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The New Girl in School: Transgender Surgery at 18

By ANEMONA HARTOCOLLIS JUNE 16, 2015

In a cozy cottage decorated with butterflies to symbolize transformation, Katherine Boone was recovering in April from the operation that had changed her, in the most intimate part of her body, from a biological male into a female.

It was not easy. She retched for days afterward. She could hardly eat. She did not seem empowered; she seemed regressed.

“I just want to hold Emma,” she said in her darkened room at the bed-and-breakfast in New Hope, Pa., run by the doctor who performed the operation in a hospital nearby. Emma is her black and white cat, at her home outside Syracuse in central New York State, 250 miles away.

Her childlike reaction was, perhaps, not surprising. Kat, whose side-parted hair was dyed a sassy red, is just 18, and about to graduate from high school.

It is a transgender moment. President Obama was hailed just for saying the word “transgender” in his State of the Union address this year, in a list of people who should not be discriminated against. They are characters in popular television shows. Bruce Jenner’s transition from male sex symbol to a comely female named Caitlyn has elevated her back to her public profile as a gold-medal decathlete at the 1976 Summer Olympics.

With growing tolerance, the question is no longer whether gender

reassignment is an option but rather how young should it begin.

No law prohibits minors from receiving sex-change hormones or even surgery, but insurers, both private and public, have generally refused to extend coverage for these procedures to those under 18. In March, New York's Medicaid drew a line at that age, and at 21 for some procedures.

But the number of teenagers going through gender reassignment has been growing amid wider acceptance of transgender identity, more parental comfort with the treatment and the emergence of a number of willing practitioners. Now advocates like Empire State Pride Agenda are fighting for coverage at an earlier age, beginning with hormone blockers at the onset of puberty, saying it is more seamless for a teenage boy to transition to becoming an adult woman, for example, if he does not first become a full-bodied man.

“Some of these women are passing, but barely, when they transition at 40 or 50,” said Dr. Irene Sills, an endocrinologist who just retired from a busy practice in the Syracuse area treating transgender children, including Kat. “At 16 or 17, you are going to have such an easier life with this.”

Given that there are no proven biological markers for what is known as gender dysphoria, however, there is no consensus in the medical community on the central question: whether teenagers, habitually trying on new identities and not known for foresight, should be granted an irreversible physical fix for what is still considered a psychological condition.

The debates invoke biology, ideology and emotion. Is gender dysphoria governed by a miswiring of the brain or by genetic coding? How much does it stem from the pressure to fit into society's boxes — pink and dolls for girls, blue and sports for boys? Has the Internet liberated teenagers like Kat from a narrow view of how they should live their life, or has it seduced them by offering them, for the first time, an answer to their self-searching, an answer they might later choose to reject?

Some experts argue that the earlier the decision is made, the more treacherous, because it is impossible to predict which children will grow up to be transgender and which will not.

“Basically you have clinics working by the seat of the pants, making these

decisions, and depending on which clinic you go to, you get a different response,” said Dr. Jack Drescher, a New York City psychiatrist and psychoanalyst who helped develop the latest diagnostic criteria for gender dysphoria.

On the other hand, Dr. Drescher said, “Is it fair to make a child who’s never going to change wait till 16 or 18 to get treatment?”

A Teenager’s Pain

Kat Boone did not fit the stereotype of a girl trapped in a boy’s body.

As a child, she dressed in jeans and shirts, like all the other boys, and her best friend was a boy. She liked to play with cars and slash bad guys in the Legend of Zelda video games. She still shuns dresses, preferring skinny jeans and band T-shirts.

But as a freshman in high school in Cazenovia, N.Y., she became depressed and withdrawn. “I knew that the changes going on with puberty were not me,” Kat said. “I started to really hate my life, myself. I was uncomfortable with my body, my voice, and I just felt like I was really a girl.”

When she discovered the transgender world on the Internet, she had a flash of recognition. “I was reading through some symptoms, not really symptoms, but some of the attributes of it did click,” she recalled.

It took a few months, but one night, she crept into her mother’s room and sat on the bed, crying. When she finally came out with what was bothering her, her mother’s first impulse was to comfort her, holding her hand and saying: “It’s O.K. It’s O.K.”

But inside, Gail Boone was terrified. She had wondered if her son was gay, and that, she says, would have been easier to deal with than a child who wanted to be the opposite sex.

“There’s this fear,” Ms. Boone said, “what is this going to do to my kid, what are people going to think, what are people going to think about me?”

Kat’s father, Andrew, had moved out when she was in fifth grade, and it took a few months for Kat and her mother to find the courage to tell him. Gail Boone had a background in psychology, which helped her understand. Mr. Boone, an operations and project manager, had a harder time, but was

brought around for the sake of his child.

He read books about being transgender and raked his memory for clues in Kat's early childhood, but could not find any. "Maybe she thinks this is the thing, and there's something else going on," he remembered thinking. "How do we know?" He wished there were something scientific like a blood test that would give him 100 percent certainty.

Mr. Boone recalls going into "a zombie trance," a period of mourning for the child he thought he knew. "I was really eating myself up because I couldn't help this overwhelming feeling as if my child had died," he said. "But here was my child right in front of me."

At 16 and a half, after seeing a therapist, Kat began taking estrogen and a blood pressure drug, spironolactone, that is also used to block the actions of testosterone, to help her look more female. In the fall of junior year, she showed up at school wanting to be called Katherine, or Kat, because she likes cats. She does not want anything to do with her birth name, Caden. She also has discovered that she likes girls. "I identify as a lesbian," she said, though her attractions have not been reciprocated.

It was the cutting that convinced them that if she could not live as a girl, Kat would kill herself. She still has two angry scars on her left forearm. "It became clear to me that this wasn't a passing phase or some choice or reaction," Mr. Boone said. "This was truly the basis of what she was."

Part of what brought her father around was the support network that has sprung up around transgender issues. In Syracuse, it is the Q (for queer or questioning) Center, run by the nonprofit ACR Health.

It is not easy to find. Visitors have to be buzzed in through an unmarked back door in a shabby neighborhood. But inside, it is homey, with a well-appointed library, a kitchen and a meeting room outfitted with beanbag chairs.

A meeting of teenagers in April began with each one declaring a name and pronoun of the day. Their choices were not always intuitively obvious. A young man with a scruffy beard and shaggy hair asked to be called Jackie and with the pronoun "she."

"One of the nice things a trans person gets to do during transition is pick a

new name,” said the facilitator, Mallory Livingston, a lawyer, “assigned male at birth,” now looking feminine in a tight pink camisole, black lace-up boots and miniskirt. “I went with the name of a character from my kids’ favorite movie, a strong female swordsperson.”

But there were hints of the pain the children had to endure. One child was required to use a separate bathroom at school, and a hidden camera was later found there.

Kat told the group that she was looking forward to surgery in six days. They clapped. “I’m scared,” she confessed.

A Young Movement

The ability to alter a child’s gender physically has never been greater.

But the drive to treat children is relatively new. One of the first and biggest hormone programs for young teenagers in the United States is led by a Harvard-affiliated pediatric endocrinologist, Dr. Norman Spack, at Boston Children’s Hospital.

Dr. Spack recalled being at a meeting in Europe about 15 years ago, when he learned that the Dutch were using puberty blockers in transgender early adolescents.

“I was salivating,” he recalled. “I said we had to do this.”

The puberty-blocking protocol gained legitimacy in 2009, when it was endorsed by the Endocrine Society, the leading association of hormone experts, on the recommendation of a task force including Dr. Spack.

The protocol calls for administering puberty-blocking drugs, generally Lupron, an injection, or histrelin, an implant, that are normally used to treat precocious puberty as well as prostate cancer and endometriosis, abnormal growth of uterine tissue.

The theory is that this drug-induced lull from about 12 to 16, sometimes younger, will help teenagers decide if they truly are transgender, without committing to irreversible physical changes. Puberty blockers are reversible. But in practice, some experts warn, once children have “socially transitioned” it is very difficult to go back.

If a psychological evaluation confirms gender dysphoria, teenagers are

treated with cross-sex hormones (estrogen for boys, testosterone for girls), so they will, in effect, go through opposite-sex puberty. A consequence of going through the whole protocol is infertility.

The blockers cost thousands of dollars a year, and like all drugs used for transgender treatment, have not been approved by the Food and Drug Administration for that use, though they may be legally prescribed “off label.”

Dr. Spack said his clinic had treated about 200 children since 2007, and less than 20 percent had been covered by insurance. “That’s where the dilemma came in: Who the hell could afford it?” he said.

Doctors say that if children are started on puberty blockers young enough, insurance is less likely to question it. Some doctors have been able to drive the price down to \$120 a month by getting the adult implant, which is much cheaper than the pediatric one, from sympathetic urologists and stretching it out over two years instead of just one.

While hormones for minors are sometimes covered by insurance, surgery almost never is. But several doctors said they had performed surgery on minors. Kat’s surgeon, Dr. Christine McGinn, estimated that she had done more than 30 operations on children under 18, about half of them vaginoplasties for biological boys becoming girls, and the other half double mastectomies for girls becoming boys.

“We’re trying to find the sweet spot,” Dr. McGinn said. “The problem is, it’s not an age, it’s a situation.”

Advocates say that extending treatment to teenagers will alleviate depression and suicide. With that in mind, Oregon’s Medicaid began covering the gamut of treatment, regardless of age, in January. Patients as young as 15 do not need parental consent.

The evidence is mixed. A large-scale Swedish study at the Karolinska Institute found that starting about a decade after gender reassignment surgery, transgender people were still more than 19 times as likely to die by suicide as the general population.

Complicating matters, studies suggest that most young children with gender dysphoria eventually lose any desire to change sex, and may grow up to

be gay, rather than transgender. Once into adolescence, however, their dysphoria is more likely to stick.

Dr. Paul McHugh, a professor of psychiatry at Johns Hopkins University Medical School and its hospital's former psychiatrist in chief, is skeptical of the use of surgery for a psychological condition, and even more so for children. "Bruce Jenner — who cares?" said Dr. McHugh, who said he played a role in closing a transgender surgery program at Johns Hopkins about 35 years ago. "He's a wonderfully successful person. He's got all kinds of social networks. He's got plenty of money. No one's objecting to him if he wants to live as a woman. This is America, be my guest.

"But we're talking about children with a future ahead of them."

A New Beginning

Kat went into the surgery on April 7 with high hopes.

Dr. McGinn was far from Cazenovia, in Lower Bucks Hospital in Pennsylvania. But Kat's parents trusted her not only as a specialist, but also as a role model: She had been a dashing male doctor in the Navy, before becoming a beautiful female doctor in civilian life.

Kat had been accepted at Champlain College in Vermont, where she planned to use her artistic talent (she designed the rose tattoo on her shoulder) to study video game design. Her goal was to start college as a woman. Through luck — a cancellation — they were able to book a date during spring break, when Dr. McGinn's calendar begins filling up with college-bound patients.

Gail Boone's insurance plan initially denied coverage for the operation. A customer service agent told her genital reconstructive surgery was allowed only for conditions like birth defects. "You got it," Ms. Boone retorted.

They prevailed.

It was too late to change some things, like Kat's tenor voice and facial hair. "I hate my voice," she said. "I shave." She chose not to save sperm — to her, a revolting reminder of masculinity — so she cannot have children, the one sacrifice that gave her father a pang.

The operation involved deconstructing her male genitals and repurposing

the nerves and skin as female anatomy.

When it was over, Kat developed aspiration pneumonia and had vomiting and dry heaves for days, normal reactions to anesthesia, narcotics and antibiotics, but Dr. McGinn said Kat was hit harder than most.

Before the surgery, she had been impish and playful. Now she buried her nose in her Nintendo 3DS and cracked a rare smile at an old text message consisting entirely of “Meow,” “Meow.”

Her father felt helpless as she refused food and lost about 20 pounds. Dr. McGinn said it was not unusual for patients to become depressed after surgery and compared this to postpartum depression.

Kat was anxious about having enough privacy in college, since her new vagina needs constant care or it will close off like a wound. “The only thing I’m thinking about now is the room situation,” she said.

Six weeks after the operation, she was still so weak that she had to take the elevator at school instead of the stairs.

At her two-month checkup, she had gained back half the weight she had lost, but still looked frail and self-conscious. She treated herself to a new hair color — strawberry blond — for graduation.

Kat said she had “zero regrets.”

But it was clear to all of them that the operation was not a quick fix.

It is not a “yippie, jump up and down fireworks situation,” Mr. Boone said. “It’s a grand relief that something that’s been such a bother to her is finally gone.”

Correction: June 16, 2015

Because of an editing error, an earlier version of this article erroneously attributed a distinction to New York’s Medicaid program. It is not the nation’s largest (the state with the largest Medicaid enrollment is California).

Correction: June 16, 2015

An earlier version of a picture caption with this article misstated the circumstances of Katherine Boone’s suicide threat. She cut herself when she

was 17, not 16, and when she had already begun gender reassignment, not before.

Susan C. Beachy contributed research.

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