek the most positive outcome for the children, the common narrative that is currently used to support puberty suppression may inadvertently denigrate transgender lives and obscure the social conditions that harm transgender youth and adults. The goal of this short analysis is not to argue against puberty suppression but to draw attention to complexities overshadowed by the narrative of saving children from the looming disaster of puberty and from future abject lives as transgender adults, as told by some advocates of treatment. I briefly address the potential implications of this account for the well being of the children brought under clinical

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purview. To illustrate this narrative, I use the example of a major bioethics article published in support of the treatment.

Children diagnosed with Gender Identity Disorder are offered puberty blockers (Gonadotropin Releasing Hormone (GnRH) agonists) at the pre- or-early pubertal stage (often ages 9–13) to suppress puberty as the first step to transitioning to the desired sex, followed by cross-sex steroid hormones at ages 14–16. These agonists block pubertal changes including, but not limited to, the development of secondary sexual characteristics such as breast development and menstruation in natal girls and growth of facial hair, low voice, and Adam's apple in natal boys. The prevention of pubertal bodily changes facilitates acquiring the physical appearance of the opposite sex/gender in adolescence and adulthood. Gender-typical appearance often eases social life. During their years on puberty blockers, adolescents' genitals and reproductive tracts remain in a pre- or early pubertal state, and the pubertal growth spurt is suppressed. If followed by cross-sex hormones, as has been the case with almost all the patients from the clinics that have published reports, the possibility of reproduction is eliminated. Some of the known side effects of the blockers, such as decreased bone density, are reported to be mostly compensated for a few years after the administration of steroid hormones. GnRH receptors have been found in organs as varied as the skin and the heart, however. The possible effects of halting puberty on the brain and cognitive development are currently unclear and debated.

Specters of violence and suicide among transgender youth and adults, as inevitable consequences of puberty, are frequently mobilized to achieve a compelling narrative about the necessity of medically treating children. In the article, "Lives in a chiaroscuro: Should we suspend the puberty of children with gender identity disorder?", one of the major bioethicists engaged in the debates over the "puberty suppression" treatment of children, states that "GID [Gender Identity Disorder] is a severe medical condition, associated with strong disgust for the body and profound uncertainty over the sense of the self" (Giordano 2008, 581). She argues that the distress caused by the unwanted physical changes of puberty threatens transgender children with suicide and violence and should be prevented by the "revolutionary instrument" offered by endocrinology: suspending puberty. Moreover, if puberty can be suppressed, the next step in transition is easier: "starting cross-sex hormones on a body that has not developed the 'wrong' sex characteristics allows achievement of a much more 'normal' and satisfactory appearance" (580). Hence, preventing pubertal changes protects children from the bullying, discrimination and violence to which transgender people are subjected. The author argues that puberty suppression will prevent drug abuse, HIV, hepatitis, and criminal behaviors such as prostitution and illegal immigration (resulting from desperate efforts to raise money for transition and, if necessary, crossing borders to countries where treatment is more available) and imprisonment.

The author concludes her article with the story of a murdered transgender prostitute, warning healthcare professionals that by withholding the treatment, they are complicit in such a horrid future, while by offering children the treatment, they can save their lives:

The following epitaph was published, with many more, by a non-profit charity in a website. It concerns a prostitute, murdered in Italy in 2003.

My name was Adrian Torres de Assuncao. I was a Brazilian woman aged 24. I lived in Brescia, in Italy. One night a client hit me in the face with a hammer. Despite the pain I kept working and I didn't go to hospital because I feared they would send me back home (I was a clandestine immigrant). When I agreed to go to hospital it was too late. I died on the 7th of October.

This epitaph illustrates the fate of many of those who are left alone to deal with GID. Sufferers who are not helped in a timely manner, as a matter of survival, will take any chance to obtain the desired gender, even if this exposes them to serious risks, because anything is better than life in an alien body. In 2003, 38 similar murders have been reported across the world. Many of these victims were transgender adolescents or young adults, and it is well possible that, if early treatment was more largely available, many of them would still be alive.

“If allowing puberty to progress appears likely to harm the child, puberty should be suspended. There is nothing un-ethical with interfering with spontaneous development, when spontaneous development causes great harm to the child. Indeed, it is unethical to let children suffer, when their suffering can be alleviated. This is not responding with medicine to a problem that is social in nature. This is responding with medicine to a serious medical problem that causes enormous distress to the sufferers and makes them prefer unqualified help, street life and even death, to life with GID.” (Giordano 2008, 583)

The author employs a sensational narrative of adult transgenderism to arouse sympathy for children diagnosed with GID (more recently called transgender children) and outrage at their fate and guilt at remaining passive in order to move the reader into action. The article invokes the suffering of transgender people to argue for the urgency of rescuing children from such a future. It turns on the familiar stereotypes of transgender people to mobilize public sentiments, portraying transgender people who have not received medical treatment in childhood as inherently damaged. This narrative locates the cause of the suffering and violence that betrays the body of the future transgender person within her, arising from puberty. The actual murderer barely enters the stage as the cause of the murder; neither do transphobia, as well as violence against women, immigrants, sex workers or poor people.

It could be argued that this striking narrative of the miserable transgender adult, dead or just steps away from death, was tactically and polemically used in the face of resistance from certain factions of the medical establishment that would not succumb to any argument, short of complicity in murder, to endorse this new treatment.² This narrative is indeed powerful and effective precisely because it hinges upon, and circulates through, the familiar trope of the abject trans person. Such a narrative is currently playing a powerful role in shaping the direction of this clinical field as well as the opinions of clinicians, parents and the general public. This argument figures as one of the main guiding rationales for the treatment of children. While not all the clinical accounts of transgender children and their urgent need for puberty suppression adopt such a dramatic narrative, its core argument for puberty suppression is frequently repeated by numerous clinicians and advocates of the treatment: preventing the body from developing unwanted secondary sex characteristics saves children from violence, suicide, self-harm, and mental illness at the onset of puberty (which therefore constitutes an emergency) and from violence and discrimination (and in some accounts, unemployment, drug use, prostitution, suicide) which besets non-passing transgender adulthood.³

In this account, puberty appears as a “natural disaster” that ravages the child’s body and its (gendered) integrity from within. It is an emergency, a disaster that is predictable; hence the intervention gains a preemptive feature. This sense of emergency (the onset of puberty) intensifies the public’s (as well as doctors’ and parents’) impulse for immediate action. Constructing puberty and its sufferings as a natural disaster that befalls these children resembles the particular ways that natural disasters in Africa, for instance, are portrayed. No one is responsible, but emergency aid is morally mandated. The disaster is inevitable.

There is no pertinent context or history to it (Mathers 2012). It is how things are for those “very different” people. The popular media depicts these children as very strange and fascinating and at the same time, deserving compassion. Their strangeness speaks to the strangeness of children to adults as well as the strangeness of gender subversive people to the gender-typical people. In this mission of “saving strangers” (Wheeler 2000), these children are strangers—not in remote lands, but strangers within. The child’s body requires saving from the devastation that the wrong hormone will unleash. These children precariously occupy the liminal space between childhood and adulthood and between women and men. They are about to cross the most entrenched and guarded human border, prompting impulses to regulate and control as well as aid them.⁴ They, and thus we, should be spared the further turmoil of puberty, a “natural disaster,” which also sexualizes these gender-disruptive bodies.

Children and the social anxieties over children’s bodies play a powerful role in contemporary cultural politics (Stephens 1995). Representations of child victims, whether the starving child, the sexually abused child or in this case the transgender child, have been central to the projects that aim at soliciting compassion and aid. The “affective authority of children as sufferers” (Malkki 2010) is a potent cultural source of mobilizing emotions. Protecting childhood innocence plays a crucial role in the clinical and public appeal of the medical treatment of transgender children. The author and other advocates of the treatment are well-intentioned, genuinely compassionate professionals who care about the well-being and fate of these children. They see and hear about the suffering of gender non-conforming children and transgender adults, and the ostracization and violence they are subjected to; they want to prevent children’s pain. They call for compassion and encourage other clinicians to overcome their hesitations and treat these children before it is “too late” (puberty). The humanitarian urge that guides their preemptive intervention is key to understanding the current enthusiasm in media and rapid acceptance of the treatment among clinicians, parents and activists.

There is no question that beginning at a very young age, many of these children suffer at the hands of the gender arrangements that make no place for them. They are harassed and ostracized. The cruelties that a five-year-old boy in a dress endures from adults and other children alike are shocking and alarming. Parents face very difficult circumstances and decisions, sometimes even fearing for their children’s lives. However, these children are also brave, resilient, intelligent and creative. To pathologize their refusal of and discomfort with the social expectations of their natal sex and locate the source of the problem within the child ignores the conditions in which the suffering has developed. Simplifying and decontextualizing their suffering might lead clinicians astray in recognizing what is vexing the child and make promises that the magic bullet of puberty suppression might fail to keep. In addition, to portray gender non-conforming/transgender children’s suffering as natural and inevitable, can lead to a fatalism (Kleinman and Kleinman 1997) that falls short of offering any thriving future for them without major medical interventions. The claim that violence, discrimination and self-harm are direct and inevitable consequences of puberty may constrict the decision-making of parents and children and the horizon of imagining other viable futures. Consent to a medical treatment that is preventive in nature and justified by *future* gains while entailing harms requires clinicians to allow the parents to imagine and explore various possible *futures* for these children, not the single future of suicide and murder.

The moral imperative for puberty suppression, guiding the aforementioned author and other advocates, has the power to downplay or make invisible the harms that the intervention might cause to these physically healthy children, breaching the primary medical ethics

principle of “do no harm.” Currently, the health consequences of the treatment are relatively unexplored. The treatment is being implemented, however, under the pressure of the emergency of saving the child from the devastation assumed to follow the onset of puberty. It must be remembered that puberty suppression as the first step to medical transition, if followed by cross-sex hormones, which has been the case for almost all reported cases, leads to infertility due to the permanent immaturity of the gonads and the reproductive tract. The absence of the discussion of sterilization of children as a major ethical challenge in this bioethics article, and many other clinical debates on puberty suppression, is striking. For any other group of children, such an intervention would be discussed extensively with ethics review boards. (What grounds might justify the permanent elimination of the child’s reproductive ability? Should parents be able to make such a decision for the child? Which futures are opened by the treatment and which ones are foreclosed? How might benefits be weighed in relation to the loss of reproductive capacity?) The media would likely react with investigations and questions about the long-term consequences of treatment. These “queer” children’s bodily integrity and reproductive rights should not be any less pressing than other children’s. Needless to say, children are not legally capable of consent, and 9–10 year olds are not capable of understanding all the health consequences of the treatment. Parents are asked to make life decisions on issues as critical as fertility for young children. Can they make an informed decision and evaluate benefits vis a vis risks when confronted with such horrendous forecasts for their children?

This essay does not intend to argue against puberty-suppression treatment of children, full discussion of which is beyond the scope of this short piece. It aims to call attention the effects of scare tactics and sensational stereotypes of transgender people used to convince people of the necessity of treatment. Depicting a frightening and abject future and locating the cause of that suffering and violence within the child herself may not be conducive to the well-being of gender non-conforming children. We might need to rethink the current exotic appeal of transgender children and the urge to save them from themselves. Finally, and most importantly, we should pause on the paradox of helping and saving the “transgender child,” from the development of bodily features incongruent with their gender identities, through a narrative of suffering and abjection of transgender adult life. Is this account trans-friendly, as currently perceived, or does it inadvertently promise the prevention of visible transgender adults?

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Endnotes

- 1 Currently the terms “gender variant” children, “gender non-conforming” children, children with “Gender Identity Disorder” and “transgender children” are used by different actors to refer to children with gender atypical and/or cross gender interests, behaviors and desires. “Gender Identity Disorder” and “transgender children” often imply greater intensity of cross gender interests or a desire to be the other gender and suggest a clinical undertone. In the past few years there have been a small number of children who have transitioned to live as the other gender. These terms are recent, and their definitions and boundaries are contested and shifting. Since there is no consensus over the differential application of these terms to the variety of gender atypical children, I will most often use the term “gender non-conforming” throughout this essay as an umbrella term.
- 2 This article intervened in the debates over “puberty suppression” in the UK, where the National Health Service (NHS) declined to provide puberty blockers to children diagnosed with Gender Identity Disorder. The debate was resolved after years of intensive advocacy in January 2012 when the British NHS made the

- decision to permit and provide puberty suppression treatment for children, available through the centralized national health system.
- 3 Currently, in the clinical debates, “transgender” has replaced the older term “transsexual”, i.e., a person who medically transitions, whereas “transgender” originally stood as an umbrella term for all gender non-conforming people. Since clinicians acknowledge the gender non-conforming childhoods of some gay adults, the diagnostic dilemma is whether these gender non-conforming children will grow to be “gay” or “transgender.” If the latter, “puberty suppression” followed by cross-sex hormones and later surgery, is considered an appropriate treatment. If the former, such treatment would not be warranted. Critics of puberty suppression often argue that clinicians might be treating children who might simply end up as gay adults. Still other outcomes or futures are not imagined or discussed, for example, experiencing degrees of gender non-conformity without full medical transition or any at all. Clinicians’ familiarity with transgenderism is often limited to those adults who seek their services, and the narratives patients produce to access those services, and at times the media portrayal of transgender people. Thus, clinicians may not be familiar with the range of transgender people and experiences reflected in community rather than medical settings.
- 4 I have benefited from the work of scholars such as Miriam Ticktin (2011) and Didier Fassin (2011) on humanitarianism in thinking through the calls to aid transgender children, even though they have not written about children and gender. My analysis of the narratives of transgenderism is indebted to Carole Vance’s general analysis of the totalizing effects of melodramatic techniques that aim at simple and emotionally gripping narratives at the expense of complexities and contradictions (2011, 2012).

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