

# Transgender Children

## Conundrums and Controversies— An Introduction to the Section

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*This paper introduces the readership of The Psychoanalytic Study of the Child to the topic of transgender children, which will be investigated in the papers that follow. A flashpoint in the recent discourse that escorts children who self-describe as gender nonconforming is whether or not to support the practice of the medical suspension of puberty of these children by the administration of hormonal treatment. Relevant up-to-date research findings on this subject will be reviewed here. Despite those advocates and opponents who swarm around both poles, any reliable conclusions as to the long-term safety and psychological effects of puberty suppressants will remain provisional until future studies proffer more definitive answers. While we await further study, the journal sees the necessity to press for dialogue concerning this conundrum.*

*Anchoring this section is a clinical paper by Diane Ehrensaft, Ph.D., which documents the psychotherapeutic treatment of a transgender child who was prescribed puberty suppressants. The commentaries that follow and that are briefly summarized in this introduction will accent the psychoanalytic developmental point of view. This will provide the principal framework for the study of this controversy, which underscores the complementary dimensions of linear and nonlinear progressive*

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*The Psychoanalytic Study of the Child* 68, ed. Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight (Yale University Press, copyright © 2015 by Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight).

*hierarchical growth. In this context, features such as the developmentally normative fluidity of self-structures, including gender role identity, and the evolution of concrete thinking toward metaphoricity and figurative meaning-making in middle childhood and adolescence will be examined and applied to the clinical data. In addition, the argument that the use of puberty suppressants exacts a premature foreclosure on the reorganizing potential of developmental growth, and the proposed effects of the crosscurrents of the sociocultural body politic on these children and on the decision to opt for the suspension of pubertal growth will be explored.*

UNDERSTANDING TRANSGENDER CHILDREN HAS EVOKED GREAT INTEREST and perplexity in our contemporary world. A greater number of youths than ever before, which in years past was considered a rare avis, are entering our consulting rooms with presentations within this scope (Spack et al., 2012; Meyer, 2012), whether it be gender dysphoria, gender variance, gender hybrid, gender queer, or gender fluid. Therapeutic and conceptual quandaries such as whether these children should qualify as requiring treatment at all, and if so, what kind and with what aims in mind have been hotly contested. But what has become a flashpoint in recent discourse that escorts this topic is the practice of the medical suspension of puberty by the administration of hormonal treatment (Byne et al., 2012; de Vries et al., 2010; Hewitt et al., 2012; Shumer and Spack, 2013; Giordano, 2008; Zucker et al., 2011). Puberty suppressants arrest temporarily the emergence of secondary sex characteristics; without these, the child's option to transition to the opposite gender would in most instances be closed; should the child eventually opt to transition to the opposite gender, such a transition would be in most instances irreversible (de Vries et al., 2010). The rationale given for this treatment, provided by specialist clinics in Canada, the United States, the United Kingdom, and several European countries (Hewitt et al., 2012) is to allow the transgender child time—up to several years—to explore her preferences and not be coerced by her biological clock to choose which gender she wishes to be (Ehrensaft, this volume; Hembree et al., 2009). Advocates and opponents swarm around both poles, and any reliable conclusions as to their long-term safety and psychological effects will remain provisional until future studies proffer more definitive answers (Byne et al., 2012).

For these reasons, the editorial board of *The Psychoanalytic Study of the Child* is aware of the necessity, if not urgency, to address this topic. In this section, Diane Ehrensaft, Ph.D., the director of Mental Health Child and Adolescent Gender Center and a child gender specialist,

anchors the topic with a presentation of a clinical case of a transgender child who was prescribed puberty suppressants. Three psychoanalysts, specialists in child analysis, will offer commentaries on her theoretical and clinical perspectives.

By way of introducing transgenderism to our readership, I will review relevant findings from the recently published report on the treatment of gender identity disorder<sup>1</sup> assembled by the task force of the American Psychiatric Association, as well as other recent studies. I will also highlight the controversies and questions that have emerged from this literature, which illuminate the conundrums that confront parents, physicians, mental health practitioners, and the larger community in assisting these youths as they negotiate their gender identity over the course of those transformative shifts that occur as the child moves forward toward adulthood.

The plethora of theoretical vantage points in psychoanalytic thinking that are in vogue today, inclusive of the discipline of child analysis, may be overwhelming in their applications to a systematic study of any selected topic. Therefore, the position taken in this volume is to narrow the scope of our investigation and target the study of transgender children primarily, though not exclusively, through the lens of the psychoanalytic developmental point of view. I refer to the inclusion of the complementary dimensions of linear and nonlinear progressive hierarchical growth. This is a model of interweaving and interacting domains—the inherent maturational processes, disposition, and the familial and cultural environmental surround—which comprise the formation of a new realm (A. Freud, 1965). The developmental approach is distinctive for its emphasis on the forward movement of growth and the extraordinary discontinuous changes that accompany the nonlinear shifts as children move from one organization to another. Structures and functions undergo fluctuation, fluidity and novel forms: “. . . the confluence of many influential factors steer [the developmental orientation] in one direction or another, defying prediction and any form of determinism” (Auchincloss and Samberg, 2012, p. 58).

#### DEFINING TRANSGENDER

The task force (Byne et al., 2012) defines the term “transgender” (p. 762) to denote individuals who demonstrate cross-gender identifications,

1. To quote Ehrensaft’s footnote in this volume: “Although Gender Dysphoria has replaced Gender Identity Disorder in the new Diagnostic Statistical Manual (DSM V), the concept of Gender Identity Disorder as a diagnostic category is still widely in use in many people’s thinking.”

whether or not they have initiated hormonal treatment that induces transition to the opposite sex. For many child analysts, a sticking point in this definition is that psychoanalytic investigators view some manner of cross-gender identifications across the developmental spectrum as normative: in and of themselves, such identifications are not signposts that denote disturbance. Rather, as Knight states in her commentary, they reflect the expectable disequilibrium of self structures that gives the child the chance to play with different possibilities of gender role identity. As structures remain fluid and discontinuous in growth, so a child's internal sense of her gender identifications mirror that same fluidity.

Consequently, within the parameters of *The Psychoanalytic Study of the Child's* purpose in examining Ehrensaft's viewpoint and treatment of her child patient, we will use the term "transgender" with particular qualifications. Namely, we define it as reflecting within the child an unyielding discomfort in her biological sex and a profound identification with the gender of the opposite sex (American Psychiatric Association, 2000; World Health Organization, 1992). Persistent and unrelenting cross-gender thoughts and behavior are manifest and undeniable among these children.

#### PSYCHOTHERAPEUTIC TREATMENT OF TRANSGENDER CHILDREN

Presently, therapy approaches are designed to facilitate the psychological wellness of the transgender child (Byne et al., 2012). However, what that entails is under dispute. The APA task force outlined several avenues, each tutored by differing underlying principles concerning how to bring about that sense of well-being. Should a treatment approach actively encourage the transgender child to adopt the culturally prescribed codes of gender behavior in order to ameliorate ostracization from peers? One approach (Zucker, 1990) espouses this perspective. The assumption underwriting this point of view asserts that positive self-esteem is better regulated and preserved when children are integrated into their social landscape and bond with same-sex cohort. Another paradigm assumes a neutral position in regard to the child's cross-gender behavior. Proponents take a wait-and-see outlook, to allow progressive development to unfurl in its own fashion without interference from outside sources (Ehrensaft, 2011; Hill and Menvielle, 2010; Pleak, 1999). The practice of this perspective is sometimes inclusive of the child's environment, in that parents and the child's community are engaged to minimize and troubleshoot the potential damaging effects of cultural stigmatization. These therapists take the opposite view of

the first treatment option, where the transgender child is persuaded to fit in to the community's standards concerning gender conforming behaviors and dress codes. They aver that self-esteem will be enhanced by promoting the child's recognition that her transgender or gender variant preferences may encounter hostile reactions in the outer world. How to strategize and manage these negative forces is a predictable outgrowth of this treatment approach.

Lastly, a third method works against the argument of neutrality. These therapists lean toward or actively affirm the prepubertal child's gender variant desires and offer the provision of assistance to segue the child into gender role transition on a social level; should the transgender desires continue into puberty, this approach would support the option of pubertal suppressant agents (Ehrensaft, 2011; Brill and Pepper, 2008). Proponents in this camp aver that some children will continue on this trajectory through adolescence and into adulthood, so that smoothing their passage at a younger age benefits their overall adjustment.

The opposing argument to this model rests on the empirically derived evidence that most gender variance in children does not persist into adolescence (Davenport, 1986; Green et al., 1987; Wallien and Cohen-Kettenis, 2008; Zuger, 1978). This finding is especially germane to Ehrensaft's treatment and discussion of her patient, Jacqueline/Thomas. A majority of untreated children between the ages of eight and twelve who receive no mental health intervention and present with transgender leanings *desist*, that is, they naturally arrive at a fresh experience of contentment with their natal sex over time, generally by the onset of puberty itself. What tips the scales toward desistance is unclear, but several triggers are hypothesized: the expectable hormonal changes that accompany early puberty, exclusion from peers, and shifts in cognitive development (Wallien and Cohen-Kettenis, 2008). Those children who *persist* in their transgender preference into puberty and adolescence are more likely to continue this tendency into adult life (Zucker, 2008b). No differentiated variables have been reliably identified that would indicate which prepubertal children will persist or desist as adolescent development proceeds (Cohen-Kettenis and Pfäfflin, 2010; Wallien and Cohen-Kettenis, 2008; Zucker, 2007; Zucker and Cohen-Kettenis, 2008).

Thus, actively supporting or encouraging transgender self-states in middle childhood may act as a subtle leverage toward transitioning. Such stimulation, however tactful or nuanced, may interfere with whatever course the child's development might naturally lead her without it (Pleak, 2010). An additional source of disquiet is that once a child makes the transition across the gender divide, reverting back to the natal gender may present difficulties (Steensma et al., 2011). These

children struggle with their change of heart when family, peers, and the community have embraced, if not inspired, their former desires.

#### ADOLESCENTS WHO IDENTIFY AS TRANSGENDER

The progression for prepubertal youngsters and adolescents who self-identify as transgender is varied and layered with choices concerning the medical options currently available that can suspend puberty and change one's sex, either partially or wholly. That is, transgender individuals may make a definitive decision to become one gender or another, but, as Ehrensaft states in her paper that follows, others create their own version of gender, which may retain characteristics of both sexes. Some adolescents have felt themselves to be transgender since childhood; but unlike these individuals who experience a continuity of transgender identity from one developmental organization to the next, there are those for whom a transgender orientation first appears in early puberty or adolescence proper: the desire to be the opposite sex is a freshly emergent phenomenon with no prior antecedents in childhood (Byne et al., 2012).

At present, there are two studies, one in Toronto, Canada (Zucker et al., 2011), and the other in Amsterdam, The Netherlands (de Vries, Kreukels et al., 2011), that have acquired sufficient data to fulfill an "empirical 'experience base'" (Byne et al., 2012, p. 764) and which throw light on some of the issues that concern these two groups of transgender adolescents. Both sets of data from these clinic settings report consistency in their findings that the management in those adolescents who report transgender feelings from childhood is more straightforward than in those adolescents for whom transgender feelings are first reported in the pubertal or adolescent process proper. This is partially explained by the trend in the latter group to show significant psychological disturbance that is independent of the transgender experience. For example, it is important to differentiate whether or not the emergent transgender feelings in these adolescents are consequential to an incipient psychosis, schizophrenia, autistic spectrum manifestations, trauma, or other disorders that may cause gender disorientation and dysphoria (de Vries et al., 2010). Of equal relevance, the complications in the management of adolescents also pivot on the controversies that abound over the use of puberty suppressants.

#### ARGUMENTS IN FAVOR OF THE USE OF PUBERTY SUPPRESSANTS

Transgender adolescents do not infrequently experience depressive reactions to the onset of secondary sex characteristics at puberty. In recent

years, those whose responses to these biological changes are severe and unabated have been offered the opportunity to medically suspend puberty for several years. Advocates of this approach cite the advantage of allowing the young adolescent a respite from making a decision that may entrap her “in a body that is experienced as alien” (Giordano, 2008, p. 580): a period of time spent on reflection, possible psychotherapy services to aid in introspective curiosity, and an exploration of feelings. Lastly, this time affords the opportunity, if desired, to live *in vita sua* as a person of the opposite gender. These rationales are seen by those who endorse this perspective as a considered approach to the young adolescent’s dilemma. In this way, it is reasoned that the youth may be able to test the waters of his imagination and be better equipped to arrive at an informed decision.

A second advantage reported by this group concerns the fact that the secondary sex characteristics of pubertal development, once set in motion, are either relatively permanent or present special problems in reversing, should the young adolescent eventually wish to make a full transition. The repercussions of experiencing undesired pubertal development are significant (Byne et al., 2012). Features such as height and size—and for men who transition to females, voice quality—cannot be modified with cross-sex hormone treatments or even with cross-sex surgery. For females who transition to males, invasive surgeries such as mastectomies may be necessary for a complete bodily transformation. Thus, those who opt for the suspension of puberty will have a smoother transition to a sex change should this be the desired outcome (Giordano, 2008). As mentioned above, confounding this state of affairs is the impossibility of making a definitive determination in advance as to which youngsters will persist or desist over the course of progressive development. Given this uncertainty over prediction, advocates maintain that as puberty suppressants can be stopped should the adolescent wish to discontinue the transitioning process, puberty will proceed “as normal” (Giordano, 2008; p. 580; Hembree et al., 2009). Finally, proponents offer that transgender children who are denied puberty blockers are reported at high risk of suicide and of sourcing illegal markets for hormones and medications in lieu of carefully monitored medical supervision (Giordano, 2008; Rotondi et al., 2013). Their reasoning asserts that avoiding such calamities overrides the complexities and uncertainties that accompany the decision to provide puberty suppressants, as will be discussed below. From some quarters, then, the cumulative effect of these points has resulted in a favorable reception for the option of offering medically induced puberty suspension.

## ARGUMENTS OPPOSED TO THE USE OF PUBERTY SUPPRESSANTS

Arguments raised against the use of puberty suppressants point to several areas of concern. While there are no reported adverse short-term physical effects from the use of puberty suppressants, their use is so recent that follow-up studies that track the consequences of long-term effects are not yet possible (Byne et al., 2012). Specifically, questions concerning sex steroid deficiency on bone metabolism in children has not been subject to tracking and assessment over extended periods of time, which would be necessary for determining possible risk factors for osteoporosis. As brain maturation in the adolescent process is significant for its momentous growth, experts have expressed their concern regarding the possibility of unknown cognitive fallout that may attend the suspension of puberty: presently, there is no research available that investigates long-term effects. Similar concerns have been issued regarding the use of puberty suppressants on future reproductive capacities (Giordano, 2007). The “still emerging evidence base” (Hewitt et al., 2012, p. 581) and the necessity for “rigorous assessment . . . along with the stringent auditing and publication of outcomes” (ibid.) cannot be overplayed. It is not surprising, then, that those who oppose the use of puberty suppressants question certain lines of reasoning cited by advocates to avoid what the latter believe to be an even worse consequence, that is, children trolling the black market for hormones, or managing possible suicide risk and depressive episodes (Giordano, 2008). By weighing one set of troubling potential outcomes against the other, those who contest this position question the validity of making such qualitative and subjective determinations as to which outcome would be worse. In the absence of data and follow-up assessments, can one know that offering puberty suppressants would assuredly foreclose on suicidal risks or depression in all cases, particularly if these risk factors interweave or overlap with other disturbances that emanate from independent sources? For instance, the Dutch and Canadian studies and others have suggested some positive outcomes for those children who receive them, in the alleviation of depressive feelings and behavioral difficulties. However, other feeling states remain untouched, such as gender dysphoria, anger, and anxiety (Cohen-Kettenis, Shagen, and Steensma, 2011).

Other detractors opine additional reservations. They believe that transgender trends in both prepubertal and early adolescent youngsters may reflect long-standing unconscious communications between parents and children that may or may not have specific links to gender identity matters. In such cases, they argue that a transgender picture

veils a legacy of other problems, but the concrete operational child (Piaget) who is bounded and constrained by her unsophisticated cognitive and affective capacities may relate her feelings about the world in forms and expressions that amass around various self-states, including gender identity. Within this context, the child's plea for solutions such as puberty blockers, and the threat of suicide if these are not provided may be the literal expressions of preoccupations and emotions that are more accurately conceptualized in figurative terms.

As Knight suggests in this section, latency-aged children whose cognitive and emotional resources are still concrete may believe that sexual arousal toward a member of the same sex implies that their body is the wrong gender; that is, that to ensure their heterosexuality, they assume their gender assignment must be incorrect. Younger children with persistent cross-dressing behaviors have been reported to show difficulties in gender constancy acquisition—the ability to recognize the immutability of gender over time (Zucker, et al., 1999)—which may undergird gender confusion on the cognitive level for some older children.

Opponents from the psychoanalytic developmental camp put forward what is likely to be their principal argument. Does the use of puberty suppressants obfuscate the role played by the pubertal upsurge and the attendant developmental process and how these epigenetic changes inform and influence the transgender child/adolescent's experience of her gendered self? Namely, like the majority of middle childhood-aged transgender children who eventually arrive at a feeling of comfort with their biological sex by preadolescence, might some young adolescents who initially request puberty suppressants also reach a newfound ease with their natal sex if they may experience the naturally occurring hormonal changes and developmental transformations of adolescence?

Skeptics also state their apprehension about a prepubertal child's limited cognitive capacity to fully grasp the current medical and psychological uncertainties that swirl around the use of hormone suppressing agents. Does their use violate ethical considerations and codes that protect a child's rights and welfare, not only within the boundaries of our current knowledge base and data collection, but in the data that will emerge in the future?

Ehrensaft's paper enlivens the current discussion within the mental health community about how to conceptualize the gender nonconforming child by her bold hypothesis that this child "dismisses or resists" the maxim that we must all give up and mourn the sex we never were and will never be. Rather than labeling these children as "developmentally arrested" or having fallen prey to a persistent delusion, she defies these

notions with the proposition that such children, “the ultimate anti-essentialists” are aware that gender is not dictated by the body only but by psychical meanings and assemblages as well. For Ehrensaft, through refusing to relinquish her gender “inclusivity,” the transgender child’s gender creativity should be celebrated. Ehrensaft cites conservative societal restrictions as a central foe in the transgender child’s quest to uncover her “true gender.” Her focus, in her treatment model True Gender Self Therapy, centers on buttressing the child’s authentic gender self in the hope that the child’s less authentic “false gender self” will be naturally jettisoned. Within this context, Ehrensaft takes the view that offering the transgender child the opportunity to utilize puberty suppressants during middle childhood provides her with the space to experiment with experiencing in real time what she feels is her true gender self by literally slipping into the shoes of the opposite sex. Her thesis, escorted by her treatment modality and its theoretical groundwork, is the subject of the commentaries that follow. Knight, Brinich, and Weinstein and Wallerstein deliberate on the quandaries inherent in Ehrensaft’s formulations and elucidate other related conundrums that hopefully will stimulate the readers’ own reflections.

Rona Knight expands on the paradigm of nonlinear, progressive hierarchical development. She brings to this perspective a lively discourse concerning contemporary research models that illuminate the fluid quality of normal gender role identity over the arc of the human lifespan. In particular, she proffers high praise to the proponents of dynamic nonlinear systems theory. Knight’s referencing of biological influences, such as neonatal exposure to varying levels of androgen, brings the reader to an in-depth appreciation of innate variants that inflect and inform gender preference and behaviors. Interacting with the biologically inspired is the sociocultural domain, and she also invites our attention to research that has pinpointed how environmental influences, such as the overt and covert messages that are sent by parents to children, influence their gender behaviors and impressions concerning gender and gender roles.

Knight turns to Ehrensaft’s True Gender Self Therapy as it plays out in the consulting room with Jacqueline/Thomas. She observes that Ehrensaft’s treatment is designed to unearth the concealed or denied gender preference—that of the opposite sex—which challenges the position of the usual psychoanalytic investigations into the child’s myriad unconscious meanings and narratives concerning sexuality, aggression, selfhood, gender, and even homosexual fantasies, which may be screened behind the placeholder of transgenderism. Drawing upon Piaget’s categories of cognitive development, Knight shows the signifi-

cant influence of concrete thinking in the middle years and its role in shaping gender experience. Thusly, for her, foregrounding the figurative meanings over the literal desire to be one gender or another is an imperative facet in treatment paradigms that approach this issue and marks a point of departure from Ehrensaft's model that accepts the emphasis on gender as a manifest, literal concern.

In this way, listening to and considering how a child's gender preference may be turned on its head several times over in the years to come is central to the debate about suspending puberty. For Knight, the use of puberty blockers bars the developmental feature of transformations from expression over the critical years of the adolescent process. In this way, nature itself is prohibited from playing its role as the in-habitus assist, guiding the child's movement toward the gender or gender variation she wishes to be.

Paul Brinich's textured discussion informs Ehrensaft's presentation through the lens of progressive developmental transformations within the larger context of our current sociocultural sensibilities. Fast-forwarding into the future realm of the child's natural developmental thrust, that interplay of nature and environmental shaping that accompanies the child's ever-changing shifts into new organizations is subject to the cultural tropes of contemporary life. In our time, Brinich observes, the narrative of gender has been liberated from myopic constraints. Gender is inclusive of a broadening reach of new forms, inflected by the currents of the contemporary sociocultural body politic, as evidenced by those very aforementioned terms at the outset of this introduction: gender variant, gender queer, gender hybrid, gender fluid. Would such novel assemblages of gender have been remotely possible even a decade ago?

Brinich also brings the dimension of nonlinear progressive development in Ehrensaft's coinage of the term "True Gender Self." He sees in it an oxymoron: as development rests, at least in part, on the principle of biologically inspired nonlinear growth, what is true for gender or for any aspect of a child's identity, for that matter, is subject to continuous transformational change. Thus, he poses the question: "Can what is 'true' at age 3, or 13, or 23 become 'false' at 33 or 43 or 53?" Perhaps, Brinich suggests, a more "modest" proposal that accommodates to nature's discontinuous path would entertain the notion of a "currently adaptive" gender self. In that way, the binary code of male or female can be sidestepped away from the tradition-bound mores that locate gender in reductionistic fashion.

Readers will appreciate the steady and scrupulous gaze of Weinstein and Wallerstein's contribution. These authors compose their discussion

as a careful reading of Ehrensaft's treatment approach. They sift the definitional paradoxes that hover about True Gender Self Therapy by way of Winnicott's "true self" and Kohut's "mirroring" technique. From this perch, the authors probe the theoretical underpinnings of the therapy, which permits the readership its own agency in considering whether a child's gender experience is "core" and consequently, "immutable" or, on the other hand, a "complex communication from the child that needs to be decoded." The arguments outlined are critical for how a therapy designs its mission statement: is its goal to treat the gender self as an objective truth that requires sparse inquiry, and thus the work must function as a protective carapace from a possibly hostile and stigmatizing environment? Or is its purpose to *promote* inquiry and tap into unconscious meanings that accrue to gender and explore the metaphoricality of the aggregates that have been brought to bear in sculpting that gender self? One position views the external world as the obstacle to the transgender child's well-being; the other considers internally sourced elements as informing gender preference. Traditional pillars of child analysis, such as frequency of sessions, the child's phenomenological experience, and the use of transference are also brought into deliberation vis-à-vis Ehrensaft's model.

Finally, Weinstein and Wallerstein address the issue of puberty suppressants. They cite the importance of bodily and hormonal shifts during pubertal development in their potential to shepherd the reorganization of the personality in adolescence, which goes beyond the issue of gender experience per se. In referencing quantitative and qualitative research studies that also show the remarkable influence of puberty as marking the advent of the young adolescent's first passage into novel and growth-enhancing experiences, such as love relationships, her preoccupation with the uncertainty of identity, or her newly emergent defiance of parental authority. Puberty is a paramount process that informs how gender identifications will re-form toward the close of the developmental process. With these benefits in mind, the authors conclude their commentary with words of caution. Until future research can provide us with reliable predictions as to which prepubertal youngsters will persist or desist in their gender dysphoric feelings, supporting the use of puberty blockers not only inhibits those features of early adolescence that will inflect gender identity in its fluid course, but it will also "foreclose the potentially organizing experience of development" overall.

Perhaps the questions and conundrums so posed are not within the purview of the psychoanalyst's clinical and investigative template. Yet they are weighty problems that cannot be brushed aside as we await further research and study. Until then, it is incumbent upon our child

analytic community as stewards of what is developmental in all of its complementary domains to press for continuing dialogue about the transgender child. The papers herewith are an effort to foster these conversations.

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# Listening and Learning from Gender-Nonconforming Children

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*The twenty-first century brings to our clinical doorsteps increasing numbers of children exploring and questioning their gender identities and expressions. This paper begins with a reassessment of the psychoanalytic thinking about gender and then outlines a clinical and developmental model of gender adapted from D. W. Winnicott's concepts of true self, false self, and individual creativity. The underlying premise is that gender nonconformity, when the core psychological issue, is not a sign of pathology but rather a reflection of healthy variations on gender possibilities. Working from that premise, composite clinical material from the author's practice as a psychoanalytic gender specialist is presented of a gender-nonconforming child transitioning from female to male, to demonstrate the psychoanalytic tools applied, including listening, mirroring, play, and interpretation, with the goal of facilitating a child's authentic gender self. Emphasis is placed on learning from the patient, working collaboratively with the family and social environments, and remaining suspended in a state of ambiguity and not-knowing as the child explores and solidifies a True Gender Self.*

FOR THOSE OF YOU OLD ENOUGH TO HAVE HAD YOUR CHILDHOOD imbued with Popeye the Sailor Man, you may remember Popeye, in his gravelly voice, belting out this famous line "I yam what I yam an' that's all I yam." Simply, that is the theme of this discussion: our psychoanalytic work with children and their gender involves learning from the child—who I am. I start from the premise that it is not for us to dictate or legislate, but for the children to explain their gender, whether

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*The Psychoanalytic Study of the Child* 68, ed. Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight (Yale University Press, copyright © 2015 by Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight).

it be conforming or nonconforming. I bring you my thinking within the twelve months that a law was signed into effect by Governor Jerry Brown in California that reads as follows: “No mental health provider shall provide minors with therapy intended to change their sexual orientation, including efforts to change behaviors or gender expressions” (California Senate Bill 1172, 2012). Such practice was assessed as harmful and scientifically unsound. California’s action, now followed by identical legislative proposals in two other states, matches the *Standards of Care* set forth by the World Professional Association for Transgender Health in 2011: “Treatment aimed at trying to change a person’s gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success, particularly in the long term. . . . Such treatment is no longer considered ethical” (Coleman et al., 2011, p. 16). This policy statement and legislative action serve as a wake-up call for all of us. It is time to peruse our clinical theories and practices with the aim of fortifying the mental health of children of all genders, ethically and with no harm done.

I situate myself in the school of thinking that conceptualizes gender as fluid rather than dichotomous. In essence, this is an extrapolation of Sigmund Freud’s *Three Contributions to the Theory of Sex* (S. Freud, 1962) in which he posited, as articulated later by Anna Freud, that our bisexual tendencies, considered part of the inborn constitution, “endow all individuals with psychological characteristics not only of their own but also of the opposite sex” (A. Freud, 1965, p. 195). Whereas Anna and Sigmund Freud were referring to sexuality and erotic object choice, I am proposing that the same paradigm can be applied to our gender: we are not born binary but rather gender inclusive. Beyond birth, gender development becomes an interplay of nature and nurture. Within this conceptual framework, the variations on gender that unfold over the course of development do not constitute abnormality but rather creative differences. To use Ken Corbett’s words, “Genders both in their central and marginal expressions open out into lives that are led through many ways of being and feeling well” (Corbett, 2009, p. 126). Yet, regretfully, to date, children and youth who show up with the marginal expressions may end up in the hands of mental health professionals who will assess their gender transgressions as pathological, their parents’ practices as problematic, and hope to cure them of a diagnosed Gender Identity Disorder.<sup>1</sup>

1. Although Gender Dysphoria has replaced Gender Identity Disorder in the new *Diagnostic Statistical Manual (DSM V)*, the concept of Gender Identity Disorder as a diagnostic category is still widely in use in many people’s thinking.

I am neither an essentialist nor a social constructivist concerning gender. To be either at the exclusion of the other would be ignoring the holistic reality of gender as both born and made. Rather, I think of gender dialectically as a tension between body and psyche, body and culture, psyche and culture. When thinking about early gender development, again referring back to our psychoanalytic forbears, we can find this gender paradigm embedded in Anna Freud's writing on internal harmony and mental health. The forces determining healthy development are both internal and external:

What needs to be integrated with each other at this time are the potentialities inherent in the inherited constitution; the vicissitudes connected with the gradual structuralization of the personality; and the influences emanating from the parental environment which is responsible for the atmosphere in which development occurs. (A. Freud, 1981, p. 111)

Regarding gender development, I would simply extend the statement further to include not just the parental environment but the social and cultural terrain in which any child grows, highlighting again that gender is both an internal and external affair woven together.

To date, I have found no conclusive evidence to tell us the why of gender, although extensive evidence suggests that both nature and nurture have strong hands to play in the process. In the context of treatment, I would propose that our main task is to concentrate more on the *how* of gender, specifically the ways in which an individual puts gender together, either in conformity or transgression of cultural norms and social expectations. In making sense of gender, I embrace the dual concepts of gender identity and gender expression. Gender identity is who I know myself to be as male, female, or other; gender expression encompasses all the ways in which I perform my gender, both for myself and for others. Although similar in meaning to earlier established terms "core gender identity" and "gender (sex) role socialization," the terms "core gender identity" and "gender (sex) role socialization" have been applied to a developmental latticework with a fixed trajectory within the first six years of life. Gender identity and gender expressions, on the other hand, refer to aspects of self that can be established or altered over the course of a lifetime, not just within the earliest years of life, concepts more in line with the model of gender presented here. To borrow from the constructs of D. W. Winnicott (Winnicott, 1971), gender identity is about the "being" of gender, while gender expression is about the "doing" of gender. In my observations and treatment of children and families, it appears that gender identity is far more resistant

to environmental intervention or shaping, while gender expressions are more highly influenced by nurture and culture.

Anthropological investigation enlightens us about the myriad ways that both gender identity and gender expressions can vary dramatically from culture to culture and from one historical era to another. Looking within the boundaries of North America, we can discover multiple genders in the Native Americans or First Peoples. The two-spirited, or third or fourth genders, of Native American culture do not live as either boys or girls, men or women, but somewhere in between, holding the spirit of both the male and female within them. They have often been healers, artists, mediators, and leaders and have been recognized among their people for their flexibility and expanded perspectives. They signify the postmodern concept of gender fluidity, except they go back to premodern times. The berdaches, as the two-spirited Native Americans are referred to, have been seen as exhibiting behaviors that were natural and not to be controlled, habits that showed up early in childhood—"It's natural. They were born that way. It is their nature." In the words of Osh-Tisch, a third-gender member of the Crow tribe, "That is my road. . . . I have done it ever since I remember because I wanted to do it" (Roscoe, 1998, p. 27). Since the gender nonconformity was believed to be in the child's nature, Native American parents did not try to change the child. Instead, they allowed the child to either cross genders or live as both. In India, we find a similar category of a third gender, known as the *hijra*, defined as an individual who is neither man nor woman. The *hijra* do not garner the same universal respect within their own culture as the berdaches do within Native American tribes, and are often relegated to segregated communities, but they do exist as a recognized entity within Indian culture.

Turning to historical shifts in gender sensibilities, I'd like to share a recent experience. On a visit to the Metropolitan Museum of Art exhibit on impressionism and fashion, I came upon a Renoir painting, *Madame Georges Charpentier et ses enfants*, completed in 1878. In the portrait, a mother sits with her two children, Paul, age three, and his older sister, Georgette, age six. Two elderly women stood next to me, gazing at the canvas. One, puzzled, asked the other, "But where's Paul?" Her companion pointed to the child sitting on the settee next to the mother and read to her the caption for the painting, which explained that in the fashion of the times in France, little boys of three did not yet have their hair cut, and were donned in dresses and frills, like their sisters. Indeed, Paul and Georgette were indiscernible from one other, both with long cascading blond curls, dressed in blue satin dresses with lace

trim. The first woman just shook her head in disbelief, muttering, “How could they?” European and also American parents of that epoch and into the early twentieth century could and did—in many places, particularly among the upper classes—undifferentiate small boys from girls in dress and appearance; it was the norm of the times and accepted by all as gender appropriate. At the same time that we see the wide variations in gender norms over time and space, anthropological research also tells us that to date we have no identified culture that does not use some form of gender organization—be it binary, multiple, poles, spectrums, or NOS—“not otherwise specified.” So I also start from the premise that gender to date is a universal organizing feature of human society; it is a question of how we organize it, in all its complexities, which I am inviting us to reconsider.

In that light, I call on the oft-quoted words of the late Ethel Person regarding the evolution of our psychoanalytic understanding of sexuality and gender: “we would do well to follow Freud’s example and supplement the crucial information we glean from the couch with information garnered from the street, as well as from different historical epochs, different cultures, and other academic and scientific disciplines, information that is relevant to fine-tuning our observation and ever-changing theories” (Person, 2005, p. 1278). I would like to extend that quote one step further and take us from the couch to the street to the *playground* and back to the couch, to learn from our youngest children the dramatic shifts presently occurring in the exploration of “Who are the genders in your neighborhood?”

#### THE GENDER LENS FROM WHICH I SEE

Some of the children in the neighborhood have come out to say that they are not the gender that everyone thinks they are. Those children are the ones who typically make front-page news or TV specials. In that iteration, we are prone to begin thinking in a tripartite, rather than binary, way about gender: you are either boy, girl, or trans, the three new categories of gender. Such thinking is equally as binding and constricting as the binary gender models. A very small percentage of the gender-nonconforming children who present themselves to us *will* be persistent, insistent, and consistent in their declaration that they are not the gender written on their birth certificate, but rather the opposite one, or another one altogether. They typically do not say “I feel like a girl (boy)” but rather “I am a girl (boy)” (Ehrensaft, 2011a, 2011b; Steensma et al., 2013). These declarations often begin as soon as language develops, and may show up even earlier, as when one toddler

is videoed tearing the barrettes out of her hair in distress, a distress followed many years later by her transition to male, with the accompanying male hormones to fortify that transition. In addition to gender-label declarations, these children typically express discontent with their gendered bodies and have more intense cross-gender presentations than their nontransgender gender-nonconforming cohort (Steensma et al., 2013). The insistent, persistent, and consistent cross-gender affirmers, a very small minority, are the only children who would be the transgender children in our neighborhood.

The transgender children are to be differentiated from other children who are fine with the gender assignment on their birth certificate but not with the proscriptions and prescriptions of the culture as to how to “do” that gender. Some of this latter group of children will show themselves to be gender fluid, some to be gender hybrids (part boy/part girl), some as gender queer (“I dispense with your categories of gender altogether”), and some later as gay or lesbian.

Evidence of gender nonconformity, whether it be transgender or the other types, often shows up early in childhood, as early as the second year of life. For some children, the gender nonconformity remains in place throughout their lifetime, especially for those who establish a transgender identity. For others, the gender nonconformity may evolve and change over the years or disappear altogether. For yet another group of children, the appearance of gender exploration, gender stress, or transgender affirmation may first show up only in adolescence, often with the onset of puberty and the new evidence of secondary sex characteristics that accompany this stage of development as the trigger. In sum, there is no consistent developmental trajectory, and the main mistake in the past and continuing into the present is to mislabel these developmental progressions as “just a phase.” It may be, but most likely it is not. To date, there are no formal epidemiological studies documenting the prevalence and incidence of gender nonconformity in youth, and the estimates that have been put forward are vastly discrepant from one another (Coleman et al., 2011), ranging from 1 in 100 to 1 in 10,000.

What we do know is that gender-nonconforming children are showing up in larger numbers each year at clinics throughout the United States and Western Europe (Spack et al., 2012; Meyer, 2012). With their growing numbers, these children present us with the opportunity to rethink our assumptions, theories, and practices with children who challenge the normative gender grain of our culture. As the gender language used to express themselves may at times be undecipherable to us, it is a timely endeavor to develop the interpretive skills to understand

what each of the children is communicating to us about their unique unfolding gender, both in its identity and expressions.

In my own clinical practice and those of my colleagues, which I recently canvassed, of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has “desisted” and asked to return to his or her assigned gender. To the contrary, it is typical for us to observe a reduction of symptoms such as anxiety, depression, or oppositional behavior and an upsurge in positive mood, contentment, and well-being when the children are settled into their affirmed gender. This is not to say that the children do not continue to experience anxiety-provoking situations, but rather that they do so with greater aplomb, especially if social supports are in place, both at home and in the community (Ryan et al., 2010; Spack et al., 2012; Travers et al., 2012). As we listen and mirror back what we see in these children, we observe them poignantly finding themselves and consolidating a solid sense of self through their social transition. Within this phenomenon there certainly may be incidences in which children might revert to their assigned gender, and indeed we would expect to see that if we embrace the concept that gender is a lifelong unfolding rather than set at a moment in time in childhood; we simply have not observed such return to the gender on their birth certificates among the children in our own practices.

Having myself now worked with many gender-nonconforming children and their families, I have learned that gender exploration is not child’s play, but rather a serious and sometimes urgent endeavor. I have learned that parents may be faced with a problem but are not themselves problematic. I have said in many other venues that if we listen, the children will tell us who they are (Ehrensaft, 2011b; Ehrensaft, 2012; Spiegel, 2008). In a culture that has depended on the bedrock of gender as a stable and labeled part of existence, first situated in the labor and delivery room when the genitals are observed and the gender declared, this statement generates a fair amount of anxiety and misperception. Some assume that in this model we take a moment, listen to the child’s gender declarations, take them at face value, and then rubber-stamp the child’s affirmed gender, as stated by the child. Nothing could be further from the truth. Like any other process of discovery, gender exploration is a long and careful endeavor, interweaving the conscious and the unconscious, the psychic and the social, the social and the cultural. This is not a one-person operation on the part of the child. Rather, it is a relational process between child and adult, interweaving thoughts and feelings. If a child should come to us as psychotherapists

or psychoanalysts, in need of sorting out gender and discovering his or her own unique gender, the tools of the trade are the same as in any other therapeutic endeavor: providing a safe holding environment, fortifying a therapeutic alliance, playing, suspending oneself in a state of not knowing, allowing a place where pain and suffering can be understood and relieved, employing the tools of neutrality, empathy, observation, relationship, and interpretation to enhance self-understanding and a consolidation of a self. In the cases of children who are gender-nonconforming, the focus will be the gender self, and the goal will be not only the consolidation of that self but the building of gender resilience.

Why resilience? The majority of children who need mental health services to address their gender conundrums are suffering not from a psychiatric but a psychosocial problem—"I am what I am" is frequently met with upset, aspersion, rejection, and distress from the outer world. The children are stigmatized. They may feel a cacophony between the gender they know themselves to be and the body that presents itself to both themselves and the world. We hear a common lament from some of the children: "Why did God make a mistake and make me a girl?" "Why can't you put me back inside and make me come out a boy?" Whether it is social aspersion or incongruence between assigned and felt gender, the children, along with their families, will need to build a psychological tool kit to meet up with a world that may not be accepting and/or a gender-assigned body that feels out of synch with the gender messages from the brain.

Before illustrating the clinical model from which I work, let me back up to the concepts that guide me. The concept of the gender binary has been replaced in recent thinking by the concept of a gender spectrum—children place themselves along that spectrum in an infinite combination of gender expressions and gender identity formation. I have extended that idea one step further by proposing a concept of a "gender web": each child will weave together a three-dimensional web that will be his or her individual gender self. Nature and nurture will come together in a combination of chromosomes, hormones, hormone receptors, primary sex characteristics, secondary sex characteristics, brain, mind, socialization, and culture to create an infinite variety of gender combinations. In sum, each child's gender web is a synthesis of nature, nurture, and culture, and involves a complex relationship between the body, the mind, and the surrounding environment. Like fingerprints, no two people's gender webs will be the same. Unlike fingerprints, an individual's gender web can change over the course of a lifetime. In childhood, it is up to the child, not the parent, to spin the gender web. If the parents grab the web's threads from the child,

it collapses the opportunity for the child to discover his or her own authentic gender.

Once again, I turn to the work of D. W. Winnicott, who afforded me the opportunity to extend my thinking even further about the child's crafting of the gender web. I have adapted Winnicott's concepts of the true self, false self, and individual creativity to make sense of children's gender unfolding. To review, the true self is the authentic core of an individual, of which the initial kernel is evident at birth, but then immediately interwoven with the social environment, beginning with the primary dyad between parent and child. The false self is composed of the psychological layers developed to envelop the true self, set up to protect the true self from psychic harm and to adapt and conform to environmental expectations. Individual creativity refers to the impulses inside an individual that act to construct the uniqueness of that individual (Winnicott, 1960; 1965; 1971). In the gender adaptation, the True Gender Self begins as the kernel of gender identity that is there from birth, residing most importantly in our brain, mind, and body. Once we are born, and even in utero, the True Gender Self is most definitely shaped and channeled through our experience with the external world, but its center always remains our own personal possession. The False Gender Self is the face a child puts on for the world, based on the expectations of the external environment and the child's interpretations and internalizations of either "appropriate" or adaptive gender behaviors. Gender Creativity is the process of the child weaving together body, brain, mind, psyche, socialization, and culture in an effort to compose an authentic gender self.

Gender Creativity is where Irene Fast's theory of gender development (1984; 1999) comes into play. In her theory, very young children, once aware of gender, embrace gender inclusivity: "I can be all genders." It parallels a developmental stage of magical thinking (Fraiberg, 1959), in which there is a belief in infinite transformational possibilities and subjective logic dictates that if a frog can turn into a prince, surely a girl can turn into a boy and a boy into a girl. With cognitive and emotional advances and navigation of the oedipal phase, a child grows to realize that it is impossible to be both a boy and girl or to trade between the two. A requisite stage of mourning the loss of the gender that the child can never be prepares the child for the acceptance of his or her immutable singular gender and the relational and behavioral accoutrements that accompany that embraced and fixed gender.

The gender-nonconforming child either dismisses or resists that mourning stage and continues to explore the margins of gender with its mix-and-match possibilities. Some might say that these children are

suffering from a developmental arrest, fixated at a stage based on delusion and artifice, rather than material reality. I would like to propose the alternative possibility that these children refuse to relinquish the gender inclusivity of their earliest years and have come to realize that gender is not simply dictated by the body but strongly influenced by our psychic constructions. We could say that they are the ultimate anti-essentialists, who challenge us to reconsider that gender can be all-and-any, rather than either-or. In that sense they are able to maintain what so many of us have relinquished in our earliest childhoods as we strived to accommodate to a social world in which gender is defined by what is between our legs rather than what is between our ears. Rather than an arrest, we can recognize the children's persistent gender inclusivity as an accomplishment, one in which they are better able than those who have relinquished gender inclusivity to privilege psyche and social construction over deterministic biological materiality, much to their artistic and creative credit.

This is not to say that these children fail to accomplish the cognitive tasks of differentiation, categorization, and integration that come with the entrance into the preschool and primary school years, but rather that they are not bound by such schematizations when it comes to the emotionally and socially laden issue of gender. In "Trans: Gender in Free Fall," Virginia Goldner poses the question "Is gender invariance necessarily a developmental achievement, another milestone in Piagetian conservation—or is it simply a concession to normativity?" (2011, p. 162). In different terms, she is raising the same consideration I am—perhaps the youngest of our gender transgressors in our culture are resilient and creative enough to cast a very wide gender net, not encumbered by as many years of the social gender prescriptions and proscriptions as their elders are and with the benefit of a cultural loosening of those very dictates and prohibitions over recent years. Rather than gender in free fall, they are living gender in free form, and in their gender inclusivity, inviting us to loosen our own binary bonds and do the same. Goldner acknowledges the new transgender adult mentality: "My body is no longer my destiny. It is now my canvass" (p. 166). For the new gender-nonconforming generation of children, their body never was their destiny—and never will be, as long as they remain in a state of gender inclusivity with the opportunity to paint their own canvas.

A seven-year-old child was brought to me by the parents because both the parents and the child had questions about the child's gender identity. I walked to the waiting room to be greeted by a child in basketball shorts, tank top, and running shoes, looking like any boy on a school playground. The child then entered my office and spun

around. Down the child's back cascaded a long blond braid secured at the end with a bright pink bow. The child spun around again, faced me, and explained, "You see, I'm a Gender Prius. A boy in the front. A girl in the back. I'm a hybrid." This child maintained her assigned gender—female—but refused to conform to the binary identificatory category "girl." Further exploration revealed that a commitment to a singular category of either male or female was internalized by this child as both binding and a "not me" experience—each meant that another aspect of self was foreclosed and lost—internally, a relegation to one binary gender box or the other denied the other half of the child's experience and collapsed into nothingness. Within the psyche, this was a child who lived in the middle, neither boy nor girl but both. "Gender Prius" was this child's articulation of self at this particular cross section in time, the child's own narrated gender snapshot at age seven. Where the Gender Creativity will take her over the course of her childhood is yet to be seen. In the meantime, our Gender Prius stands as a fine example of Irene Fast's concept of gender inclusivity sustained by this child with ample fortitude and *jouissance* well beyond the toddler stage. Her body is not only a canvas; it lends itself up to a three-dimensional gender sculpture.

#### THINKING THERAPEUTICALLY

Parents will contact a mental health professional when they have concerns about their child's gender behaviors, feelings, stresses, or distresses. It is usually the child who is the initial agent in this process, by signaling to the parent in any number of ways that "who I am" is in contradistinction of who the parents expected that child to be in terms of gender identity or expressions. Yet it is the parents not the child who typically present themselves to the clinician with their concerns. Based on collaborative discussions between the parents and the professional, the child may then enter a therapeutic process to have a room of his or her own to explore and work through confusions, dysphoria, angst, conflicts, fears, or what have you. Alternatively, the child may stay home while the parents continue to meet with a professional to work through their own worries, confusions, angst, conflicts, and fears with an aim of ensuring the child's healthy gender growth. Whether it is the child or the parents who are seen, in the model of therapy that I have dubbed True Gender Self Therapy, the goals remain the same. The developmental goal is the establishment of a child's authentic gender self with the assistance of Gender Creativity, working in the intermediary space between inner and outer. In this endeavor, the hope will be to minimize

the necessity for False Gender Self constructions while at the same time recognizing their protective function for the child in a social environment that is not yet ready to accept the child in all the child's gender uniqueness. The therapeutic goal will be to build gender resilience, both the child's and the family's.

The two underlying principles of the therapy practice are: (1) If you want to know a child's gender, ask the child; it is not ours to tell, but the child's to say; (2) Parents have little control over their child's gender identity but significant influence over their child's gender health (Ehrensaft, 2011a, 2011b). Making the unconscious conscious is definitely a key instrument in allowing the child's True Gender Self narrative to unfold, with specific attention to defenses of repression and denial that bury the True Gender Self deeply underground and create a crusty, protective layer at the surface, one that may be able to meet the world adaptively but constricts the child internally, sometimes to the extreme of psychic suffocation. Yet, although I mentioned earlier that all the standard tools of psychological engagement are appropriate to this task, I have found that mirroring, with both its affective and cognitive components of reflecting back to the child in word and action what the therapist sees there, has proved to be a central therapeutic tool in facilitating a child's unfolding of the True Gender Self, accompanied by the reveries and deeply rooted mentalizations embedded in that process. If we want to know how a child identifies, we listen to the child, pay close attention, provide a safe-enough holding environment, mirror, interpret when appropriate, and over time, that child will tell you. From the children I have seen to date, I have discovered that the children will be the experts of their own gender identity, and while gender expressions may vary over time, their gender identity shows more temporal consistency and simply needs to be brought to the surface.

Returning to the goal of building gender resilience, a final objective of True Gender Self Therapy is to facilitate a child's acquisition of a psychological tool kit, so to speak, one that will allow a child to internalize a positive self-identity while recognizing situations in which that identity may be in need of protection from an unwelcome or hostile environment. The specific tools for self-protection should be consciously constructed rather than unconsciously driven; in essence, it is the intentional crafting of an outer rather than inner False Gender Self that is flexible rather than rigid and under the child's conscious control, to be used as needed as a protective cloak. Optimistically, this co-construction will be needed only temporarily, as the therapist, in collaboration with other adults in the child's caretaking world, moves from the couch into the community to build more gender-accepting

environments, especially within the child's school, where much of the child's day will be spent. The intent in these efforts is to remove the need for either unconsciously driven false or consciously designed outer gender self constructions while expanding the opportunities for spontaneous Gender Creativity.

True Gender Self developmental and therapeutic goals are in line with Mark Blechner's work on identification of groups who have been labeled psychopathological as a result of prejudice. In this situation it is recognized that an individual may be suffering from social stigma and reaction to unbearable social requirements, rather than psychopathology, and there is acknowledgement that the individual's problems will be cured by changing the person's relationship to society, rather than intrapsychic change. In other words, for the ultimate removal of psychopathology, society itself must change (Blechner, 2009). To facilitate this acknowledgment regarding the psychosocial positioning of gender-nonconforming children, I would propose that we start by substituting Gender Identity Creativity for Gender Identity Disorder as our guiding principle, not for curing gender disease but for promoting gender health, defined as the acquisition of an authentic gender self.

The role of the parents is critical in achieving the developmental and therapeutic goals. In Winnicott's (1965) theory, the parent-infant dyad is primary in setting the stage for the expansion of that early kernel of the true self by mirroring the child, that is, by allowing the child's spontaneous expressions to unfold rather than imposing the parent's will and personality on the child. If environmental impingement trumps facilitation of spontaneous unfolding, the child is denied authenticity and compelled to mold to caretakers' expectations of self. If we apply this concept to gender development, it will be the parents' job to mirror back to the child the gender that child experiences him- or herself to be. If the child's inner sense of gender is different than what the parents are both seeing and responding to, the child may deflate or the child may protest. If given the opportunity to protest, the message is, "Hey, you've got it wrong. I'm not the gender you think I am" or, alternatively, "I can't do gender the way you want me to." If the parents can adjust their reflective mirror, the child finds him or herself in clearer focus. If they cannot, gender begins feeling like the distorted mirrors in a fun house: someone is reflecting back to them a sense of gender that looks nothing like the gender they experience themselves as being. It is not uncommon for a parent to say to a little boy who says he is a girl, "Honey, boys can play with Barbies, too, not just girls. We can buy you a Barbie." In response, it has not been uncommon for the child to protest: "I *know* boys can play with Barbies. That's not what I said—I

said I'm a *girl* who wants to play with Barbies." That child is putting out a plea for parental mirroring that feels reflective rather than distorted. That child is also telling the parents, "Please do not be the one who paints the gender portrait of me. Put your brush down and pass back to me my own self-portrait, not of your design, but of mine." To do that, the parent often has to work through the discomfort and angst of one's own gender predicates and also make room for recognition of the child being different from them (Solomon, 2012).

Ken Corbett (2009) identifies the sometimes hyperboled expressions of female gender by gender-nonconforming little boys. Poised between the psychic and the social, the gender-nonconforming boy who cries out, in word and action, "How loud, how colorful, how bejeweled do I have to be before you will see me?" (p. 159) is in a state of melancholic suffering in which his gender desires are rebuked and repudiated by those around him. I have certainly seen these extreme states of exaggerated gender performances in children I have worked with, particularly boys, which makes sense, because boys in our culture are policed far more heavily than girls in their gender desires, as evidenced in the APA's *DSM IV-TM* (1994). A boy only has to *prefer* cross-dressing or simulating female attire to qualify for the diagnosis; a girl has to *insist* on it. Whether expressed by a boy or a girl, thinking about these hyperboled gender expressions in relational terms, we observe an outlaw phenomenon in which the protesting children take their "doing gender" to the extreme so that those around them get the point. Yet what happens when that repudiation is replaced by recognition? Referring back to the mirroring concept, when stigma is lowered, social acceptance increased, and parental mirroring adjusted to fit the child who appears before the parents, rather than the one they hope to have, the hyperboled sense of gender seems less in evidence. There is no longer a psychic need to scream for recognition.

Two children who have recently visited the Child and Adolescent Gender Center Clinic at the University of California San Francisco Benioff Children's Hospital are perhaps exemplary of this. It should be noted that both children were screened for chromosomal anomalies that might have accounted for gender-nonconforming presentations, and none existed for either, each being unambiguously XY and XX respectively. Casey is nine. She was assigned a male gender at birth, but over the course of her first eight years expressed repeatedly that she thought she was a girl, not a boy. Between third and fourth grade, her parents allowed her to transition to her affirmed female identity. They were supportive of her transition and worked with her school to facilitate the transition and build in the educational supports Casey might need. The fourth-grader

who walked into the Gender Clinic was not bedecked in sparkles, frills, or jewels. She had long cascading curls, wore a flannel shirt, jeans, and hiking boots. Right after her came an eight-year-old boy, Danny. Danny was assigned a female gender at birth, but was insistent from age two on that Danny was a boy, not a girl. Danny's parents are divorced, and Danny's father will only recognize Danny as a girl. Danny's mother has sole physical and legal custody. She has acknowledged Danny's gender desires, and Danny has been living as a boy, except at his father's. The child who walked into the Gender Clinic was not dressed up in army fatigues or striving for a "macho" presentation. He was dressed rather like Casey, in the prevalent unisex uniform of their age cohort, wearing a striped T-shirt, jeans, and navy sneakers. He had a short-cropped haircut. In cultural terms, his presentation was so consistent with normative boy presentation that the pediatric endocrinologist, whose very job was to assess the child's physiological status along the Tanner Stages of puberty, and therefore knowing full well the child's natal sex, upon hearing that Danny suffered from enuresis, began to give the mother a lecture about boys' anatomy that might be contributing to her son's wetting, forgetting completely that this was a female-bodied boy.

Are we seeing here a lower-key, relaxed rather than noisy, almost hysterical presentation of gender when we replace blinding police floodlights with soft lighting and safe landings for the gender nonconforming children who are simply telling us, "I am what I am"? If so, could we attribute these more-tempered presentations in part to a more sensitized process of mirroring and a diminution of impingement on the part of the parents, which might end up being our most important clinical intervention in promoting a child's gender health?

It is right about now where the thought might be brewing "But what about the situations in which gender is a symptom of some other psychic disturbance?" That can certainly happen but far less frequently than most people assume, particularly those who formulate gender-nonconforming presentations or desires in young children as evidence of trauma, attachment disruptions, or disturbed parent-child relations (Coates, Friedman, and Wolfe, 1991). The majority of children who are coming to clinics or individual practitioners to address gender issues do not have histories of attachment disruptions or disturbed parent-child relations, and the most common form of trauma they present is usually a consequence rather than a cause of their gender nonconformity, typically a result of parental or social rejection, harassment, and bullying. Still, the most challenging task as clinicians is to tease out those situations in which gender conundrums' roots are some other deeper psychological disturbance or disruption from situations in which a child

is simply trying to get to the root of the authentic gender self in all its complexities. To make matters even more complicated, we have to contemplate the gnawing chicken-and-egg question: How do we know that a child's psychological conflicts, syndromes, or disorders are not the sequelae of being forced to live a gender-inauthentic life rather than of an independent core psychological problem residing in the child?

We do have an *ex post facto* test at our disposal to answer this question: if the disequilibrium in psychological functioning is a secondary effect of being barred from living an authentic gender life, and the child is given the opportunity to live that life with acceptance and as much sheltering as possible from outside stigma, and the child then gets significantly better and the symptoms subside, gender was most likely the root of the problem, solved by cutting a path to allow the True Gender Self to walk through. This is not an academic exercise. It is an observation reported repeatedly by parents and professionals alike as they watch a child's mental health and well-being improve once the constricting bindings of gender are replaced by a broad band of gender expressions in line with the child's gender desires (Spack et al., 2012).

Lastly, what if there are psychological problems that run parallel to a child's gender conundrums or confusions? Does a "co-morbid" psychiatric disorder preclude a child being able to transition genders or receive interventions such as puberty blockers? I would answer—only if gender nonconformity is considered "morbid," and since I do not operate from a disease model of gender, the other psychological problems are relevant only inasmuch as they are impediments to gender resilience and compromise a child's ability to express the true gender in a potentially gender-unfriendly world. In all cases, the clinical work is the same: using the therapeutic tools outlined earlier to learn from the child what is ticking inside.

#### FROM THE PLAYGROUND TO THE COUCH: JACQUELINE/THOMAS

We all know that children are more apt to jump on the couch than to lie on it. So using the couch metaphorically, I would like to share some excerpts from a therapy conducted over a four-year period. The techniques employed in this therapy are drawn both from my training as a developmental psychologist and gender specialist along with the tools of the relational, or two-person, psychoanalytic model (Mitchell, 1988), in which a dialogue between patient and therapist and their relational matrix as the therapeutic couple is the means to discovering the child's truth (Spezzano, 1993), in this case, the True Gender Self. As mentioned earlier, whereas bringing the unconscious into consciousness

is one cornerstone of the work, the act of mirroring back to the child the child's articulation over time of that child's unique gender web is typically the crux of the therapeutic endeavor. Because the web is a consolidation of nature, nurture, and culture, the collateral work with the child's parent(s) or primary caretakers(s), along with collaboration with other parties active in the child's life, becomes an essential component of the process.

#### JACQUELINE'S GENDER HISTORY

Jacqueline's mother, Adrian, first contacted me when Jacqueline was nine years old to address her daughter's perceived gender angst.<sup>2</sup> Adrian was a single mother who had conceived her child using a known sperm donor. She gave birth to a daughter and was delighted to have a girl. By age two, her little girl refused to wear dresses and threw away her dolls and pink stuffed animals. She asked for balls, trucks, and action figures. Adrian was able to adapt to the daughter she had with her nonconforming gender expressions, but she became troubled when Jacqueline, still in preschool, began to complain about being a girl, saying maybe she wanted to be a boy sometimes. Throughout grade school, Jacqueline kept her hair cropped short, wore jeans, T-shirts, running shoes, and a baseball cap, with most of her clothes purchased from the boys department. She would only wear pajama bottoms and no tops when she went to bed, and she protested that she could no longer go topless at the community swimming pool, to which Adrian had put a stop when Jacqueline turned seven, explaining to Jacqueline that for girls her age, it was no longer appropriate to appear in public with their chests uncovered.

At age nine, Adrian observed her daughter growing increasingly distraught about and preoccupied with gender conundrums—could she keep living as a tomboy or was she maybe a boy boy? In early consultations, Adrian expressed her own anxieties about Jacqueline's apparent gender dysphoria. As a mother who had for years dreamed of giving birth to a little girl, her deepest hope was that Jacqueline would settle on being a gender-nonconforming girl, maybe a lesbian, rather than a transgender male. She desperately did not want to lose her daughter, but having done her own reading and having talked to other parents of gender-nonconforming children, she was preparing herself to accept whatever was best for Jacqueline rather than what was wished for by her.

2. All names and identifying features of individuals have been changed in this presentation.

In my consultations with Adrian, I learned that Jacqueline had recently been sharing reveries about being a boy and loved it when people took her for one. She had reported a dream to her mother in which she discovered a button inside herself that she could push to turn herself into a boy. Dressed like a boy, she still played mostly with girls and a few “nice” boys. She avoided the loud, rowdy ones. One reason for this was that temperamentally, Jacqueline was a very quiet, shy, slow-to-warm-up child, preferring to fly under the radar screen rather than have attention focused on her. She told her mother she’d like to be a boy, “mostly, kinda.” In public, if given a choice, she would go into the single-toilet public restroom marked MEN, but she chose the women’s restroom over the men’s when there were several stalls rather than one—again, because she loathed drawing attention to herself and thought people might stare.

#### GENDER CONUNDRUMS IN THE CONSULTATION ROOM

The child I met in therapy closely matched Adrian’s description of Jacqueline’s personality. Overall, she was extremely shy and a child of few words. Speaking about feelings was particularly difficult for her and engaging in projective play activities, such as drawing, the sand tray, or puppet play, yielded few results and made Jacqueline acutely uncomfortable. This meant that our work went at a very slow pace, with me spending many of our first sessions initiating conversations that allowed her to open up a little at a time and discovering that her limit for engaging in dialogue was about twenty-five minutes, after which she would ask timidly, “Can we play a [board] game now?” breathing a sigh of relief when I assented. So the therapy quickly settled into twenty-five minutes of talk and twenty-five minutes of board games in each session, with Jacqueline taking a seat at my desk and me moving my chair close to her to facilitate more intimate conversation, which Jacqueline readily accepted. Because of Adrian’s work schedule and her limited financial resources, Jacqueline and I were only able to meet on a once-a-week basis, which further slowed the forward pace of our work together.

I have learned in my years as a child gender specialist that gender-nonconforming children, even in the most supportive families, have often internalized by a very early age “We don’t speak of such things.” Thus, as part of my assessment process with a child, I refer to myself as someone who knows about gender things and report to the child a very brief snapshot of what the parent(s) have shared with me about their child’s gender nonconformity, and I give the child an opportunity

to respond. In Jacqueline's case, I told her that I had learned from her mother that she liked to wear boy clothes (which was also obvious from her gender presentation in my office), be mistaken for a boy, play with both boys and girls, had been wondering with her mom about who she was, and had I gotten that right? Jacqueline did not make eye contact with me but appeared to be listening intently, answering quietly, "Yeah, that's kind of right." My silent interpretation at that time, which I held for later, was that Jacqueline lived in a layered internal world, firm at the core and then covered with doubts. I intuited that she might consciously know more than she was telling and that she might be caught in a conflict with her either conscious or unconscious knowing of her mother's strong wishes for a daughter, tangled up with her own confusion of whether she was one or not. What would she do if the choice were between losing her mother's love and affirming what she might be coming to know about her own gender?

That latter question came to bear over the course of our first year together. Getting to know me better and resonating to my initial observation that in addition to being a person of few words, Jacqueline seemed afraid that if she spoke up she might hurt someone, Jacqueline first expressed that she was fine being a girl as long as people did not expect her to wear dresses and as long as they let her play basketball with the boys, but then she wasn't so sure. She shared with me, in her own tentative language, that she really thought maybe she felt more like a boy but didn't want to lose all her girlfriends, so maybe she should leave it the way it was. In addition to reflecting back to her the girl-boy vacillation that was going on in her head, I wondered with her whether it wasn't just her girlfriends she was worried about losing, but maybe her mother as well. Tears came to her eyes, and she grew silent for some seconds, then mutely nodded her head in the affirmative.

#### GENDER SUPPORTS: MATERNAL AND MEDICAL

This led me to invite Adrian in for several collateral sessions in which we explored in more depth Adrian's anxieties about Jacqueline opening up further about gender desires and discoveries and the potential loss of a daughter that might ensue. Each of the two members of this relational matrix—mother and daughter—were living in fear of losing each other, and each had to work through their anxieties about this, with Adrian taking the lead to communicate to her child, not just in words but in feelings, that whoever Jacqueline was, her mother would love her. The lack of that parental support can often prove to be the primary obstruction to the child's freedom to creatively explore gender,

and I assessed this to be true for Jacqueline, with Adrian expressing her doubts and fears to Jacqueline not overtly but in subtle innuendo. As this parental obstruction was removed through Adrian's own internal work, Jacqueline began to open up and muse more about her gender position, as when she shared with me in one session, "I think I'll still be the same person if I'm a boy instead of a girl, won't I?" I asked her what she thought the answer was, and she began to muse about all the times she had already sat in her room addressing herself as "he" and that nothing seemed to change at all, except that she seemed "kinda happier."

As Adrian did her work to sort out her anxieties about Jacqueline's gender explorations, Jacqueline began to show the first signs of puberty. Having been alerted by parents of other gender-nonconforming children with whom she was in contact, Adrian took it upon herself to become educated about puberty blockers, through reading, Internet research, and consultations with Jacqueline's pediatrician. Adrian was now faced with a dilemma: whether or not to talk to Jacqueline about the possibility of taking puberty blockers as Jacqueline moved into puberty—a medical intervention to stop the flow of a female puberty that might prove to be unwanted, if not traumatic (see Ehrensaft, 2009)—and give Jacqueline more time to explore her gender.

Puberty blockers, also known as GnRH agonists, were originally introduced in the 1970s to stanch the onset of puberty in young children presenting with precocious puberty. Upon stopping the administration of the drug, normal puberty will resume within six months. In the 1990s the clinicians at the first established child gender clinic, located in the Netherlands, began using the GnRH agonists for a new population, puberty-aged youth who were presenting with significant gender dysphoria (Cohen-Kettenis and Pfäfflin, 2003), affording them the opportunity to have more time to explore their gender identity before moving into the puberty of their assigned gender and, alternatively, preventing the onset of an unwanted, potentially traumatic puberty that would match a child's assigned gender but not the child's affirmed gender identity. As in the use of GnRH agonists for precocious puberty, the effects are reversible, if a child decides to proceed in the assigned gender identity rather than change genders. At the same time, if a youth is clear that the affirmed gender is a trans identity, blockers afford that youth the later opportunity, with the aid of cross-sex hormones, to proceed in developing the secondary sex characteristics of their affirmed gender, without the imposition and risks of future medical interventions in adulthood, such as mastectomies, electrolysis, and facial reconstructions to align their physical appearance with their affirmed gender.

Spack et al. (2012) published findings from the GeMS (Gender Management Service) program for youth in Boston that reflect “that psychological functioning improves with medical intervention” (p. 422) for transgender youth, which included both the administration of puberty blockers and, later, when appropriate, cross-sex hormones. From observations of youth in my practice and reports from others, there is no doubt that the availability of hormone blockers has been a tremendous gain for transgender and gender-nonconforming youth. In a follow-up study by members of the Amsterdam clinic, where puberty blockers were first introduced, results corroborated Spack et al.’s findings, indicating that behavioral and emotional problems and depressive symptoms decreased, while general psychological functioning improved significantly subsequent to the administration of puberty blockers for gender dysphoric youth (de Vries et al., 2011). There have been no reports to date of any short- or long-term medical risks of blockers, including negative impact on bone density, which have been many people’s concerns (Gooren and Delemarre-van de Waal, 1996; Spack, 2013). It should be noted, though, that extended longitudinal data into middle adulthood are only presently available for children who were administered the drug for precocious puberty; the use with gender-nonconforming youth has been too recent to yet have such long-term longitudinal data. The main problem with hormone blockers in many countries is that they are exorbitantly expensive and, if not covered by medical insurance or government programs, out of reach for any but those with substantial financial means.

Adrian was well aware of the facts about puberty blockers and was also apprised that puberty blockers are most effective if they are administered before the end of Tanner Stage II of puberty, in which the earliest signs of puberty are emerging but no significant physiological puberty changes have occurred. Unfortunately, the fast, ticking biological clock of Jacqueline’s emerging puberty was out of synch with Jacqueline’s slow progression forward in sorting out her gender questions. Adrian felt torn about intruding on Jacqueline’s preadolescent innocence with potentially disruptive information about bodies and secondary sex characteristics and was still working through her own anxiety about Jacqueline possibly exiting girlhood to enter boyhood. Decentering from that anxiety and focusing on Jacqueline’s potential needs, Adrian came to terms with the implications of her gender-nonconforming daughter’s impending entrance into Tanner Stage II of puberty, when puberty blockers prove most effective. She was able to weigh the potential intrusion against the potential harm done if she failed to provide Jacqueline with information about the possibility of taking puberty blockers when,

with the biological clock moving so quickly, it might be “too late” to ward off the negative if not traumatic psychological responses to an unwanted puberty. She imagined Jacqueline later accosting her reproachfully, “If you knew about them, why didn’t you tell me in time?” To Adrian, the choice of omission seemed far riskier than the effects of commission, and thus she decided to have a discussion with Jacqueline about the availability of blockers and their effects. We could say her decision was counterphobic in face of her own anxieties, but I assessed it more as Adrian’s wish to do what was best for her daughter, as confusing as it was to figure out what that would be.

With professional advice from a pediatric endocrinologist, and after extensive consultation with me, Adrian, first ascertaining that Jacqueline was fully apprised about puberty and the physical changes that come with it for both males and females, spoke to her daughter about the blockers in as sensitive a manner as possible. She explained how puberty blockers worked, how they could buy Jacqueline more time to sort out her gender without the intrusion of body changes, how they were not permanent and she could stop them any time she wanted and go back to have her body change in ways that girls’ bodies do, and that puberty blockers could be something she could consider. Adrian reported that at first Jacqueline listened quietly, but then grew fidgety. The more Adrian talked, the more agitated Jacqueline became. This was unusual behavior for Jacqueline, typically a laconic child. She finally looked down to the floor and mumbled to Adrian, “Yeah, maybe I could take that medicine.” Then she suddenly leapt up and fled to her bedroom, slamming the door behind her, blurting out, “But girls are nicer than boys.” Adrian felt totally deflated and questioned whether she had made a big mistake in bringing up puberty blockers at all. It also opened up hope for her that maybe Jacqueline was going to remain a girl after all.

#### JACQUELINE AND THE BLOCKER DOCTOR

In my following session with Jacqueline, she was unusually quiet, even for her. She told me about the conversation with her mother about those “blocker things,” then tears welled up and she laid her head on the desk. The doubts at the surface and the gender rumblings from below were all coming to a head, and Jacqueline was clearly feeling overwhelmed. In that moment I made a therapeutic decision to say nothing to Jacqueline, but to sit with her quietly and mirror back to her the level of distress she was feeling, along with a wish: “Why couldn’t gender just be easier?”

During the following week Jacqueline, upset and worried, approached Adrian. She expressed that she did not want to grow up, she was actually terrified of growing up, and wished she could suspend herself in time and remain a ten-year-old child forever, where she could dress as she liked, present herself as she liked, and not be burdened by the stresses of both changing bodies and shots to actually stop you from changing. She asked Adrian to back off and not talk about puberty blockers anymore, at least for now, which Adrian obliged. Both Adrian and I were left with questions and concerns: Was Jacqueline, usually so taciturn, telling us that girls were nicer and she wanted to be one, which was her mother's wish? Was Jacqueline perhaps a gender-fluid, not a transgender child? Was this simply too much information for Jacqueline to handle as she was trying to pace her own gender explorations in therapy? Catapulted into action by the early appearance of puberty, Adrian chose to take the risk of introducing the topic of puberty blockers too early for where Jacqueline was emotionally in her gender journey, but just in time regarding the physical changes in Jacqueline's body. On balance, it seemed to Adrian a better option than waiting to bring up the availability of puberty blockers too late when Jacqueline was further into puberty, with no time to retreat and think it over for awhile. But was it? Over the subsequent weeks this question hung with me as well as I watched Jacqueline temporarily shut down and not want to think about gender at all.

Then, some weeks after Jacqueline's request for a moratorium on puberty blocker discussions, accompanied by her self-enforced prohibition on any shared dialogues about gender at all, Jacqueline began to slowly open up in the therapy sessions. She had questions she wanted to ask me about how the hormone blockers worked, and she wondered if they would ever come up with a pill because she hated shots and the alternative of a subcutaneous implant seemed even yuckier. I shared with Jacqueline that I first wanted to understand with her what made her want to stop the moratorium about blockers. She told me that she had needed some time to go off and think on her own. I wondered with her how it helped to do this alone rather than with me, and, after some minutes of silence, she was able to tell me that her head was buzzing with too many things at once and she'd needed to turn everything off for awhile, and the only way to do that was to turn me off—and her mom too, but now she was back. I was recalling my own guiding principle that it is not for us to tell, but for the children to say, and I held a concern that too much telling regarding puberty blockers was experienced by Jacqueline as an impingement from which she felt a need to retreat. On the other hand, perhaps the buzzing in her head

represented all the gender tensions and conflicts coming to the light of day, which can certainly make a great deal of noise on their way up. Either way, I wanted to return to her question, particularly because Jacqueline asking a question of me was a rare event in our work. Regarding the blockers, I told her that the bad news was that they hadn't yet invented a pill, and interpreted the dilemma of "pain and gain" as she imagined puberty blockers as part of her life.

Jacqueline's mental buzzing began to settle down into cohesive thoughts. She expressed that sometimes she thought it would be better if she were a boy—it would just feel more "right," but only if she could move to a new school and start over. She suggested, at first very tentatively, that maybe she could have an appointment with the "blocker doctor" to find out more about puberty blockers. For the first time, she asked me a direct question about herself and how I thought about her: "Do you think taking blockers would be a good thing for me to do?" I responded that this was a really important question, and the only way to answer the question was to find out more about what *she* had been thinking about it. Jacqueline, who rarely made direct eye contact except when beating me at a board game, slowly looked up and said, "I'm pretty sure I'm a boy." Throughout, my therapeutic provisions for Jacqueline had been primarily in the form of a holding environment, one in which I listened and reflected back what I was hearing, with minimal interpretation and maximum attention to building a therapeutic dialogue toward discovering Jacqueline's True Gender Self. At this point in the treatment, I assessed that we were finally in dialogue with one another and that I could let my silent interpretations begin to speak.

Over the subsequent weeks, Jacqueline, although still shy and somewhat reticent to share what she was thinking, began to open up more, both in her therapy sessions and with her mother; all arrows pointed in the direction of her consolidating a male gender identity. She dropped her tentativeness and made clearer statements: "I know I'm a boy, I was just always afraid to come out and say it." Her fears involved not just the loss of the love of her mother but the loss of the parts of her that she so valued and resided in in her relationships with both her female parent and her female friends—the quietness, the attention to feelings, the collaborative, cooperative spirit among them. At a deep level, she had incorporated the cultural dictum that only girls were allowed those attributes, no boys need apply. Only when she brought these fears to the surface and put them into words in the therapy session was she able to claim a male identity for herself while preserving the gender expressions of her heretofore female self.

Jacqueline repeated her request to make an appointment to see the blocker doctor, and Adrian set forth to schedule appointments with a pediatric endocrinologist who was trained as a gender specialist. Both I and Jacqueline's pediatrician consulted with the endocrinologist, and it was decided that Jacqueline, who was now well into Tanner Stage II of puberty, would start a course of puberty blockers. It was also fortunate that Adrian's place of employment provided insurance that covered the prohibitive cost of the medications and all other gender-related medical interventions, so that the treatment could commence.

#### JACQUELINE'S TRANSITION TO THOMAS

A few months after starting on puberty blockers, Jacqueline expressed that she was ready to transition to being a boy, at home. She chose the name Thomas for herself and asked her mother and grandmother if they would start using both that name and male pronouns. She was too shy to ask me directly to do the same, so I proactively intervened and asked what name I should be using. Although my training has taught me to wait until the patient brings up material, rather than intruding with the therapist's own agenda—as in my original assessment process in which I introduced gender to break the ice of a potentially prohibitive topic—I felt that Jacqueline might still feel too inhibited to be so bold as to assert a name or pronoun change in my office, so I took the lead and asked what she would like me to do. After a few moments of silence, Jacqueline first muttered, "Oh, I don't know; it doesn't matter," and then a few minutes later, Jacqueline looked down and said quietly, "Well, I guess you can call me Thomas." I explored with her what the name Thomas meant to her, and she reflected that it felt like letting someone come out to play for the first time. It was curious that this child did not choose a new name nearer to the one she had been given at birth, as Jack or even Jacky could have sufficed as a male assignment in closer proximity to who she had always been, but the unconscious need to bring a hidden core male self to the surface and differentiate it from the female outer self, which now felt like a "not me," overrode any desire or need for continuity. So Thomas it was, and Thomas it has been ever since, a Thomas fortified by the mirroring back by both me and Thomas's mother and grandmother that *he* was the child we were now seeing.

During the transition from Jacqueline to Thomas there was one therapeutic moment, seemingly inconsequential, that I think spoke volumes about the positive effects of the introduction of puberty blockers and Jacqueline's subsequent expressed desire to transition to male. Thomas

had just returned from a weekend family conference for gender-nonconforming children and youth and their families, accompanied by both his mother and his grandmother. It should be noted that this was the first year that Thomas agreed to attend this annual conference. In the previous two years, Jacqueline had made it very clear that she was not, under any circumstance, going to be forced to go to the conference. This year, as Thomas, he went willingly. Our therapy session following the conference was about to come to a close. Thomas had only cursorily talked about the conference. In the past, this child's consistent mode at the end of every session had been to look down, mumble a barely audible good-bye, and exit. On this particular day, we were about to have a two-week break because I would be taking a vacation. As Thomas got up to leave, he looked right at me with an ear-to-ear smile and announced, with a clear voice and a twinkle in his eye, "Hope you have a great vacation . . . wherever you're going. See you when you get back." I had never seen such self-assurance, and I had never experienced such closeness with Thomas in all our four years of work together. It was as if the Mona Lisa, now transitioned to the Mono Liso, had actually smiled and spoken, and it was at that moment that I recognized the fruits of all of our labor. Releasing the gender conundrums and allowing them to be put into words led to a corrective mirroring experience, so that we found Thomas in translation and could now recognize Thomas as the boy he was. Thomas was definitely coming out, not just about gender but from his protective shell. Discovering a True Gender Self in the context of a protective mirroring relationship, Thomas was also finding the road that would lead him to an authentic, spontaneous, and creative life.

#### CONCLUSION

Facilitating a child's transition from one gender to another or uncovering a child's true gender fluid self should be done with careful reflection and evaluation, with enough time for exploration and affirmation. Many parents want to be able to look into a crystal ball and be assured of an accurate and permanent gender future for their child before making any major gender decisions. Professionals often share that same urgency to be able to get the child's gender in focus as soon as possible. The problem is that children are moving, evolving organisms who may go through several iterations of self before acquiring their final identities. While their gender history, particularly a long-standing affirmation of a gender they claim to be theirs, is critical information, such histories cannot perfectly or linearly predict the future. Thomas seemed firmly

established as a boy at age eleven. He was taking puberty blockers that would allow him to move to hormonal treatments if he continues to affirm himself as male. If adolescence, however, reopens Thomas's earlier questions—"Am I a girl? Am I a boy?"—the most important psychological intervention for Thomas will be exactly what he has been provided with to date: a place to continue to explore his gender to arrive at a True Gender Self.

As clinicians, we will need to train ourselves to live with ambiguity for extended periods of time as a child weaves together an authentic and unique gender web. To make matters more complicated, as Avgi Saketopoulou points out, "treating atypically gendered children at this point in time carries the additional burden of trying to imagine a world that does not yet exist. What does this future that we are asked to envision hold for fluidly gendered kids?" (2011, p. 204). The answer to that question resides in the gender-nonconforming children themselves, as we listen and learn from them.

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# Free to Be You and Me

## Normal Gender-Role Fluidity— Commentary on Diane Ehrensaft’s “Listening and Learning from Gender-Nonconforming Children”

RONA KNIGHT, PH.D.

*This paper suggests that gender role fluidity is a normal self state throughout development. It discusses the nonlinear progression of gender role identity that is constantly fluid and reactive to biological, environmental, and psychological changes. Given the normal fluidity of gender role identity, it argues that giving puberty blockers to young children is against the best interests of the child’s development.*

“I’m not! And if turning up my hair makes me one, I’ll wear it in two tails till I’m twenty,” cried Jo, pulling off her net, and shaking down a chestnut mane. “I hate to think I’ve got to grow up, and be Miss March, and wear long gowns, and look as prim as a China aster! It’s bad enough to be a girl, anyway, when I like boys’ games and work and manners. I can’t get over my disappointment in not being a boy; and it’s worse than ever now, for I am dying to go and fight with Papa, and I can only stay at home and knit, like a poky old woman!”<sup>1</sup>

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*The Psychoanalytic Study of the Child* 68, ed. Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight (Yale University Press, copyright © 2015 by Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight).

1. Louisa May Alcott, *Little Women*, Bantam Classic ed. (1868–1869; reissue, New York: Bantam Dell, 2007).

“Pudd’nhead Wilson says Hellfire Hotchkiss is the only genuwyne male man in this town and Thug Carpenter’s the only genuwyne female girl, if you leave out sex and just consider the business facts.”<sup>2</sup>

FROM THE WRITINGS OF SHAKESPEARE (*TWELFTH NIGHT*, *MUCH ADO about Nothing*); Mark Twain; Louisa May Alcott; and contemporary characters in literature that include Scout in *To Kill a Mockingbird*; Frankie turning into Francis in *Member of the Wedding*; Pippi Longstocking, who is full of phallic exuberance; and Smidge, the sensitive boy with strong maternal instincts, writers throughout the centuries have articulated the theme of gender role fluidity. Homosexual behavior and role reversal cross-dressing are as old as recorded history (Crompton, 2006).

Given that such feelings and behaviors have existed throughout time, gender fluidity might be considered a normal, classic aspect of human development. In my discussion of Dr. Diane Ehrensaft’s paper, “Listening and Learning from Gender-Nonconforming Children,” I will show how modern thinking about and research in development support the idea of gender fluidity throughout the life span and discuss some ideas of how this should or should not be treated in children.

A definition of terms is in order before further discussion of this issue. Gender and sexuality are researched, theorized, taught, and used in practice by several different professions and subspecialties within professions, leading to variances in nomenclature. Ehrensaft uses “gender identity” to define knowing the self to be male or female (often referred to as “core gender identity” or “natal sex”), and “gender expression” to mean all the external and internal ways people think about and express their gender identity (often referred to as “gender role identity”). In my discussion, I will use “core gender identity” to mean the biological determination of being a boy or a girl, and “gender role identity” to define the ways children use aspects of male and female gender role and expression in their conscious and unconscious sense of themselves.

Ehrensaft’s paper gives us a particular view into the present-day mental health and pediatric discussion and treatment of fluid gender role identity and gender role nonconformance in children. She asks us to think about what is in the best interests of these children regarding the development of their minds, their senses of self, and their bodies when they have a fluid gender role identity or when they insist they are a girl in a boy’s body or vice versa.

2. Mark Twain, “Hellfire Hotchkiss,” 1897, unpublished and unfinished novel until incorporated into *Mark Twain’s Satires & Burlesques* (Berkeley, CA: University of California Press, 1966).

While she conceptualizes gender as fluid, her actual practice with children discussed in her paper indicates a conflict between dichotomous and fluid gender identity in children, adolescents, and adults. While she sees the construction of gender expression as a weaving together of the forces of nature and nurture, she also writes that “gender identity [knowing your natal sex] is far more resistant to environmental intervention or shaping.” How, then, does one think about the children who from a very early age insistently believe that they are not the gender written on their birth certificate? Ehrensaft labels these children as transgender and describes them as gender dysphoric. While Ehrensaft’s theory of True Gender Self Therapy includes listening to the child’s gendered sense of self and allows for a more fluid and changing expression of gender, she becomes much more dichotomous when working with children who have gender dysphoria and express a persistent desire to become the opposite sex they feel themselves to be.

Ehrensaft and the endocrinologists working with gender dysphoric children suggest using puberty blockers in middle childhood to give these children a chance to “try on” being seen and existing as the opposite of their core gender identity. Puberty blockers stop an eight- or nine-year-old girl or a ten-to-eleven-year-old boy from producing their body’s hormones that would bring into being secondary sex characteristics, as well as the cognitive, biological, and psychological changes that would accompany those pubertal changes. Thus, her paper requires us to think about the psychological and biological effects of puberty blockers and the medical decisions being made by the parents and endocrinologists of the children and adolescents who believe they are not of the natal identity they were born with. Given the wide degree of time from childhood through adolescence to experiment and try on different gender expressions, I think it does a growing child and adolescent more significant harm than good to foreclose this fluid and unfolding process while development is still moving in fast-forward.

To discuss the potential serious psychological impact of this type of focused psychotherapy and the use of puberty blockers on young children, I will first outline how child development is understood by researchers in child development and what we know about children’s conscious and unconscious ideas about gender from some of this research. I will then discuss the feminist literature that has been at the forefront of the theoretical discussion of gender and sexuality. Finally, I will use the theoretical, empirical, and clinical literature to discuss Dr. Ehrensaft’s model of psychotherapy and what I see as the problem in giving puberty blockers to children with gender dysphoria.

## THE DEVELOPMENTAL THEORY OF DYNAMIC SYSTEMS

Dynamic systems theory proposes that individual systems—cognition, actions, self states, to name just a few—are influenced by the interplay of biology and environment, producing a complex interaction of systems that are fluid, variable, function driven, flexible, and nonlinear. As new stimuli from either biology or environment are encountered, structures break down and novel, functional, alternative changes in structural systems develop to respond to the incoming stimuli. Changes in one structural system, let's say cognition, can effect changes in other systems, such as self states, causing a cascade of changes within and between systems. In terms of psychological growth, each novel state is progressive, discrete, idiosyncratic, and unpredictable.

This dynamic systems approach to development (Thelen and Smith, 1994; Sander, 2002; Mayes, 2001; Galatzer-Levy, 1995; Tyson, 2002) informs our understanding of human development as well as individual differences in development. Spencer and Perone (2008) point out that the challenge of understanding how a dynamic system change requires looking at multiple time scales to see how attractor states emerge in real time and how they do or do not become more stable to particular situational input throughout development.

Thelen and Smith (1994) were the first researchers to show how infant and toddler cognitive and action development demonstrated dynamic systems theory. Over the past twenty years this theory has been shown in research in motor development (Corbetta and Thelen, 1996), cognitive development (Spencer et al., 2007), socioemotional development (Lewis, Lamey, and Douglas, 1999), and most recently in gender development in normal children between the ages of six and eleven (Knight, 2011). These studies show that development is nonlinear and discontinuous. There are periods of significant disorganization in which structural systems break down and reorganize in transformational ways. New information from the body and the environment is assimilated and accommodated by increasingly complex systems in the mind and the body. Stable configurations of cognitive, biological and emotional systems suddenly become destabilized for no outward apparent reason and shift into periods of fragmentation. As Galatzer-Levy (2004) describes, it is a system constantly on the edge of chaos.

This level of disorganization and reorganization, continuously repeated in biorhythmic systems of increasing complexity, has been found in other living organisms “from the dino-flagellate to the human” (Sander, 2002). Therefore, I think it is safe to say that while the

greatest maturational pull forward is from infancy through early adulthood, change and transformation in structures occurs throughout the life span, from the cradle to the grave.

#### GENDER FLUIDITY IN MIDDLE CHILDHOOD

The middle years of childhood begin with a period of fragmentation—a breakdown in self cohesion—that is followed by a fluid process of change and reorganization that influences self and ego structures, gender role identifications, sexual and aggressive feelings and fantasies, and one's sense of oneself in the world beyond the sphere of the family (Knight, 2011). These periods of disorganization and reorganization suggest a nonlinear development and fluidity in structures that constantly pull development forward in an ever-changing manner.

This disequilibrium of self structures gives the child the opportunity to try on different possibilities of gender role identity, what Ehrensaft calls “gender expression.” As structures remain fluid and discontinuous, so a child's internal sense of his or her gender identifications also becomes fluid. Ames et al. (1974), in their study of hundreds of normal children's Rorschach responses, also found gender confusion and either-or gender responses in her middle childhood subjects. My study found that boys and girls make different uses of and have different meanings attached to gender role identity at different ages. Some manifest trends did emerge.

Boys experienced their masculine identity as very aggressive and feared their aggression would get out of control or explode. They used feminine gender identifications to help them manage their aggressive impulses. This may be the boys' identification with their perception of their mothers' relational role and strategies for dealing with aggression. However, they sometimes experienced their femininity as scary and distressing and feared it would lead to them getting hurt. The girls at age eight felt separated and more on their own and developed strong male identifications, sometimes telling Thematic Apperception Test (TAT) stories as though they were a boy. At this age they perceived their fathers as more capable and competent in the outside world, even though all of the girls' mothers worked outside the home. This male identification may be the girls' perception of their fathers as the more competent parent as they continue to develop a more mature sense of personal will, intention, and agency. Following this strong male identification at age eight and nine, the ten- and eleven-year-old girls continued to have fluid gender identifications. This study also found that despite the fact

that both parents worked outside the home, parental gender roles and ways of relating to their children remained as traditional as they were in the 1950s and before.

Contemporary gender theorists (Elise, 2000; Benjamin, 1995) have posited that children see fathers as possessing power, agency, activity, and the ability to move into the outside world, while mothers are perceived as lacking those qualities. As the school-aged child moves out in the world of their peers, they continue to identify their mother as tied to the home and thus devalue her strength and power, while fathers are seen as representing the outside world. The girls' test responses in the Knight study (2005, 2011) expressed their conflict of wanting to move into arenas outside the home in their developmental push forward, and the pressure they felt, internally and externally, to remain inside the home in a mothering capacity. Typical of this was one girl's TAT story about her wish to go out and play sports and her concern about disappointing her mother, whom she perceived as wanting her to play with dolls. In the end, she decided to do both.

The gender role fluidity found in these children suggests that this is a *normal process*. As self structures remain fluid in development, so gender identification also remains fluid.

#### GENDER THEORY

Many writers have proposed that the ability to continually elaborate opposite sex feelings and behavior continues past the oedipal period, through the child's ongoing capacity for flexible cross-gender identifications (Bassin, 1996; Benjamin, 1995; Aron, 1995; Dimen, 1991; Goldner, 1991; and Harris, 1991). Benjamin (1991) suggests that gender role identity is not tied to anatomical difference. She believes that children use male and female identifications to create aspects of their sense of self. In Elise's paper "Gender as Soft Assembly" (2000), she proposes that one's thoughts and feelings about gender are fluid and open to continual changes from internal development in biology and psychology and from external factors that impact one's gender performance and identity. Chodorow (1992) proposes that gender role differentiation is a relational process that starts at birth and continues throughout the life cycle, and that choosing a binary gender representation is a compromise formation. Kirkpatrick (2003) sees gender as resulting from the kaleidoscopic overlapping of many elements that can reinforce, neutralize, or modify gender identifications throughout development. The gender fluidity that I found in the normal children I studied supports these theoretical positions. Very few people in our field

today would question the idea that all of us have within us male and female gender identifications with our parents and siblings. I would also suggest that the homosexual play that is typical of children in middle childhood involves the children's ability to take both gender sides in their fantasy play with each other and sets the stage for adolescent and adult sensual and cross-gender empathy.

#### INFLUENCES ON GENDER ROLE IDENTIFICATION AND PERFORMANCE

Cross-gender identifications with caring figures are one influence on gender role identity and fluidity; the social environment of the growing child is another. Infant and toddler research has shown that boys and girls are treated differently by their parents starting at birth. Mothers encourage boys toward more independent behavior, and girls are encouraged to remain close. Boys are encouraged to control social interchanges more than are girls, who are encouraged to find pleasure in closeness and the interactive regulation of relationships (Olesker, 1984; Biringen, Robinson, and Emde, 1994).

Biological influences also impact gender behavior. Studies looking at neonatal exposure to different levels of androgens have been shown to affect gender play behavior in both boys and girls (Auyeung et al., 2009; Hines et al., 2002; Homburg, 2009). Adrenarche, which occurs between six and eight years of age, is a period in endocrine development when androgens are produced in the body, which leads to the beginning of puberty, and their levels can also affect gender role behavior in children (Finkelstein, VonEye, and Preece, 1994).

#### DISCUSSION

I have presented developmental theory, my research, aspects of the gender literature, and biological research in this detail because it informs my response to Ehrensaft's paper. Ehrensaft reports a case of a toddler girl in great distress who pulled the barrettes out of her hair and happily transitioned to male in adulthood. This vignette leaves open many questions. What possible androgen exposure in her neonatal period and what early infancy experiences with her family led her to not want to dress like a girl? What was the marital relationship like? What were the parents' conscious and unconscious thoughts and feelings about femininity? What were the siblings relationships like, and how did the parents treat siblings of different genders? There is no information reporting what type of treatment this child and parents received.

While Ehrensaft (2011) discusses her fine therapeutic work helping parents adjust to their child's gender fluidity or normal homosexuality in another paper, what is concerning about the type of treatment she calls True Gender Self Therapy that she is promoting for children who present with extreme gender dysphoria is the degree to which such treatment with these children does not delve into the unconscious thoughts and feelings these children have about their core gender identity and gender role expression. As a child psychoanalyst, I think that these gender dysphoric children need intensive, four-times-a-week psychoanalysis at a very early age and an equally intensive psychotherapy for their parents. Fraiberg, Adelson, and Shapiro's (1975) therapeutic model of working with the child and parents very frequently at a very early age demonstrates how necessary it is to work with the unconscious feelings and defensive behaviors in parents of babies and young children so as not to negatively impact the child's psychological growth and sense of self. Working with a young child in a four-times-a-week child analysis over many years of development allows a child and therapist to understand the many factors that influence unconscious thoughts and feelings, as well as to track changes in those fantasies or conflicts as they develop, co-constructing a self-and-other narrative that provides a child with structure for further development. This process entails mourning body parts wanted or aspects of childhood left behind, which is a normal developmental process of mourning.

Equally troubling is the literal meaning Ehrensaft sometimes proposes as opposed to the many figurative meanings that gender acquires for each gender dysphoric child at each stage of development. In her once-a-week treatment of Jacqueline, the treatment is presented in a very binary either-or way, with no attempt to find out what Jacqueline's life would have been like if she had been allowed to express her gender fluidity and expression on the canvas of the body she was born with. If Ehrensaft believes, as research has shown it to be, that "gender is a lifelong unfolding rather than set at a moment in time in childhood" (Ehrensaft, 2015), then the aim of treatment should be helping a child accept whatever gender they feel like expressing in the body that they have. Typical of a less concrete model of fluid gender expression is the example of the Prius child who looked like both a boy and a girl, so creatively expressing the "and" aspect of gender fluidity rather than the "either-or." The Prius child aptly demonstrates Ehrensaft's idea of a gender spectrum that allows a child to express his or her fluid gender role identity appropriate to the child's level of emotional and cognitive development, and Ehrensaft's work with the parents to allow this expression of gender fluidity.

While Ehrensaft proposes that True Gender Self Therapy involves making the unconscious conscious, it appears to me that she is only interested in uncovering whatever gender seems hidden by repression and denial rather than helping the child to examine his or her feelings and the meaning the child makes of gender, sexuality, aggression, sense of self, self with other, and how all of these intermingle and interweave into narrative structures. As research and developmental theory has shown (A. Freud, 1963; Blos, 1967; Knight, 2011) conscious and unconscious gender role identifications and expressions remain fluid through adolescence and may not show consistency over the wide developmental period from infancy through adolescence. Recent worldwide research has shown that people in their twenties are still in a period of adolescence (Arnett and Eisenberg, 2007), and many of them are still experimenting with their gender role expressions and sexual object choice.

Children before middle adolescence have concreteness to their thinking (Piaget, 1967), which does not seem to be taken into account by gender professionals. Like the children they are treating, endocrinologists and mental health professionals who recommend puberty blockers to children before the onset of puberty assume concrete solutions to what are very deeply embedded and constantly changing concrete senses of self and gender and gender role identifications. To give these young children medicines that will stop their biological growth for many years deprives them of the chance to experience their bodies growing in any age-appropriate way. If anything, keeping them small and young-looking makes them abnormal for their age and prevents them from experiencing all the hormonal effects on their minds and their bodies along with their peers, setting them further apart from the experiences of their peers. I would think puberty blockers might make them feel even more separate and could encourage a false self as they watch their peers grow and develop secondary sex characteristics while they can only pretend. This then becomes a very complicated and layered issue for these children, who might also feel jealous of the peers of their wished-for natal sex, desperate to be like them and change like them, and angry at their parents and doctors who won't give them the hormones that would allow them to develop like everyone else their age and wished for gender.

Research on children diagnosed with Gender Identity Disorder in childhood shows that most GID children ultimately choose same-sex partners in adolescence and young adulthood (Drummond et al., 2008). The outcome research on children who are given puberty blockers is scarce but what *is* known is that many of the children who are given puberty blockers return to a comfort level with their core gender identity

in early adolescence (Byne et al., 2012; Wallien and Cohen-Kettenis, 2008), notwithstanding Ehrensaft's report to the contrary. In addition, the peer-reviewed literature (Byne et al., 2012) has shown that it is not possible to *reliably determine* which children will become desisters or persisters (Cohen-Kettenis and Pfäfflin, 2010; Wallien and Cohen-Kettenis, 2008; Zucker, 2008). There are no studies that I could find that deeply look at the experiences and underlying feelings the desister children have during the time their development is stopped and *why* they then choose to stop the blockers. In addition, these children are being given body-altering drugs for which no studies of long-term biological effects of these drugs have been completed (Byne et al., 2012).

The finding that many of the gender dysphoric children who are unhappy about their core gender identity choose same-sex partners later in life (Byne et al., 2012) is thought-provoking. Because there are no research studies but only clinical reports about the normal childhood development of gay men and lesbian women, is it not possible that many or most of these children are really expressing their sexual attraction for same-sex children and preferring the play activities of the opposite gender? Louisa May Alcott based her character of Jo in *Little Women* on herself. In an interview she gave to Louise Chandler Moulton (Whiting, 1909), Alcott said, "I am more than half-persuaded that I am a man's soul put by some freak of nature into a woman's body . . . because I have fallen in love with so many pretty girls and never once the least bit with any man." Given (1) the concreteness of children's thinking, (2) the lack of a language for young children to express their homosexual desires, and (3) a homophobic society that is unwilling to think about normal homosexual development in young children, homosexual children could arrive at a mental health professional's office with gender dysphoria, not understanding that they could *be* their core gender identity *and* have the fantasies, desires, and gender role performance that society doesn't usually accept for their natal sex. These children need a place to express these feelings without being further confused by the suggestion of puberty blockers, which make them have to concretely consider their core gender identity during middle childhood, when there is constant disorganization and reorganization going on in their minds and bodies and fluidity in their sense of self.

From infancy through adolescence, development races along on a complex and fast track. Ehrensaft (2011) cautions about moving too quickly in the transgender process, noting an example of a child who quickly changed from being a boy to a girl and subsequently had to be hospitalized and placed in residential psychiatric treatment. This

raises the issue of the concretization of gender possibly being used to mask an underlying psychotic process that may take years to uncover, or that may not occur until mid to late adolescence. Given the normal periods of fragmentation and ego disorganization that occur in middle childhood and the unpredictability of nonlinear development, how can a mental health professional definitively determine that there is not an underlying psychotic process being focused through gender (Wallien, Swaab, and Cohen-Kettenis, 2007)?

In middle childhood boys and girls can look alike in their unisex clothes worn by children today. Kids can wear their hair short or long no matter what gender they are. Our culture has reached a point in time where boys can wear a ponytail to school and girls can cut their hair short and wear jeans. As normal children reach the age of around ten years, they begin to feel the changes to their body or know the changes are about to come. Another interesting finding from my research was that neither the boys nor the girls wanted to grow up. Partly this was their wish to remain children and not have to mourn the ending of this phase of their lives, and partly this was their desire to not have their bodies change as they were heading into puberty. The girls expressed unhappiness about their breast development, and the boys did not look forward to puberty. One boy's response sums up the feelings:

RK: Has your body been changing?

Boy: I don't think so.

RK: I mean, you haven't started developing and going into puberty?

Boy: Not yet, thank God.

RK: "Why thank God?"

Boy: I don't want to change yet.

RK: Why not?

Boy: I don't know. I want to be young.

In summary, there are a multitude of conscious and unconscious feelings that effect and are affected by gender and are also expressed through gender that change from year to year due to biology, psychology, and the environment. In my opinion, to interfere with the normal psychological, biological, and sociological development of a child when one cannot be clear about the effects or the short- or long-term outcome of such a massive biological interference (Byne et al., 2012), does significant harm to the child. Children have neither the legal right nor the mature judgment to make such life-changing decisions and must rely on their parents' judgments for them. My concern is that children are dependent on and influenced by the adults around them and often

feel the need to be or do what those adults consciously or unconsciously want in order to retain their love and attention. Oftentimes, such adult agendas are not in the best interests of the child.

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# Discussion of Diane Ehrensaft's "Listening and Learning from Gender-Nonconforming Children"

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*My discussion of Diane Ehrensaft's paper begins with some comments that extend her ideas. I suggest that the interaction of nature and nurture in the creation of gender begins before birth and perhaps even before conception. I argue that there are practical limits to the degree to which we can expect sociocultural forces to yield to Ehrensaft's call for a broadened narrative of gender. I then go on to pose some questions: Should children have complete autonomy regarding their bodily development, as Ehrensaft seems to suggest? Does such autonomy extend to areas beyond gender, such as issues of racial identity? And I close with some criticisms, chiefly that gender identity should not be conceptualized as something that is clearly or immutably defined in childhood, but as a component of one's self that constantly interacts with one's biology, psychology, and sociocultural milieu from conception until death. Child and adult psychoanalysts are only beginning to accumulate the data necessary to respond to Ehrensaft's challenging hypotheses.*

I ACCEPTED THE INVITATION TO COMMENT ON DR. EHRENSAFT'S PAPER because it introduces us to a topic that rarely has been discussed in the

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*The Psychoanalytic Study of the Child* 68, ed. Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight (Yale University Press, copyright © 2015 by Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight).

psychoanalytic literature. Children who feel that they “are” a gender other than that suggested by their external genitalia pose a special challenge to child psychoanalysts—who live, professionally speaking, at the intersection of body, mind, and culture—as we try to understand how it is that these children have come to feel that way.

Ehrensaft urges us to approach the topic with open minds. That is not an easy task; we all are creatures of our own histories and cultures, and every society has a vested interest in promoting its survival via procreation, an act that generally<sup>1</sup> requires that people be separated into “male” and “female.” As a result, every society has evolved methods of identifying and segregating the sexes in ways that promote and/or control fertility.

From time immemorial there have always been some people who do not fit comfortably into the categories supplied by the society within which they live. In the case of sex and gender, there are some individuals whose biology does not conform to what is expected (true and pseudo-hermaphrodites, Turner syndrome, and so on); and there are many individuals who chafe beneath the constraints of the gender-linked behavioral patterns prescribed by the society into which they have been born.

It would be a mistake to view gender-linked behavioral patterns as immutable or universal; they are neither. One need only consider the changes in attitudes toward same-sexed marriage that have taken place over the past decade to see that behaviors that once seemed beyond the pale are now widely accepted across many countries and cultures. Furthermore, as Ehrensaft points out, some contemporary societies provide much more room for people whose behavior falls outside the norms for male and female (for example, the *hijras* of Hindu South Asia) than is usually found in American or Western European societies.

My response to Ehrensaft’s paper falls into three sections. I begin with a number of comments that extend ideas that she addresses. I then pose some questions designed to provoke further thought. And I close with some criticisms that Ehrensaft and her colleagues might wish to consider as they continue their work.

My comments, questions, and criticisms all are founded in my own biopsychosocial history. I am no more able to jump over my own shadow than the next person. This is where Ehrensaft’s paper becomes espe-

1. I insert “generally” here because Assisted Reproductive Technology (ART) has challenged the traditional ways of achieving pregnancy, broadening them in ways that only could be dreamed of a few decades ago. While up to now no one has managed to create a viable human zygote without using male and female germ cells, even this seemingly impassable barrier may be breached in the future.

cially valuable: It shines some light on topics that have been at the center of psychoanalysis since its beginning, but does so from angles that differ significantly from those that were in vogue when I was figuring out how to be a boy, a man, or a child psychoanalyst.

#### COMMENTS AND EXTENSIONS

From Sigmund Freud's point of view, Dr. Ehrensaft's phrase "gender-nonconforming children" might be seen as almost an oxymoron. Freud's (1905) *Three Essays on the Theory of Sexuality* outline some of the challenges faced by children as they grapple with the different strands of libidinal sexuality that Freud describes. Freud's well-known characterization of children as "polymorphously perverse" (Freud, 1916, p. 209) is itself a reflection on the fact that children have not yet woven the many and various strands of sexuality into something approaching what is normative in adulthood. Young children are especially imaginative and unconstrained in their ideas about sex and gender. Although to a contemporary ear, Freud's use of the term "perverse" has moral overtones, Freud himself used the term in a more neutral way. To him childhood sexuality was "perverse" only in the sense that it does not conform to the social norms that attempt to define and contain sexuality—a task that strains every culture known to man. Freud's emphasis on the innate bisexuality that is part of the human condition, along with his refusal to view homosexuality as pathology (Freud, 1935), suggests that he would be unsurprised by the variations in gendered (or ungendered) behavior that Ehrensaft has observed in the children with whom she works.

Ehrensaft suggests, "It is time to peruse our clinical theories and practices with the aim of fortifying the mental health of children of all genders, ethically and with no harm done" (Ehrensaft, 2015, p. 29). While I agree with Ehrensaft's call for an increased tolerance of differences in gendered behavior, and while I hear in it an echo of Anna Freud's "wide range of 'variations of normality'" (1962, p. 158), I suspect that social realities may force us to accept something less. Just as Goldstein, Freud, and Solnit pointed out how the "best interests of the child" often cannot be realized and must be replaced by the least detrimental alternative (1973, pp. 53–64), it seems likely that we will have to help the children that Ehrensaft sees find their own least detrimental alternatives; there is no available path that leaves "no harm done."

While Ehrensaft writes, "Beyond birth, gender development becomes an interplay of nature and nurture" (Ehrensaft 2015, p. 29). I would push the boundaries of that interaction back farther in time. The development of a gendered identity represents a coming together of nature

and nurture that goes back at least as far as the moment of conception. Intrauterine effects on gendered behavior have been demonstrated, and I suspect that with further research it will become clear that both germ cells—the sperm and the egg—are not immune from environmental effects that antedate conception but then go on to be expressed in the zygote that becomes an intrauterine fetus, in the extrauterine infant, and in the growing child.

The narrative of gender in our culture varies in its strength and specificity across time, place, occupation, and other variables. It is worth remembering that both Iris Murdoch and Marilyn Monroe were female in sex and gender; and both William Buckley and Clint Eastwood were male in sex and gender. These contrasting dyads illustrate the huge range in the expression of gendered behavior that was possible in the twentieth century, and it seems certain that that range will expand in the twenty-first.

It's worth noting and remembering that most parents who have had two or more children of the same biological sex can attest to the fact that there is quite a range in how one "is" a boy or a girl. I know of a girl who, as a six-year-old, proclaimed that she was going to be a cowgirl, a ballerina, a tightrope walker, and a nun. Masculine, feminine, bisexual, and asexual all in one go! One might say that this youngster outdid Ehrensaft's "gender Prius. A boy in the front. A girl in the back."

Two psychoanalytic colleagues have challenged my own attitudes, thinking, and feeling about these matters. One was a husband, a father to two children, and a remarkably creative researcher. Some years after his wife died he began a relationship with a man, and they maintained that relationship for nearly two decades until my colleague died. The other psychoanalytic colleague was, like the first, a prolific and generative academic; for many years she was married to a man, but after that marriage ended in divorce, she partnered with a woman whom she then married.

I had known the first, male, colleague while he was still married to his wife and was aware of some of the turmoil created by her illness and death. I was astonished when I later heard of his new relationship with a male partner. I was less astonished when I learned of the second, female, colleague's relationship with a woman, in part perhaps because I had not known the second colleague while she was living with her husband. In both instances, however, I found myself grappling with a question: How is it that a person with an apparently stable gender identity and who has been in a long-standing heterosexual relationship finds him- or herself in a new, homosexual relationship? Is object choice independent of gender identity? Or should we conceptualize gender

identity—what Ehrensaft prefers to call the “gender web”—in four dimensions, rather than the three (biopsychosocial) that she suggests? As a developmentalist, I would argue that gender identity (and gendered behavior) should be seen as an intersection of biological, psychological, and sociocultural factors that interact with each other across a fourth dimension of time. My identity, my gender identity, and my (gendered) behavior all exist on a developmental continuum, which is in constant flux. My two colleagues demonstrated, relatively late in their lives, that they were gender nonconforming in some aspects of their behavior. Did this represent some radical rearrangement of their personal biopsychosocial selves? Or was it a less radical but still significant evolution? As a psychoanalyst, I would say that we cannot answer these questions without truly psychoanalytic data. But if I had to put my money on one proposition or the other, I would opt for my evolutionary hypothesis rather than that of a sudden, radical rearrangement.

This leads to Ehrensaft’s description of what she calls True Gender Self Therapy (TGST) and its goal of building “gender resilience” in children and their families. While the concept of “gender resilience” makes sense in the context of the paper Ehrensaft has written, it seems clear that the resilience about which she speaks must extend far beyond gender, especially if we agree that gender and its behavioral manifestations are constantly evolving (in both the individual and the social surround). The concept of “True Gender Self” (which I will take up again in the section devoted to criticisms) begs the question: How do we decide what is a “true” gender self? Can what is “true” at age three or thirteen or twenty-three become “false” at thirty-three or forty-three or fifty-three? Perhaps we should replace that “true” gender self with a more modest “currently adaptive” gender self. This would, at the very least, emphasize that these matters are not fixed but continue to evolve as long as we are alive.

#### QUESTIONS

Ehrensaft writes, “In childhood it is up to the child, not the parent, to spin the gender web.” Does that “hands-off” attitude extend to other crucial areas of biopsychosocial development such as toilet training? I very much doubt it. And yet I cannot see a huge gap between the “self” that must grapple with toileting and that which must grapple with questions of gender identity and gendered behavior. Is the true self a pooppy self or a clean self? My own answer to that question would be “neither” (or both)—but regardless, children and their families have to come up with something that is currently adaptive; at one age that

might involve diapers, at another normal underwear, and then much later diapers once again.

What would Ehrensaft do with a black child, adopted into a white family, who insists that he or she is white? Who refuses to associate with people who share a similar pigmentation? Is the child's true self white, black, or something in between? My guess is that Ehrensaft might argue in favor of some kind of "racial creativity" that evades the usual boundaries of race as defined by the culture within which the child is growing up. Those boundaries would be quite different in Oakland, California; Oslo, Norway; and Johannesburg, South Africa. In each place the child would have to find a series of sequentially adaptive solutions to what it means to be a person with dark pigment in that particular social milieu.

Is Ehrensaft's True Gender Self different in kind from the selves that engage with the challenges of toileting or the socially derived boundaries of race?

#### CRITICISMS

Writing about her patient Jacqueline/Thomas, Ehrensaft asserts that "the unconscious need to bring a hidden core male self to the surface and differentiate it from the female outer self, which now felt like a 'not me,' overrode any desire or need for continuity." It seems to me that this statement reflects the very kind of binary (either-or) thinking that Ehrensaft has repeatedly criticized in her paper. Likewise, Ehrensaft's suggestion that therapists and parents should mirror a child's "true" gender self without distortion is an ideal that can never be achieved—and at least partly because "true" gender identity is not fixed but is constantly evolving within a social field that also is evolving.

I dislike Ehrensaft's use of the adjective "traumatic" in the context of the use or nonuse of puberty blockers. Is puberty inherently traumatic? I might answer that question in the affirmative; it certainly does have a way of overwhelming previously achieved modes of defense and coping, leaving the pubertal child feeling exquisitely vulnerable from all sides. But I think Ehrensaft actually is using "trauma" in the sense of "stress": She wishes to spare Jacqueline/Thomas the additional stresses that will come if her/his body begins a visible developmental shift toward a normal pubertal female body. Does this qualify as a traumatic experience? Certainly it would be difficult, but unless Jacqueline/Thomas is left without any support, I doubt that such a development would be inherently traumatic in the strict sense of that word.

With Ehrensaft, I would wish that Jacqueline/Thomas and her mother could have the necessary time to consider the available options, without the ticking of the biological clock. But, for better or worse, her/his body did not agree. Nor does our culture: One of its highest priorities is facilitating the procreation that is required for the preservation of the species. Given these two facts—that sexed bodies usually will develop into sexually mature organisms capable of reproduction and that our culture depends upon procreation for its very survival—it seems to me that Ehrensaft’s call for gender identity creativity is sailing against some very strong currents.

#### CLOSING REMARKS

Diane Ehrensaft has addressed a challenging, timely topic in a very thoughtful way. Our control of our own biology is reaching into areas previously thought to be beyond our influence. Meanwhile social mores are evolving in ways that could hardly have been imagined a decade or two ago. This confluence of changes faces psychoanalysts with a host of issues that in the past could have been and were ignored. In much the way that Assisted Reproductive Technology has challenged our ideas of what it means to be a parent (Shapiro, Shapiro, and Paret, 2001), the presence of what Ehrensaft calls “gender-nonconforming children” and the availability of an ever-growing range of medical interventions that can block or divert or modify our sexual capacities faces us with the question of what it means to be male or female . . . or something other than these two. The fact that a person can be, from a biological perspective, one sex while having a gender identity that differs from that biological sex stands as a challenge to the next generation of child and adult psychoanalysts. It seems we have much to learn, and I thank Diane Ehrensaft for beginning the conversation.

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# If We Listen

## Discussion of Diane Ehrensaft's "Listening and Learning from Gender-Nonconforming Children"

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*Given the absence of reliable predictor variables that differentiate between children whose gender dysphoria will desist versus those in whom it will persist into adolescence, child analysis, with its unique capacity to search beyond the manifest content of a patient's desire, potentially offers a venue from which to assess the developmental achievements that might impact a decision to support or question the utilization of puberty blockers to forestall the physical manifestations of gender. An examination of Ehrensaft's True Gender Self Therapy notes an inherent contradiction between her stated view of gender as "an aspect of self that can be altered over the course of a lifetime" and the notion of an unchanging gender self that only needs to be uncovered. The latter position veers toward an essentialist position that neglects the exploration of gender fantasies and defines gender in a manner that necessitates an environmental or medical response.*

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*The Psychoanalytic Study of the Child* 68, ed. Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight (Yale University Press, copyright © 2015 by Claudia Lament, Robert A. King, Samuel Abrams, Paul M. Brinich, and Rona Knight).

WE WOULD LIKE TO THANK DR. EHRENSAFT FOR THE OPPORTUNITY to discuss her thought-provoking paper that brings to the fore the controversial topic of gender dysphoria, one that has been dealt with only summarily in the analytic literature. By introducing the incendiary question of the use of puberty blockers as a treatment to potentially prevent the pain of developing a physical body that does not meet one's internalized image, Dr. Ehrensaft forces us to confront our biases. The paper raises two issues, each of which needs to be examined independently. First, what place does an analytically oriented treatment have in helping a child resolve their gender dysphoria (regardless of the final outcome), and, second, what role should puberty blockers play in the struggle to define one's gender identity, a struggle made potentially, but not necessarily, more problematic by the onset of puberty. At the center of these questions is the ways in which analytic listening must be differentiated from a respectful attention to the child's manifest statements.

Perhaps in no other arena is it as difficult to listen, in Bion's oft-quoted stance, "without memory or desire," than when concerns about gender are raised, even more so in the case of a child where issues of cognitive development, developmentally expected gender fluctuations, and questions of capability to give consent further complicate the field. Phobic and counterphobic responses to the threatening desire to change one's natal body abound. Just how near impossible neutrality remains is clear from the divergent approaches to the treatment of gender dysphoria. These vary in the degree to which they attempt to support (for example, Hill et al., 2010), wait and watch but not suppress (de Vries and Cohen-Kettenis, 2012), or actively discourage (for example, Zucker, 2008a) gender-discordant behaviors, as well as the different modalities utilized (for example, group, individual, parent support, parent-child counseling). The variety of expert opinions are matched only by the lack of randomized treatment outcome studies, obviously methodologically difficult because of the nature of the problem. The current discussion seeks to explore what role child analysis might play in this vociferous conversation, as well as what developmental achievements (standing outside any immediate relation to gender) might impact a clinician's decision to support or question the utilization of puberty blockers in early adolescence.

Dr. Ehrensaft takes a position that actively supports the child in finding his or her "True Gender Identity." From a humanistic standpoint, one could hardly argue with the inherent decency of allowing a child to express feelings that may have been long suppressed or believed to be unacceptable to those the child loved, and this stance is undeni-

ably necessary if one hopes to disentangle the myriad possible factors contributing to such desire. Dr. Ehrensaft's sensitive work with parents, detailed in an earlier paper (Ehrensaft, 2011), shows her to be aware of the multiple, often conflictual determinants of a parent's stance toward their child's gender, and demonstrates her unfailing support for the child's individuality. However, in the context of an analytic/exploratory treatment, to support a child's individuality is importantly *not* to stop asking questions about it.

Early in her paper "Listening and Learning From Gender-Nonconforming Children" Ehrensaft proposes a view of gender identity that seems to allow for continuous questioning, naming gender identity and gender expressions as "aspects of self that can be established or altered over the course of a lifetime, not just within the earliest years of life." Such a view is indeed underscored by research on the trajectories of gender dysphoria in childhood, showing that in a significant proportion of cases, gender dysphoria will not persist into adulthood (for example, Drummond et al., 2008; Wallien and Cohen-Kettenis, 2008) and, additionally, that there is currently no reliable set of predictor variables or screening instruments that can differentiate between children whose gender dysphoria will desist versus those in whom gender dysphoria will persist into adolescence, at which point it seems to remain more permanent (Byne et al., 2012; Drescher and Byne, 2012; Wallien and Cohen-Kettenis, 2008). Only the severity of the early gender dysphoria and the cognitive belief that they were actually the other sex (as opposed to just wishing to be other than their natal gender) differentiated those who persisted in their gender dysphoria. However, these results must be interpreted cautiously, as they may reflect the retrospective reorganization of prior experience after the gender identity was solidified in adolescence.

Yet the treatment Ehrensaft proposes, True Gender Self Therapy, seems at times almost diametrically opposed to the initial framework she espouses. While she aims at "the establishment of a child's authentic gender self with the assistance of Gender Creativity, working in the intermediary space between inner and outer," she later notes, "I have discovered that the children will be the experts of their own gender identity, and while gender expressions may vary over time, their gender identity shows more temporal consistency and simply needs to be brought to the surface." Similarly, she notes that "parents have little or no influence on the child's core feelings that define him or her as gender typical or gender variant. Such core feelings appear immutable" (Menvielle, 2004, quoted in Ehrensaft, 2011, p. 533). If these core feelings are immutable, little remains for therapy except to extract the

wooly mammoth from the frozen ice in which society, the negative views of parents, and culture have imprisoned him or her; internal conflict must, by definition, play a secondary role, if any at all.

Ehrensaft bases her idea of the True Gender Self on the work of Winnicott's True Self, yet a rigorous reading of Winnicott raises important questions for her argument. In our reading, the True Self is neither a thing nor a content, but a mode of experience. Although Winnicott certainly connects the True Self to the "spontaneous gesture" and the material "aliveness" of the body, the concept itself is neither, but instead a "theoretical position" from which the former are lived (Winnicott, 1965, p. 148). The idea "does no more than collect together the details of the *experience* of aliveness" (*ibid.*, italics ours). It is presymbolic and prior to identifications (which Winnicott connects both to the False Self and to a later developmental stage). We are not arguing that the True Self is irrelevant to human development past infancy, nor that it is irrelevant to the concept of gender identity. Rather, we contend that its value comes from grappling with its paradoxes: namely, an experience of being really there that is not the emergence of any *thing* that is *there*, and an experience that has everything to do with symbol use, creative expression, and identity, but that can never be found or caught in these products. Such an understanding renders the concept "True Gender Self," and still more the capacity to "find" it, a contradiction in terms.

When the True Gender Self is conceptualized as something that exists from birth and remains relatively unchanging, the notions that children may themselves be ambivalent about their variant gender identity, that the dysphoria is the result of conflict rather than the cause, and that the manifest gender behaviors could serve defenses purposes (against fears emanating from forbidden excitements or competition, the demands of puberty or traumatic experience, for instance) are less likely to be a focus of examination. Similarly, the performative aspects of gender will be seen as emanating from an unempathic environment, which necessitates drama, rather than being a complex communication from the child that needs to be decoded. The problem, so defined, must be located primarily outside of the self, due to some verifiable external reality such as the stigmatization of family or society, against which one builds "a crusty protective layer at the surface, one that may be able to meet the world adaptively but constricts the child internally" (Ehrensaft, 2015, p. 39). Given the supposition that there is something to be found and protected, neutrality quickly morphs into advocacy.

To consider what is lost along the way, we turn to Ehrensaft's treatment and its divergences from an analytic stance. True Gender Self Therapy

is sometimes described as an analytic treatment and sometimes an analytically informed treatment (Ehrensaft, 2011). It differs significantly from other analytic treatments of gender dysphoric children reported in the literature (for example, Gilmore, 1995; Lothstein, 1988; Karush, 1993; McDevitt, 1995) in terms of the frequency of sessions, the position of the analyst who is primarily seen in treatment, the importance placed on the understanding of unconscious material, and the exploration of the child's phenomenological experience. In the reported case, Jacqueline/Thomas was seen one time per week, a frequency that not only "slowed the forward pace of our work," as Ehrensaft notes (2015, p. 45), but changed the very nature of the work, making it less likely that the transference feelings that develop could be experienced as a palpable, and hence interpretable, reality by the child, and increasing the likelihood that these feelings would be expressed in action. In earlier descriptions of True Gender Self Therapy, Ehrensaft (2011) notes that often the work goes on entirely with the parents without the direct participation of the child, highlighting the degree to which the therapeutic role centers on helping the parents mourn the loss of the child that they dreamed they would have in preparation for accepting the child that they do have. The process of finding the child is less clearly articulated but seems to focus on the child's manifest statements.

Although Ehrensaft states in her paper that "gender exploration is a long and careful endeavor, interweaving the conscious and the unconscious, the psychic and the social . . ." (2015, p. 34) there is little exploration of the unconscious in the clinical example given. Typically, the crux of the therapeutic encounter is "the act of mirroring back to the child, the child's articulation over time of that child's unique gender web" (2015, p. 44). Mirroring, a technique most associated with Kohut, offered a systematic way of entering the world of patients who were incapable of what had been defined as an analyzable transference because of early deficits in the development of the self. By echoing and reflecting, and not making premature interpretations, mirroring supported the development of a variety of relatively stable and cohesive self-object transferences (Kohut, 1977). For Kohut, mirroring was a tool in the evocation of transference, allowing a relationship to develop at a point when the patient was able to accept interpretations that offered a different perspective than one already consciously available to him or her. In its intent, it differed from empathic listening. If mirroring is seen as an end in itself, it is difficult to imagine how one can go beyond the manifest material.

In the treatment as reported, almost no information is provided about the development of the transference. (The patient will be referred to as "Jacqueline" and "she" when discussing the treatment prior to her

transition to “Thomas” and “he.”) We can infer Jacqueline’s transference reactions in behavioral actions, for example, her unwillingness to discuss her feelings and fantasies following the suggestion of puberty blockers with Dr. Ehrensaft, or the fact that she later concealed her chosen name of Thomas. Yet these responses are only summarily explored. We are left with little sense of the process that developed between her and Dr. Ehrensaft, or Dr. Ehrensaft’s reveries about Jacqueline. One need only compare the level of detail and the careful examination of meaning and the child’s phenomenological experience present in the earlier noted analytic studies of Gilmore (1995) or McDevitt (1995). The unfolding and investigation of the transference, potentially the greatest source of information on the unconscious aspects of the child’s gender choices, is virtually absent from the treatment. Nor is it utilized, as in analytic self psychology, (for example, Lothstein, 1988) as a process through which less developed aspects of the self can be realized.

Perhaps in consequence, unconscious determinants of Jacqueline’s gender behavior are left unexplored. Jacqueline’s statements about her wish to be a boy (“mostly, kinda”), her playing mostly with girls and a few “nice boys,” her initial agitated reactions to the first suggestions of puberty blockers (“But girls are nicer than boys”), her worry about the loss a shift will entail (“I think I’ll still be the same person if I’m a boy instead of a girl, won’t I?”), and her desire not to change her name with Dr. Ehrensaft are at least suggestive of conflict and a wish not to grow up or decide on a gender, rather than a straightforward dissatisfaction with her physical body. Her statements are overtly different from the primarily cognitive declarations that “I am a boy” that characterized the girls who persisted in their gender dysphoria into adolescence (Steensma et al., 2011; Steensma et al., 2013). In those studies, the children who were more extreme in their cross-gendered behavior were the ones most likely to persist. Given Jacqueline’s reticence to attend the transgender conferences, it is not clear she falls into the most extreme category. Further, the underlying motives for a wish to be the other gender during childhood emanated from different motives in persisters and desisters. While persisters truly longed for another body, the desisters, lacking a true aversion to their natal body, wanted to have another body in order to fulfill the preferred gender role. At the least, Jacqueline’s statements invite exploration as to what it was about a boy that she wanted to be, or an inquiry into what her fantasies were about the lives that boys lead. In addition, no consideration is reported about what the absence of a father meant to Jacqueline or how growing up in a single-parent family might have impacted her sense of gender. If we learn about Jacqueline’s gender identity, we do not, as Corbett (2009)

urges us to do, learn about her gender fantasies, those organizing and persistent scripts that condense “early identifications, childhood sexual theories and fantasies, experiences, and solutions to important childhood conflicts” (Person, quoted in Corbett).

As gender fantasy is flattened to gender identity, the environment must also take on a one-note position. Dr. Ehrensaft makes an assumption that Jacqueline “lived in a layered internal world, firm at the core and then covered with doubts” (2015, p. 46). The source of the doubt is attributed to her mother and Jacqueline’s fear that she will lose her mother’s love because of the mother’s conscious wish for a girl child. In previous reports of child analyses of gender dysphoric children, from both classical and self psychological perspectives, as well as research studies (for example, Coates, Friedman, and Wolfe, 1991), the mother’s fantasy life, her *unconscious* desires about the sex of the child were seen as central. Here, the mother’s manifest desires are taken at face value. Her wish to introduce blockers to Jacqueline as potentially motivated by a fear of her child’s reprisals go unexamined; there is no mention of aggression in any form.

If Jacqueline/Thomas’s doubt is not explored as conflict but instead attributed to her/his environment’s conscious wishes, how are we to know that her/his ultimate clarity about the puberty blockers is not what she/he perceives to be the wishes of her / his therapist? As Schwartz (2012) points out in a trenchant discussion of how a clinician’s essential beliefs about gender influence the choice of treatment options, Ehrensaft’s ideas about the True Gender Self move her closer to an essentialist position, which inevitably brings her to an interpretive process that is “limited in its imaginative range” (p. 472). Gender becomes defined as “a material condition that requires a material response” (p. 465). The danger is in finding in the child’s literal statements what the clinician was looking for to begin with.

What child analysis can offer to the debate on the treatment of gender dysphoria is its unique form of listening, possible only in analysis, a situation that allows for and fosters the manifestation of unconscious fantasy in the transference, through the evocation of metaphor in play and words, and the analysis of defense as well as an examination of the analyst’s countertransference responses to the material. It is the opportunity analysis affords to see the multiply layered way that the mind is organized, the admixture of identification and the development of structure, the capacity to separate self from object, and the ability to accept that all bodies involve the limitations of boundaries. The tools of analysis need not, and should not, be used in the service of encouraging a child to accept his or her biological gender, but rather to add an

additional lens to the perspective given by the child's (or the parent's) manifest statements. Analysis can help us formulate the right questions. There is no area where true neutrality, always easier in theory than in practice, is more mandatory than in our treatment of gender, where a genuine respect for the child's desire must include the ability to listen and not act. Without attending to their desires as well as their conflicts about those desires, and their apparent statements as well as metaphorical meanings, without allowing the full evocation of the patient's multi-layered and shifting internal world, support can become as constricting as condemnation. Advocacy is an admirable, necessary position, but it is a political position and not an analytic one.

#### PUBERTY BLOCKERS

In turning from True Gender Self Therapy to puberty blockers, our question remains the same: Is the use of puberty blockers a neutral, easily reversible intervention that buys the child more time to explore his or her gender, as Dr. Ehrensaft claims?

As noted earlier, without any intervention, a proportion of adolescents will return to their natal gender; the persistence rate is reported as 15.8 percent (Steensma et al., 2011). At the same time, Adams (2007) reports that of the two hundred adolescents treated at Boston's Clinic for Gender Variant Children with puberty blockers and hormones, none chose to return to their natal gender. Given the absence of reliable discriminators, doesn't this at least raise the possibility that the act of taking blockers or the decision to do so may function as an intervention that shifts the child's position vis-à-vis their alternatives? As Anna Freud points out, not only the process, but the timing of development is critical in determining its outcome. Not going through puberty at the same time as one's peers changes the experience. In adolescence, with the developmental decathexis of the parental objects, the peer group is ever more central in defining identity and aiding in the second individuation process. Jacqueline/Thomas felt transitioning would feel more right if she could move to a new school and start over. Thus she would have to leave her peer group, a significant loss. Given the acquisition of a new peer group at a critical time, if she decided to change her mind and stay with her natal gender, returning would be that much more difficult. In fact, Steensma et al. (2011) reported that for some children in their sample, the return from early transitioning in elementary school was accompanied by considerable distress.

The wish to prevent the possible negative consequences for the truly gender dysphoric child that will follow from the further development

of a body they believe is wrong is the strong form of the argument for blockers. Yet puberty is for many children a time of disorganization and pain, some of which leads to potential growth and stabilization of identity. The potential to block pubertal development raises the question of the ways in which bodily and hormonal changes potentially aid in the possible reorganization of the personality, not just the assignment of gender. In the quantitative and qualitative studies of desisting and persisting gender dysphoria (Steensma et al., 2011; Steensma et al., 2013), the period between ten and thirteen years of age was seen by both groups as crucial, with the bodily changes accompanying puberty, the experience of falling in love, and sexual attraction all influencing their final gender identification. A first love, a first rejection, the challenges to the parental authority that lead to the object hunger and affect swings of adolescence, the fear and uncertainty of identity that accompany a newly emerging body—should we necessarily “save” people from this? Until we can reliably predict in whom gender dysphoria will persist, the possibility remains that encouraging puberty blockers will foreclose the potentially organizing experience of development.

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