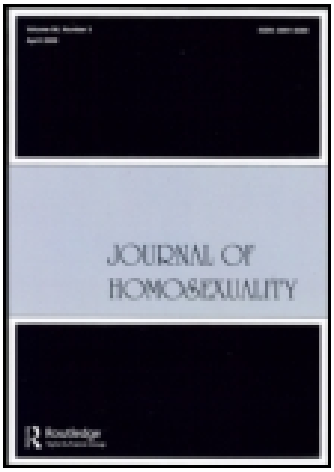

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Listening to Children Imagining Gender: Observing the Inflation of an Idea

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Listening to Children Imagining Gender: Observing the Inflation of an Idea

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Using three of the clinical articles in this special issue of the Journal of Homosexuality *as examples, the author attempts to show how their views of gender may influence clinicians' conceptualizations and treatment choices in response to children diagnosed with gender identity disorder (GID), or gender dysphoria. In particular the author argues that the belief that gender is a psychophysiological entity that is organismic and transhistorical, that is, the view known lately as essentialism, promotes more invasive interventions (e.g., endocrinological and surgical) and mistakenly deemphasizes psychological therapies as a clinical response to the suffering of trans children. He tries to show that the drawbacks of essentialism and its correlated treatment approaches are twofold, that a) they promote treatments with insufficient attention to our limited knowledge regarding their safety and efficacy, and b) they advance a reified differentiation of the genders that is politically problematic. The author suggests that a better response to trans children would be one that emphasizes the child's broadly subjective role in his or her construction of transgressive, gender-related psychological and interpersonal phenomena (both painful and not), thus, offering a deeper validation for trans children's challenges to our gender system.*

KEYWORDS gender, gender identity, gender identity disorder, gender identity disorder of childhood, gender identity disorder of adolescence, gender variance, pubertal suppression, transgender, transsexual, treatment

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I am disquieted and stimulated by my mediated encounter with the children, parents, and clinicians represented in these clinical articles.

The children have a deeply felt complaint, expressed explicitly or indirectly through the disruptions they inevitably provoke. They say they are unhappy with being named, classified, and treated in accord with the match between their visible genitalia and the prevalent set of conventions regarding those genitalia. For them, gender has become preoccupying. They are pained within this preoccupation and have formulated a solution to their pain about which they are surprisingly unambivalent, considering the almost universal antipathy with which it (their solution) tends to be greeted. They seem oddly unaware of the outlandishness of their defiant desires, even beyond the unselfconsciousness that might be expected for their ages: they offer their improbable and impossible self-perceptions and wishes boldly.

The parents seem to be trying to catch up with terribly surprising news, with varying degrees of success. They are frightened, frustrated, freaked out, and, finally, defeated, as they are forced to relinquish a cherished perception. Their particular defensive configurations vary (guilt, despair, anger, embrace), but all face extreme intrapsychic disruption and pain.

The clinicians try to make this child/parent/symptom matrix fit into a model of liberal psychiatric treatment. As is common in the medical sciences, most push against ambiguity, preferring to emphasize speculative generalizations ("genetics is likely a factor") instead of highlighting the lack of data from controlled studies. All seem acutely aware that they are in difficult waters, politically and scientifically. They try hard to accommodate the many conflicting pressures under which they labor: the child's suffering, the parents' suffering, cultural imperatives, political forces, and their own training, formal and informal.

I, privileged to be an outside the fray (though not disinterested) observer, hear something unsaid or at least not clearly articulated, that is sporadically discernible among the three groups of subjects. Each, in different ways, gives signs of trouble—psychological, political, and epistemological. Listening with the ears of a deviant psychoanalyst, admittedly eager to see gender troubled, I think I hear echoing themes representing unarticulated desires and conflicts. I hopefully imagine that these themes may prove pertinent to understanding trans children,[1] and as important to me, to understanding better what may be involved in the pursuit of sexual equality (in the broadest sense), since these children seem to me to be involved in that pursuit. Before I try to articulate these themes and point to their particular manifestations, I offer a word on methodology.

Clinical articles are usually designed to tell the reader something about an encounter between an agent of medicine and a seeker of help. In particular, they are written to show the reader something about the methods of the clinician, usually to support those methods and the theorizations on which they are based. Only secondarily, if at all, do they attempt to render the

patient as person. The articles which my colleagues and I are discussing are about people—children and parents—and, yet, they are more than usually remote from a phenomenology of the patients and families whose treatments are described. This is because, as per the instructions of the editors, they principally give us protocols, that is, approaches to diagnosis and treatment planning, only supplemented by abbreviated case material. Paradoxically, this is a situation where a felt sense of the patients (and their parents)—their personalities and idiosyncratic styles—is more than usually important (really crucial) to achieving a grasp of this particular psychosocial situation. After all, trans children purport to be representing something about their very state of being; they do not see themselves as troubled by a transient condition, like a depressed mood or an obsessional habit. Their parents tend ultimately to concur that their children's problems are truly existential, even though they may wish it were not so, and seek help in the offices of medical practitioners, not of clerics or even of psychoanalysts, where the soul and mind are addressed, respectively. Their therapists, as represented in the present articles, vary in their degree of concurrence with the existential claim.

Regardless of whether we discussants finally agree to the trans child's claim of existential difference, should we not at least include experiential dimensions—both of the subject and of the observer—in our effort to apprehend them? It is not surprising that the clinical articles are largely without phenomenological data about the children, since the editors' requests did not explicitly ask for that sort of material. But surely something will be missed if no attention is given to the expressive and qualitative aspects of these children. Imagine how they might react years from today upon reading these articles. Beyond the likelihood that they would take offense at their objectification, many might also feel that their efforts to communicate had been missed. So, as I began to compose my thoughts for my own article, it became apparent to me that without some less mediated contact with these children and their parents, my apprehension of all this was going to be handicapped, if not systematically distorted. By way of remedy, I did the obvious: I googled. I was, thus, able to view several videos of trans children. They were taken from television news shows, such as those featuring Barbara Walters and Lisa Ling. They featured interviews and candid filming of trans children, their parents, siblings, and, occasionally, their clinicians. It is worth noting here that the methodological sequence I describe is literal: I did not seek films of trans kids until I had read the clinical articles. The internal gap I experienced motivated me to want to see them.

Of course, I do not imagine that I now have objective data, or am equipped to contest controlled research findings. But I have, if only to some limited degree, heard a bit of the children's point of view, seen them represent themselves, watched some parents react and offer their own understandings, and glimpsed the clinicians at work, all albeit, through the literal lens of mainstream journalism, but at least enacted by all three

groups of subjects themselves. These perceptions, in turn, have mingled with my personal schemata of gender and authority and with my psychoanalytic imagination. In addition, I have had brief clinical contact with three trans adolescents and have heard some descriptions by other psychoanalytic clinicians.

THE CHILDREN

The two characteristics of the trans girls that were most striking to me through the videos and the articles were 1) their expressed certainty and determination about their true gender, and 2) the stereotypy of their gender performances.

The pointed representation of certainty on the part of the trans girls shows itself directly, expressed by the children themselves, and indirectly, channeled through the parents and clinicians. When asked by television interviewers if they had any doubt about truly being a girl, rapidly and seemingly without thought, came the emphatic reply: "No." Parents frequently sought medical help after their efforts and some degree of social ostracism failed to dissuade a child from active pursuit of cross-gender behavior and identity. "This child would not give up," and "life was a daily battle [over clothing and hair]" were some of the phrases heard on the videos. Parents expressed anxiety about an implicit danger of suicide, and expressed with resignation that they were "lucky it was only this." Did the trans girls know of the degree of their impact on their parents, that is, did they receive any enhanced sense of power? I cannot know this, but my impression was yes. Children listen and learn.

The trans girls' gender performances themselves had a stereotypy that left me feeling that they were not representing themselves as actual female children, but rather as arch and whimsical hyperboles of adult women's styles, or even urgent efforts to persuade the other of their femaleness. They are frequently shown expressing a stereotypical preference for pink. Images of flamboyant, narcissistically toned dancing were frequent in the videos—chosen by the filmmaker, no doubt, but enthusiastically executed by the children with parental cooperation. Scenes of trans girls excitedly selecting girl's clothing or getting their hair styled had an eerie feeling of being made to persuade. Of course it is possible that this is chiefly an artifact of film making, but the collaboratively expressed enthusiasm of parent and child seemed to belie that possibility.

In more general phenomenological terms, the trans girls seemed to me to be struggling, to be internally busy. Their insistent demand that adults accept and materially aid their non-conforming self-portrayals felt like pleading for authoritative ratifications of solutions they themselves doubted. The intensity of the demands—they tended to literally strike fear in the hearts

of parents—left me imagining a terrible sense of weakness, or even impotence, on the part of the children, but an impotence that these children were refusing to accept.

The phenomenology of the trans boys was different. They felt to me more purposeful and reflective, less expressive, and interpersonally active. At times they seemed sheepish, as if modest about an achievement. It could be said that these are merely some culturally consistent attributes of newly acquired masculinity. It did not feel that way. Their message seemed more sober and they seemed more content. Their performances seemed smoother.

THE PARENTS

The most poignant emotion the mothers of trans children left me with was grief. Something cherished had been lost, and it was a loss that it behooved a mother to accept and transcend. These mothers wept with pointed bravery, which is to say with no hint of self-pity. They would not be daunted in their love for their "new" child, but neither would they forget the first child, now seemingly lost. Interestingly none seemed especially aware that their "first" child would likely return, since most trans kids ultimately desist in their gender nonconformity. Indeed, it was surprising to me how little this fact was highlighted (with the exception of Zucker, Wood, Singh, & Bradley, this issue). No filmed parent mentioned it. Surely an emphasis on that probability might have ameliorated their pain and grief, and the necessity for such manifest courage.

The fathers seemed gripped by barely concealed anxiety. Their frozen smiles were in contrast to the mothers' open distress. They seemed to say that the tragedy belonged to their wives, whom they would support unflinchingly.

THE CLINICAL ARTICLES (OR, REALLY, THE CLINICIANS)

For me, the most important task with respect to the articles is to illuminate the unarticulated assumptions and unconscious communications that they make to patients, parents and readers. In other words, embedded in the assessment and treatment protocols, and evident in the specific recommendations made to parents, are theoretical beliefs that are taken-for-granted, and woven into the very language of the clinicians. It is this unspoken material, differing subtly from article to article—in effect a set of varying theoretical assumptions (truisms, really) about human nature—that is most significant to understanding the psychocultural matrix that is here represented.

The superordinate and most significant unstated assumption is that gender, as an organismic condition, not only as a social psychological interpretation of a genital configuration, is real. In its strongest form this assumption states that gender is not only a subjectivity, but is an objective condition of every human, the observable nature of which is independent of external situations. Furthermore, while the subjective experience of gender and its representations may be influenced by culture, its underlying nature is not. It then follows that, even if it is granted that gender's development in a given individual is affected by environmental conditions, including culture, its operation in any given moment is a function of some interplay between the individual's physiology and psychology, not his or her external situation. Thus, gender comes from within the body and is discoverable. From this point of view, the modification of gender often entails surgical or endocrinological intervention, not mere behavioral change. It is only secondarily a performance.

The reply might be that of course the reality, stability, and unity of gender is assumed in these articles; it is assumed most everywhere in human discourse, be it colloquial, medical, or scholarly, and, therefore, this is unremarkable. But among the people about whom these articles speak, gender is at issue: Its existential nature, including its source, modifiability, and location, are under scrutiny and contested, albeit, by children. These children, through their complaints and insistences, are making claims about gender that push, however ambivalently, against the assumption of real gender as articulated above. Consider this: Some of them are saying, in words or deeds, that their gender can be modified through an act of the will, or, that despite the absence of any pertinent physical change, their gender has changed, observably to them if not to their doctors and parents. Most deny any correspondence between their anatomy and physiology (of course, most particularly their natal genitalia) on the one hand and their self-affirmed genders on the other. This assumed mutability of gender, of which they propose to avail themselves, is way out of line with stable gender as written about in most of these articles.

By contrast, the superficial logic of the trans children's claims often comports well with the conventional discourse of essential gender, which, for the most part is present in most of the clinical articles. For example, they proclaim which gender they really are, purporting to describe intransigent inner conditions, and pressing for accommodation by their social environment in the strongest terms possible. At least in form this self-narration is very much in line with an acceptance of essential gender as described above—a material condition that requires a material response. Yet, this is a significantly limited acceptance of conventional gender. The words the children use to talk about their genders sound as if it is a psychophysiological reality, but their actions—impassioned demands for the other to recognize them in accordance with their own rules—and hopefully expressed

desires to be something they are not, make of gender a plaything controllable by its owner, a psychic toy whose operation is entirely up to the child, but for the requested batteries (principally parental and institutional recognition).

It is possible to respond to children in a manner that is either organized around their literal narratives, or around psychological interpretations of those narratives, which themselves take into account such inner contradictions and perplexities as described above. Toward which path the clinician leans may be strongly influenced by the degree to which he or she shares the child's apparent view of gender, that is, holds the assumptions of essential gender, or not. Simply put, if you believe gender is an internal reality, you will likely be guided or motivated to accept a literal hearing of the child's narrative, since it matches that view. The child's self-presentation may then seem straightforwardly comprehensible enough to guide you in clinical decision making. On the other hand, if your prejudice is to hear any claims about real, inner gender as necessarily—necessarily because you do not believe gender is real in the sense described above—composed of symbolic or metaphoric representations, then the child's story instigates an active interpretive process, and clinical decision making proceeds differently. Contrasting scenarios of clinical responses differentially related to the clinicians' gender assumptions are well illustrated in the five clinical articles. A close look at three of these articles[2] from this perspective will additionally show how assumptions about gender on the part of clinicians is systematically correlated with preferences for some treatment approaches and avoidance of others.

Edwards-Leeper and Spack's article (this issue) shows how a strong commitment to gender as inner reality affects clinical theory and practice. There are in their article numerous subtle examples of that commitment, but the following is fairly unambiguous: " . . . we perceive . . . severe gender dysphoria, cross-gender behavior, and strong identification with the other gender . . . to be a *primary physical rather than psychological condition* [italics added]" (p. 333). While the authors qualify this statement to indicate that they are talking about the more extreme cases of gender dysphoria, they do not deny the implication that normal gender is also physiological, an objective reality of the person's body. Moreover, they object to "insurance denial . . . based on the premise that GID is a mental disorder, rather than a physical one" (p. 323).

Two interrelated aspects of Edwards-Leeper and Spack's article (this issue) stand out for my purposes: a) their advocacy of the alleged advantages of intervention over nonintervention, either in the form of supporting social transitioning or of offering pharmacological puberty suppression, and b) their principally anecdotal defense of this advocacy.

With respect to the advocacy of intervention, Edwards-Leeper and Spack (this issue) say that they "have learned that delaying proper diagnosis

can lead to significant psychological consequences" (p. 322). This warning implies that the reliability of diagnosis and associated prognosis in this area has been established, which is the case only for diagnosis, that is, we cannot say reliably what the course will be for a given child with GID or gender dysphoria. In particular, we cannot reliably say whether he or she will persist with an expressed need to be affirmed in his/her non-natal gender, or not. In fact, the majority do not sustain the diagnosis, that is, they *de*sist. Given this uncertainty of prognosis, it is significant that Edwards-Leeper and Spack's presentation of the pros and cons of pubertal suppression, a primary intervention in their protocol and their frequent recommendation following diagnosis, is imbalanced. They offer seven physiological benefits to pubertal suppression (for the most part just a list of the physical effects) and no disadvantages. Likewise they tout the psychological advantages, but note no potential disadvantages. Their conclusion is: "Therefore, it is our clinical impression that preventing these unwanted secondary sex characteristics with puberty blocking medical intervention allows for better long-term quality of life for transgender youth than what they would experience without this intervention" (pp. 329–330). The claim of offering "better *long-term* [italics added] quality of life" based on clinical impression only, and absent significant longitudinal experience or controlled data collection, is questionable. Considering that Edwards-Leeper and Spack are advocating a pharmacological intervention aimed at prepubertal children and adolescents, a number of whom are likely to desist, it is surprising and of interest that they so minimize the importance and value of alternative interventions, ones that might have fewer unknown consequences, both physiological and psychological. An alternative sort of intervention would of course be some variety of psychological therapy. Most typically this might include support, reality testing, empathic interpretation and psychoeducation offered to both parents and children. Psychotherapeutic responses to individuals displaying gender (and sexual) nonconformity may have become associated in the minds of some with the right-wing, Christian agenda of so-called reparative therapy. But this latter practice, or any practice[3] that uses an apparently psychotherapeutic situation to foster self-suppression, or aims to replace a child's transgressive psychology with a normative one, is of course, not what I have in mind. In fact, assiduous attention to the danger of inadvertently promoting conformity and suppressing agency when responding psychotherapeutically to a trans child is necessary for by now obvious reasons. One can easily imagine how a conflict among parent, child, and therapist about limiting a particular gendered behavior might be resolved prejudicially in favor of conformity, given the differential power of the parties involved and the adults' natural propensity to want some conformity given the amount of nonconformity with which they have probably been coping.

The intransigent style (cognitive and behavioral) of trans children may deter some clinicians from considering that some of their suffering might be helped without rhetorically opposing their desires or trying to persuade them to relinquish their assertions. I will have more to say about this later, but briefly: The goal of psychotherapy in this situation would be to help the child feel better and offer reality-based guidance for social situations, as well as the prevention of self-harm, in the rare cases where that is an issue. In general, psychotherapy should entail increasing (parents' and children's) self-understanding, not coaxing or pressuring them to change their minds. The disturbing demands and claims of trans children, as well as reports of self-harm (untabulated, to my knowledge) may shock and scare both parents and clinicians into expecting less frustration tolerance from them than is realistic. Such an underestimate of the trans family's resilience may be abetted by the availability of puberty suppressing drugs. Frightened of the onset of puberty, and intimidated by the at times ominous articulations of the children, parents and clinicians are relieved to imagine even a temporary solution.

Edwards-Leeper and Spack's (this issue) usage of anecdotal data concerns me. To counter what they describe as the leeriness of parents with respect to the taking on of transgender identities on the part of adolescents with no prior history of gender dysphoria, they say: "However, many of these adolescents report that their friends are not surprised by their declaration of their affirmed gender, often responding that they had suspected it for some time" (p. 332). We must assume that Edwards-Leeper and Spack are aware that an adolescent's report of other adolescents' validation of a gender identity claim is not credible evidence of more than the first adolescent's desire to persuade. How then are we to understand their inclusion of this anecdotal information? It would seem that natural skepticism has been suspended in favor of literality. Are they trying to highlight the alleged power of essential gender by pointing to its observability by others even before the subject himself or herself has self-awareness? If so, the weakness of an anecdote such as this gives the appearance of a lack of appropriate scientific and psychological skepticism, and inattention to methodology.

Of course the problematic aspects of Edwards-Leeper and Spack's (this issue) article, detailed above, are not necessarily caused by their commitment to essential gender. But they are consistent with it and support it. It is real gender that demands treatment urgently and speaks for itself. When children claim to feel its powerful inner message, they are to be believed with less than the usual scientific skepticism.

Zucker et al.'s (this issue) article contrasts with that of Edwards-Leeper and Spack. Zucker et al. do not express an unambiguous view on the existential status of gender. Instead they offer thinking about particular patients,

aspects of gender identity disorder and some theoretical questions, in that order, thus, implicitly leaving the epistemological status of gender as an open, and likely unanswerable question. Their way of addressing theory is well illustrated in the following, in which they respond to the question of whether or not gender identity is fixed in childhood: "For most children, no one tries to alter their gender identity after it is first expressed, for a host of psychological and social reasons. To formally answer the question of whether or not a young child's gender identity is fixed and unalterable, one would have to conduct a randomized psychosocial trial in which, for half the children, some type of intervention was attempted to alter the child's gender identity. It is unlikely that such an "experiment of nurture" would attract many volunteer parent participants" (p. 375). Zucker et al. wittily remind us of a fundamental epistemological fact that is present in all discussions of gender, but which some tend to forget: The research that would be necessary to answer most questions about the origins and nature of gender with any degree of scientific certainty, cannot be done for ethical and technological reasons. Thus, they officially demur on the existential status of gender, which amounts to not making the reifying assumption that Edwards-Leeper and Spack (this issue) (and most others) make.

Three aspects of Zucker et al.'s (this issue) article stand out: 1) their portrayal of the children, 2) their theoretical notion of gender as a "phenotype," emerging out of "biological factors, psychosocial factors, social cognition, associated psychopathology, and psychodynamic mechanisms" (p. 375), and 3) their underlining of one of the few replicated findings about trans children, that a large majority desist in their trans claims and identities during adolescence.

Zucker et al.'s (this issue) descriptions of the children are notable for being phenomenological and psychological. They describe the emotional tone and style of the children's reports. They ask the parents for their own understanding of their child's behavior, and use that information in formulating a psychological understanding of the child's gender peculiarities, which often points them to psychological dimensions besides gender, such as obsessionality and power seeking. In particular, their discussion of symptomatic overlaps between children diagnosed with Asperger's syndrome and children diagnosed with gender identity disorder, questions how frequently gender disturbance is inferred as primary, when cognitive or social pathology may be playing an equal, stronger, or interactive role.

Zucker et al.'s (this issue) conceptualization of gender as a phenotype, quietly, but effectively, dispenses with gender as a separate entity altogether. They carefully discuss each factor that they see as contributory to the epiphenomenon of gender, illustrating each with clinical material. But at the end of this compelling analysis they make no summary conclusion about the existential status of gender. This is either a stroke of rhetorical genius in which they avoid participation in a politically incendiary situation,

or admirable modesty. In either case, as we shall see, Zucker et al.'s view of gender is associated with a treatment approach that is quite different from the one associated with the gender-as-physiology view articulated elsewhere.

"The majority of children followed longitudinally appear to 'lose' the diagnosis of GID when seen in late adolescence or young adulthood, and appear to have differentiated a gender identity that matches their natal sex" (Zucker et al., this issue, p. 375). Thus, Zucker et al. remind us of a fact (supported by five research articles going back to1987)[4] that every clinician and parent of a child who is gender dysphoric needs to keep firmly in mind. This fact is mentioned only once in Edwards-Leeper and Spack's (this issue) article. Perhaps this is because their clinic limits its patient population to those on the cusp of puberty and older, a subgroup of trans children many of whom are less likely than the majority of trans children to desist in rejecting their natal gender with time alone. However their description of the recommendations they make to the parents of young trans children, whom they refer out, likewise fails to emphasize the usually short natural life of GID. Their clear emphasis, instead, is on "acceptance of the child's budding gender development," not on considering the simultaneously multiple potential sources of trans children's behavior and experience, and the correlated possibility that the least intervention may be the best. Moreover, Edwards-Leeper and Spack take pride in what they see as their avoidance of the mistakes prior generations of mental health professionals made, in particular when the latter refused to accept gay and lesbian people at their word, sans diagnosis. Indeed, the analogy is tempting, but I would argue, deeply flawed, itself an aspect of the conflation of gender and sexual orientation.

Zucker et al.'s (this issue) treatment approach is quite simple: psychotherapy for the children, counseling and psychotherapy for the parents, medication for any observed psychiatric conditions for which medication is indicated. It is an approach to treatment that need not even mention the term gender. Again, Zucker et al. do not make much of the significance of this. Instead they have quietly diminished the function of real gender in their practice and theory.

At the beginning of this article, I referred to a repetitive unconscious theme that I heard variously represented by the children, parents and clinicians. Of course, the theme I have in mind is about essential gender. Let me try to narrow that down, using the observations offered so far, and material from a third clinical article.

CLINICIANS AGAIN

The two articles I've used for illustration thus far suggest that when clinicians integrate the notion of essential gender into their efforts to respond to trans

children, their therapeutic efforts change significantly. With essential gender in mind they are likely to be less psychologically minded and less thorough in their consideration of the cost–benefit ratio of invasive interventions and of research that might militate against their impulses to intervene. To be sure, they are trying to be respectful of and responsive to children's stated wishes. But it seems that beyond that, when child patients talk about their gender, their belief in its reality seems to distract the clinician from the fact that we cannot listen to children in the same way that we listen to adults. Patients' communications always need some degree of interpretation; that is especially true for children, who, necessitated by their cognitive limitations, speak more symbolically. This is why we offer them play therapy. I assume Zucker et al.'s (this issue) inclination to respond to trans children with therapeutic restraint was in part spawned by their recognition of gender as epiphenomenon, but no doubt listening to patients with interpretive ears also helped them to rethink gender. The contrast between Zucker et al. and Edwards-Leeper and Spack (this issue) tells us something important about the risks entailed in the use of the term *gender*. Perhaps aware of the danger of allowing an epiphenomenon, a shorthand term for a convergence of variables, not a thing itself, to guide practice, Zucker et al. are careful to listen, question and prescribe quite apart from it, emphasizing the convergent variables for which it is a shorthand—temperament, cognitive style, behavioral style, and so on. Edwards-Leeper and Spack do something different from Zucker et al.: They assume that gender is a primary physical condition and organize their observation and prescription around what they believe to be the effects of variations in it. Edwards-Leeper and Spack might reply that they have only specified primary physicality for the gender dysphoria syndrome, not for gender in general. But if the pathology of a system is seen as primarily physical, and its recommended treatment is likewise physical, then the system, the disturbance of which constitutes the pathology, is at least significantly, if not predominantly physical. Certainly Edwards-Leeper and Spack do not address or preclude this inference. Reading the articles with these differing stances one gets the dizzying impression of some writers carefully negotiating the dangerously misleading attributions that gender calls forth, while others eagerly deploy them. It would seem that the idea of gender is potent and troublesome. When it is significantly present, choices are made.

Ehrensaft's (this issue) clinical approach is informative here, because she combines aspects of Zucker et al.'s (this issue) psychological approach with aspects of Edwards-Leeper and Spack's essentialism. Ehrensaft's explicit technique, to both help the child with emotional distress and to make recommendations to parents, is empathic listening. But what she is listening for—"the true gender self"—pulls her back toward essentialism and literal listening. The ontological status of "the true gender self" is unclear, since it seems to be both externally real and subjective: it is "the *kernel of*

gender identity that is there from birth [italics added], residing within us in a complex of chromosomes, gonads, hormones, hormone receptors, genitalia, secondary sex characteristics, but most importantly *in our brain* [italics added] and mind . . . .its center always remains our own *personal possession* [italics added], driven from within rather than from without" (p. 341). But if the kernel of gender identity is there from birth, it cannot be created. Ehrensaft finds herself accepting without interpretation the child's claim of a real inner structure that must be accommodated externally. It is then no surprise when the clinical process she describes largely lacks a consideration of the psychodynamics of her patient. Ehrensaft tells us that throughout a session to which Brady/Sophie arrived fully dressed as a girl, "[she] kept sucking in her tummy, in an attempt to make herself more girl on top" (p. 351). This child is less than 5 years old. Sucking in her tummy will not make her more girl on top, since little boys and girls are the same on top, which Brady/Sophie surely knows: It will make her more woman, a very different thing. One possible interpretive direction in light of this slip would be that this child is more interested in a ticket to adulthood than a gender change, but for some reason sees being female as a necessary first step. But Ehrensaft makes no mention of the slip to the reader or to the patient, so I assume it eluded her. I wondered if Ehrensaft had not been briefly distracted by a countertransferential process in which the concept of the true gender self promoted an inadvertent collusion with this very bright child's defenses. To be specific, did the prospect of relief from the anxiety of intense inner (and interpersonal) conflict, unconsciously broadcast by the child and received by the therapist make the notion of an anxiolytic true gender self (and anything that goes with it, like wanting breasts) more appealing? If so, was the consequent interpretive process then limited in its imaginative range? Indeed, it seemed to me that the rich and dark constructions of Ehrensaft's patient Brady/Sophie were understated or neutralized in her account. At a point when Brady is given more permission to enact a female persona, the material in the therapy session is strongly inflected with aggression, including the image of Brady's mother feeding Brady's dead male self to the family dog. Ehrensaft sees this as a "creative, albeit gruesome whimsical solution for consolidating a transgender identity" (p. 351). Maybe. Another, I think more parsimonious possibility, would be that there are unarticulated aggressive processes in the family unconsciously perceived by Brady. Seeming empathic acceptance can function to diminish experiences of unconscious conflict and, thus, limit knowledge of a difficult part of the self. This is of course speculation in this case, but with no less foundation than hypothesizing the consolidation of a transgender identity.

Ehrensaft (this issue) does not see the true gender self as speculation. Instead she believes that its therapeutic value is shown in this treatment, as follows. At the conclusion of this patient's treatment, parents and therapist decide that it is best to permit Brady/Sophie to present as a girl at all times.

Sophie (still not 5 years old) proclaims: "I'm the happiest I've ever felt in my life." Ehrensaft furnishes a putative expert statement to the parents, which says in part: "To promote her wellbeing and emotional health, it is imperative that Sophie be seen and treated as a female by her parents, her educational settings, and the community surrounding her" (p. 353). Such certainty in matters so fraught with unforeseeable possibilities including the welfare of a child surprises me. The certainty of the child about her gender is matched by the clinician's certainty about the outcome, both of whom, I suggest, are encouraged by the notion of a true gender found at last. Moreover, I wonder if Ehrensaft has not imagined the inner life of this child, who is rather adult-like in her speech (do 4 year olds commonly speak of "in my life?"), as more adult than it is. This could be for many reasons including, of course, the personality of the child. However, I believe it is easier to be distracted from the childishness of a patient's claims when the terms they use conceptually match the clinician's ideas. Ehrensaft and Sophie agree on Sophie's gender problem: There is a little girl inside, effectively begging the very difficult question of what it *means* to a child to be a boy or a girl, on the inside. Indeed, children of Brady/Sophie's age typically conceptualize most abstractions concretely. In therapy with a child, we must not question this concreteness aloud if we are to be of help. But we must be guided by our knowledge that the adult abstraction gender, likely refers to something very different from the child's idea, and of which the child has as yet, little knowledge.

CHILDREN AGAIN

Perhaps because trans children are so much trouble—they freely embarrass and threaten their parents, provoke their therapists with creativity, unreasonableness and impracticality, and make it hard for their political defenders with essentialist rhetoric—we may lose sight of how potentially enlightening they may be. Children as a group, of course, present special problems to the mental health profession. They have limited means to express their interior lives, so we must listen and observe much more intensively, considering alternative interpretations, imagining their experience, and testing our hypotheses as we go, there and then. As I mentioned above, it was to address this very problem that play therapy was invented. It was, therefore, striking how some of the clinical articles entirely avoided interpretation of the children's behavior (including their verbal behavior), and instead took them literally. If the boy says he feels like a girl inside, then something about his boyness is acting up, instead of the more parsimonious assumption that as with all children's at first puzzling complaints, something in their experience, dynamic and as yet unknown, is being symbolized, and not that we need to consider the malfunction or influence of any particular

psychophysiological system. But the latter practice, unparsimoniously injecting the role of theorized psychophysiological gender per se, is what many clinicians tilt toward when an aspect of gendered psychology is present. Why is this? Well that is the subject of another and much longer article, but we should consider that the peculiar rhetorical and structuring power of the concept *gender* is here operating, in parents, children, and clinicians alike. Others (notably Rubin, 1975), have evolved theorizations of the compelling and intransigent presence of gendering across cultures, without positing essential gender, in effect accounting for our infatuation with it without succumbing to its claims.

It seems to me that trans children, in response to great psychic pain (and adaptively or not) have engaged the rhetoric of gender and, thus, stumbled upon a communication of such potency that their parents and therapists are detoured from listening to them as children, instead crediting them with adult-like cognition. When we infer that the trans child has a disturbance in an unobservable gender system, based on a claim of gender transformation, we are granting the truth of a child's self-analysis and proposed self-construction. I doubt that the receipt of such a gratifying abundance of respect from the clinician is consciously intended by the child. It is more likely that the child longs inchoately for an emotional experience like respect and rapidly gains unconscious awareness of the power of gender complaints to bring such gratification. When the longing is unwittingly satisfied by the parent or clinician who, thinking they understand the child's problem, validates the terms of the discussion as the child has set them, the child is likely to reiterate the complaint in those terms. For that child, a psychological structure, more or less transient, begins to develop. For the adult, the illusion of understanding begins to perpetuate itself. The most immediate lesson that the trans child has learned, and then enacts, encouraged by these interactions, is that the idea of gender is very powerful, and if you want to get a rise out of people, play with it daringly. The lesson for the parent or clinician should be: Stop talking about gender. Zucker et al. (this issue) seem to appreciate this.

It would be folly to expect any parent to look upon their young child without experientially centralizing its perceived gender as real. All the details of our cultural practices surrounding the bearing and raising of children, including language itself, militate in favor of experiencing the gender of the child not only as real, but as central in parental consciousness. The assumed validity of essential gender is both challenged and affirmed by trans children, and its simultaneous weakness and potency in the face of that challenge deals their parents a terrible blow, for their children are playing with gender in a way that traumatizes them. First, because gender is so central to parents' experience of their children, their very sense of reality is shaken. Second, the children have placed the parents in a classic double bind: They insist on the flexibility to choose their gender, that is, flout genital

rule, but then act as though the new gender is essential, inflexible. Even the rare parent, caught in this cross-fire but still trying to adopt a constructivist attitude, cannot win for losing. The child demands infinite latitude and the parent gets none. We, who would help both, are much reduced in our psychological armamentarium because of the special position of gender in the culture of parenting. But we are not empty handed. We have knowledge that if emphasized can help parents, if not to listen psychoanalytically, at least to feel calmer and do less. We know that their children's preoccupation with gender is very likely to wane. We cannot persuade most parents to become constructivists, but we are obliged to be frank with them about a full range of possible outcomes, including the often short and benign course of gender dysphoria.

SELF-HARM, TRANS CHILDREN, AND OUR DISCUSSION

The specter of harm to children—any harm to any children—is surely a powerful influence in all discussions about children, and no doubt it is playing a role, spoken or not, in this one. In reality, our society does not devote appropriately disproportionate resources to the welfare of children. But symbolically, and in particular contexts, we become obsessed with the possibility of harm to them, especially physical injury, but psychological harm as well. Aid to poor mothers and education are slashed, but you can quickly get your neighbor in deep trouble with a simple anonymous phone call to a usually underfunded child protective services agency. Protecting children from the imagined depredations of lesbians and gay men is a central trope in the right wing attack on sexual minorities, while the abuse of children in a variety of institutional settings eludes appropriate scrutiny. Many more illustrations of our culture's ambivalence toward the welfare of children could be cited, but my point for the present is that latent or manifest images of harm to the innocent bodies and minds of children, and, perhaps worst of all, of child suicides, change the tenor of any discussion. Has it changed this discussion, however subtly? Has it changed the imaginings of clinicians and parents when they consider responses to trans children's articulations of pain? These questions are not readily answerable, but, before I write my conclusions, I would offer some observations that are less debatable and, perhaps, pertinent to these questions.

I am aware of no controlled data to indicate that the incidence of self-harm among trans children is any greater than somewhere between very infrequent and rare. I am aware of no data to suggest that pubertal suppression, cross-sex hormone administration, or genital surgery diminishes the probability of self-harm in trans children. Moreover, there is no reason to believe that the three above-mentioned physical interventions are

any better for the welfare of trans children than supportive psychotherapy and psychoeducation for parents. There are anecdotal reports of threats by children and of children dramatizing the possibility of self-mutilation. There are psychiatric protocols for addressing the patient who seems to pose a risk of self-harm that are minimally intrusive and unquestionably reversible. The long-term psychological and physiological consequences of chemogenic pubertal suppression, cross-sex hormone administration, and genital surgery are unknown, and, as is the case with all self-selected populations, very difficult to assess owing to problems of control and limited sample numbers. The palpable misery of an articulate child may distract the empathic clinician or parent from the venerable admonition: First, do no harm.

CONCLUSION

I believe the disquiet and stimulation I initially experienced after reading these articles and watching some videos, was a reaction to my perception of children and adults struggling in the thrall of an artificially vitalized concept that subjugates and empowers each in complementary ways, a phenomenon both intriguing and worrisome. Most of these adults—parents and clinicians—have been persuaded that gender is biologically real, with specific rules for healthy functioning. The children, having unconsciously learned of the adults' imbuing of gender with particular potencies, that is, with reification, medicalization, and transgressive possibility, try to put it to use in the course of their own self-development. It proves to be a high-risk and high-gain tool. It has the power to command adult attention, to affect adult emotions and thus to alter the position in the family of the child who chooses to deploy it. As well, in the unconsciously operating hands of the child it can also bring enormous pain, which in its compelling resemblance to physical pain further misleads the adults toward the reification of gender. Painful and continuing maladaptation is usually the result of unconsciously instigating a noxious mechanism that is initially subjectively adaptive, but then via feedback mechanisms develops a life of its own that cannot easily be halted, despite its now problematic consequences. I would classify the disturbances of gender described in these articles as special cases of such maladaptation, novel in their content, but not in their interpersonal and intrapsychic structure.

It is disquieting to observe clinicians unconsciously colluding with troubled parents in the inflation of concepts that are inherently psychologically constricting. But there is another, perhaps deeper, reason that the observation of this particular image provokes me. None would dispute that, while the reasons for the hatred of same-sex eroticism and same-sex pairing are multiple, it is the transgression of gender norms by gay men and lesbians, especially the perceived elevation of the feminine by gay

men, and of the female body, by lesbians, that most disturbs the ruling culture. Whatever psychological mechanisms are behind it, it is the intrusion of men who are willing to be feminine—erotically submissive and openly adoring of other men—and women preferring dominance and insisting on power that threatens the social order enough to license violence against lesbians and gay men and to legislate their inequality. The intellectual scaffolding for the dread and persecution of gender transgressors is primarily the belief that the organization of society around reproductive roles correlated with particular (and unequal) social roles is the reflection of a natural biological situation, that gender is a real structure of the human nervous system, prior to culture and history, and necessary. Just as racism requires belief in natural races, sexism and homophobia require belief in natural genders. If we organize our responses to children who play or become preoccupied with gendered behavior around the idea that there are natural genders from which they are deviating or toward which they can aspire with medical help (transitioning), then, however indirectly, we are buttressing the very structures upon which the hatred of gay men and lesbians stands. Or put differently: As clinicians responding to trans children, we are responding to a subjectivity, not to the results of a biopsy or blood test. We and parents must choose whether we respond to that subjectivity as the upshot of a hypothesized psychophysiological gender system, on the one hand, or choose to go no further than regarding it as a mutable psychological situation on the other. Choosing the former, the more elaborately and speculatively theorized framework of essential gender, accepts a theoretical structure that has been used to rationalize sexism and homophobia and, therefore, tends to promote them despite good intentions.

As should be clear by now, for me, abjuring the assumption of essential gender in responding to children, is in fact the venerable practice of making fewer assumptions, that is, theoretical parsimony, not an added politicization of clinical responding. This is important because my argument against a literal hearing of trans children's claims about their genders may be mistakenly read as a high-handed, quasi-diagnostic denigration of anyone who chooses to centralize gender and genitals in their self-conception. For example, some might think it inferable from my clinical and theoretical rejection of essentialism, that male-to-female transsexuals who see themselves as having women's brains encumbered by male bodies, are inherently politically retrograde. That is not my view. It would be deeply contrary to my purpose to use my analysis to disparage any experience or to obstruct the efforts of any adult to determine any aspect of their own bodies or minds. I restrict my political critique to those with power—clinicians, theorists, and parents. While an individual's subjectivity may ultimately have political consequences, I take it for granted that political change is first of all the prerogative of institutional authority, in this case, institutionalized medicine.

It may appear to be a failure of respect for the child's subjectivity to refuse to take their desires literally, and to refuse to be guided by the terms they have set. However, to accept their terms without interpretation, and even embellish and inflate them with scientific-sounding speculation, does them no service and is pseudo-respect if not outright condescension. A psychological treatment is respectful of the individual's subjectivity insofar as it assumes the individual's freedom and agency, not when it halts its analytic function to accept the individual's disavowal of agency in favor of the imagined power of gender. That principle, central to the insight-oriented psychotherapies—always strive to return disavowed or stolen agency to the patient—might be helpfully emphasized, especially for the trans child who seeks treatment, for that child, perhaps more than others, is contending with the terrible conflict that all humans experience between acknowledging freedom, and wishing they did not have to.

There is much more to children than what they say. We owe to them a deeper listening than a literal one. We will then likely find that their engagement with gender, especially when it is transgressive or countercultural, may reveal a creativity and even a politics that can contribute to the erosion (if not destabilization) of the gender system as it presently operates. If we listen to them literally, interpret their communications and performances through the categories we adults have grown up with, and of course have ourselves failed to transcend, we will miss whatever new story they are telling or protest they are making. If we listen and respond to what they are saying in the mirror of the old system, they will seem to buy it, because it comes with the feeling, although not the reality, of being understood, which they no doubt crave. Thus, stasis is guaranteed for the child and for our culture. I am not naïve enough to imagine an intellectual transcendence of essential gender. But, in the name of equality—of gender and of sexuality—we must avoid promoting its continued entrenchment.

NOTES

1. I will use the adjective *trans* to describe the children. I am deliberately avoiding any pathologizing or reifying terminology. But I do not mean to imply by this term that I accept literally or completely all trans children's narrations of themselves. The term trans seems to me general enough to encompass transgression, transcendence, and related concepts without necessarily precluding a range of interpretive formulations.

2. I have limited myself to these three articles in order to contain the length of my commentary and for the range of viewpoints they represented.

3. Some nonreligious, but no less ideologically committed, clinicians have also contributed to the impression that psychotherapeutic or psychoanalytic responses to trans children necessarily promote conformity in disregard of health.

4. These are Green, 1987; Drummond, Bradley, Badali-Peterson, & Zucker, 2008; Singh, Bradley, & Zucker, 2010; Wallien & Cohen-Kettenis, 2008; Zucker, 2008.

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