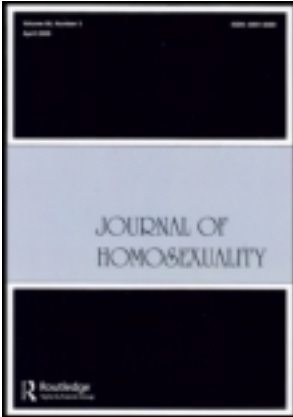


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From Gender Identity Disorder to Gender Identity Creativity: True Gender Self Child Therapy

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True gender self child therapy is based on the premise of gender as a web that weaves together nature, nurture, and culture and allows for a myriad of healthy gender outcomes. This article presents concepts of true gender self, false gender self, and gender creativity as they operationalize in clinical work with children who need therapeutic supports to establish an authentic gender self while developing strategies for negotiating an environment resistant to that self. Categories of gender nonconforming children are outlined and excerpts of a treatment of a young transgender child are presented to illustrate true gender self child therapy.

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

My description amounts to a plea to every therapist to allow for the patient's capacity to play. . . . The patient's creativity can only be too easily stolen by a therapist who knows too much. (Winnicott, 1970, p. 57)

The form of therapy in which I engage with gender nonconforming and transgender children and youth is a treatment modality I have dubbed, *true gender self therapy* (TGST). As a child clinician deeply influenced by the work of D. W. Winnicott, I unexpectedly found myself turning to his concepts of the true self, false self, and individual creativity for the underlying principles of the form of therapy I engage in with any child who is sorting

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out gender issues. Winnicott's (1970) quote above reminded me that the therapist who knows too much about gender is typically the therapist who does not know enough, and that true knowing comes from listening to the patient.

In 2003, Cohen-Kettenis and Pflafflin (2003) wrote a comprehensive review of treatment options available at the time for transgender children and youth. They concluded: "Despite the many treatment approaches, controlled studies do not exist. It is therefore still unclear whether (an extreme) GID in childhood can truly be curedNothing is known about the relative effectiveness of various treatment methodsPending controlled studies, psychotherapy directly aimed at curing GID has no place in the treatment arsenal" (p. 129). In 2012, as I write this piece, I regret to say that we have not traversed much further in executing such studies (Cf. Muller et al., 2009, for a review of studies to date). Yet, we now have research data indicating that gender nonconforming youth who receive support from their families for their sexual or gender identities show better mental health functioning than their peers who do not, as measured by direct assessment of the youth (Ryan, Huebner, Diaz, & Sanchez, 2009) or parent reports (Hill, Menvielle, Sica, & Johnson, 2010). In addition, listening to the patient has proved to be a vital source of information about the treatments we provide to transgender and other gender nonconforming¹ youth as mental health professionals. Repeatedly, the children I work with tell me, in words and actions, that when allowed to express their gender as they feel it rather than as others dictate it, they become enlivened and engaged; when prohibited from that expression, they show symptoms of anxiety, stress, distress, anger, and depression.

With that said, it is my view, after reviewing the existing data, that significant harm is done to children when adults attempt to adjust the children's gender expressions and self-affirmed identities to match the gender listed on their birth certificates and from which the children show signs of transgression. Traditionally, mental health professionals have engaged in treatment approaches aimed at shaping a child to accept his or her assigned gender and adapt to the gender expressions "appropriate" to that assignation. True gender therapy is an alternative, or might I say opposing clinical model operating from the premise that gender is not a binary category, as our dominant cultural and theoretical canons assert, but is rather a complicated three-dimensional web. Each individual will spin his or her own unique gender web, from threads of nature, nurture, and culture. Like fingerprints, no two gender webs will be exactly alike.

In the majority of children, the gender assigned at birth will match the gender they feel themselves to be. A very small minority of children will experience a cacophony between their assigned and affirmed² gender, the latter defined as the gender that a child asserts him or herself to be. As with left-handed children, who are also a small minority of the population, I

believe these children who experience this discord are not abnormal, they simply vary from the norm. Other children will accept the gender assigned to them at birth, but not the culturally defined expressions assigned to that gender. The true gender self model assumes that for all children, gender traditional and gender nonconforming alike, the primary locus of gender lies not between the legs but between the ears, or in Diamond's (2002) words, "It can be said that one is a sex and one does gender; that sex typically, but not always, represents what is between one's legs while gender represents what is between one's ears" (p. 323). In essence, the brain and mind work to establish an inner sense of self as male, female, or other, based on body, on thoughts and feelings, and absorption of messages from the external world, a sense of self that may or not match the sex that is found between one's legs. In this theory of gender development, individuals are the experts of their own gender identities and while gender expressions may vary over time, gender identity shows more temporal consistency. If we want to know how a child identifies, listen to the child, and if you pay close attention and provide a safe enough holding environment, over time he or she will tell you.

This model of gender development dispenses with the diagnosis of Gender Identity Disorder of Childhood (GIDC) of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev; *DSM-IV-TR*; American Psychiatric Association, 2000), a diagnosis and implied treatment that pathologize perfectly healthy children who are simply expressing their authentic gender identity. A boy who plays only with girls and with toys that have been culturally labeled as "girl toys" and dreams of being a girl when he grows up is not a child with a disorder, but rather a child who is creatively weaving his own gender web. The same applies to the girl who wants a boy's haircut, plays on the boys' soccer team, and blanches at the sight of a dress in her closet. The job of the clinician is not to ward off a transgender outcome, but to facilitate the child's authentic gender journey. This does not mean that gender can never be a symptom of some other underlying disorder rather than an expression of self. However, the most challenging task for the child clinician is to differentiate those symptomatic situations from the, albeit complicated but healthy, developmental journey of children who are reaching to establish their true gender identity and authentic gender expressions. If we are to place a gender diagnosis in any statistical manual of diagnoses, I would propose that the only diagnosis relevant and supportive of gender nonconforming and transgender children is *gender dysphoria*, a felt stress or distress about one's gender placement or identity. Therapeutic attention to relieve that stress involves sorting out internal conflicts about gender, working with parents to facilitate support for the child, or building a child's resilience to meet the unwelcome reception of a transphobic or genderist³ milieu. The gender dysphoric stress or distress is not meant to be the parents' or social environment's angst, but

solely the child's, defined not by others but by direct reports from or clinical observations of the child. TGST is also predicated on the observation that the vast majority of gender nonconforming and transgender children show up to their parents, rather than being shaped by them, suggesting an innate component to the gender nonconformity. The parents are responding to something exhibited by the child, rather than placing it there, and are often puzzled by the appearance of their child's gender nonconforming behaviors. In the words of one mother, "When he was two, he was always in my jewelry, my purses, always in the closet for my shoes, wanting to dress like me . . . I don't think anyone encouraged it" (as reported in Green, 1987, p. 116).

From gender identity disorder to gender identity creativity, the rubric of the psychoanalytically informed treatment paradigm I would like to present, is a model that dispenses with the notion of binary gender categories, challenges assessments of perversion and inversion cast on gender transgressive people, and strives to help children discover their gender authenticity (Ebhrensaft, 2011a, 2011b, 2011c). Central is the psychic importance of the true gender self, the potential dangers of the false gender self if left untreated, and the role of the child clinician in facilitating the child's gender creativity and authenticity. Although I focus on the development and treatment of children, I would like to emphasize that gender development is an unfolding life-long process and much of what I say applies to adults as well.

TRUE GENDER SELF, FALSE GENDER SELF, AND GENDER CREATIVITY

In Winnicott's (1960a, 1960b) concepts of human development, he identified the true self as the authentic core of one's personality, from which spontaneous action and a sense of realness come. He proposed that the original kernel of the true self is evident at birth. The potential for the true self to unfold is predicated on appropriate mirroring and emotional holding by the primary caretakers, in which the adults do not impose their own selves on the child's psyche but rather allow the child's authentic self to emerge. Winnicott defined false self as that part of the personality that accommodates to the demands of outer reality and functions to shield the true self from annihilation. According to Winnicott's theory, there are different points along a spectrum at which any one individual must call forth the false self to protect the true self's existence. One of those points is where the true self is acknowledged as a potential and allowed a secret life, while the false self holds forth to accommodate to the expectations and demands of the environment. The psychic intention at that point is the preservation of the individual in spite of abnormal environmental circumstances (Winnicott,

1960a). Individual creativity is the psychological function that launches the true self and allows it to stay afloat. It facilitates spontaneity, authenticity, and feeling real. In the beginning, individual creativity is reliant on a co-construction between the child and the people who comprise the holding environment, adults who in optimal circumstances will be responsive to the child's true self and able to follow the child's lead rather than imposing their own sensibilities about how that child should be. Individual creativity works to help an individual build a meaningful personal world for him or herself—a weaving together of internal desires with external realities to build one's subjectivity. When allowed to function unfettered, individual creativity leads to the discovery of one's quintessential self. Individual creativity is the opposite of compliance. In compliance one recognizes an external world into which one must fit. In creativity, an individual calls upon his or her own lens through which to view that external world while taking liberties to define the personal meaning of that vision. In existential terms, individuals will either find themselves living creatively and feel that life is worth living or end up finding no such creativity and doubting the value of living at all. Through creativity, the goal of life is to allow one's true self and individuality to blossom. Danger prevails when the false self takes over and suffocates the true self. In the most extreme case, an individual might want to stop living completely rather than let the false self continue to beat the true self into submission.

Although Winnicott (1960) never intended these concepts as defining features of gender, the three terms are remarkably adaptable to a nonbinary theory of gender development and treatment. This theory perceives gender as fluid rather than dichotomous, both within the individual and over a lifetime, and considers all human beings, not just the gender nonconforming child or adult, to carry within them the socially constructed attributes of both the feminine and the masculine along with characteristics that defy any such binary categorization (Corbett, 2009; Dimen, 1995, 2003, 2005; Goldner, 1991, 2003; Harris, 1991, 2000, 2005).

The true gender self begins as the kernel of gender identity that is there from birth, residing within us in a complex of chromosomes, gonads, hormones, hormone receptors, genitalia, but most importantly in our brain and mind. Once we are born, 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, driven from within rather than from without. Even in the face of imposed prescriptions, proscriptions, or repudiation, we strive to both establish and claim rights to our true gender self, which will include both our gender identity and our gender expressions, and which, although stable, may still shift over the course of our lives.

Gender expression is defined as those behaviors, actions, and choices we make to present ourselves as male, female, or some conglomeration or even negation of gender categories altogether (Brill & Pepper, 2008). The

true gender self does not necessarily match one's gender expression. For example, a transgender woman reflects back on her high school experience: "I never dressed in women's clothes at school and usually I became alienated from my friends who did this. They caught a lot of heat. But I was different. For me, it wasn't the way I looked or dressed, it was the way I felt. It's who I was, it's how I identified at that particular time inside" (Glenn, 2009, p.109). Inner feelings, not outer accoutrements, are the cornerstone of the true gender self, which can be equated with the definition of *core gender identity* in traditional theories of gender development: "the sense of one's sex—of maleness in males and of femaleness in females, and in rare case of anatomic hermaphrodites, of being both, or even a vague sense of being a member of the opposite sex" (Stoller, 1985, p. 11). Remove the words "rare" and "vague" and replace hermaphrodite with "intersex" and "sex" with "gender" in Stoller's definition and what remains is a close approximation of the definition of the true gender self, absent the fluid variations and recognition of cultural specificity of the meanings of maleness and femaleness.

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. Any child can and probably will develop a false gender self, running the gamut from the cisgender boy who puts on a macho mask to empower himself and please his Marine dad to the transgender child who hides dresses in the closet to avoid punishment from disapproving parents. Living an authentic gender life is a particular challenge for children who experience an extreme discrepancy between the gender assigned to them at birth and the gender they know themselves to be, particularly if that discrepancy is not welcomed by the world in which they live. The gender nonconforming and particularly the transgender child may need to wrap a blanket over the true gender self to ensure surviving in a world that might not be ready to embrace that child for who he or she is. That world qualifies as *abnormal environmental circumstances* in Winnicott's (1960) terminology and that blanket would be the false gender self. This process can occur either consciously or unconsciously. If such children are not given the opportunity for their true gender selves to emerge, they may find themselves at the most extreme end of the true self–false self spectrum, where intense efforts by the false gender self to shield the true gender self from annihilation, if failing, can result in the child's desire to die or be destroyed—from the despair of the true gender self never having a chance to emerge or the distress of being trapped in a life and/or body that feels too unreal. Studies document that incidences of suicide or suicide attempts are significantly higher in gender nonconforming youth than in the general population (Carver, Yunger, & Perry, 2003; D'Augelli, Grossman, & Starks, 2006; Morrow, 2004; Pilkington & D'Augelli, 1995; Yunger, Carner, & Perry, 2004), much of it attributed to the harassment and victimization from the external world but in so many cases, I believe,

also a manifestation of the false gender self's strangulation of the true gender self's existence.

To guard against such morbid eventualities, gender creativity steps in, defined as each individual's unique crafting of a gender self that integrates body, brain, mind, and psyche, which, in turn, is influenced by socialization and culture, to establish his or her authentic gender identity and expressions. In the creative impulse of gender, a little child is drawn to make something of gender that is not based just on the inside (the child's body, the child's thoughts and feelings), nor just on the outside (the family, the culture's expectations), but a weaving together of the two, with the child in charge of the thread that spins the web. Every child's gender creativity will be unique. Every child will depend on a supportive environment to allow his or her gender creativity to unfold. Every child will suffer if an intrusive environment grabs the thread from the child and spins its own web around the child.

For gender nonconforming children, gender creativity works actively to circumvent the false gender self and privately keep the true gender self alive even in situations where it is not safe to let it come out. So, for example, Jeremy learns that he is not allowed to wear his favorite red velvet dress to school, only in the sanctity of his home. He does not like that, but he learns to accept it, as his parents have empathically explained to him that his school is not ready to accept a boy in dresses and the school still has more learning to do. He negotiates this conflict through reverie. Sitting at his desk at school, Jeremy imagines himself gliding through the classroom door in his beautiful dress. His hair is long and golden and all the girls gather around to admire him. But actually, it is not him. It is her—Genevieve, a perfect name for the girl he imagines himself to be. He has missed the math lesson, but in his musings he has let his gender creativity reign, asserting in fantasy the girl he knows himself to be but cannot yet express.

Therapeutically, it is important to differentiate gender creativity from gender creation. If a transgender child just shows up rather than being shaped by the parents, how is his or her core transgender self "creative" rather than "just is"? Would the concept of gender creativity erroneously suggest that a child made a decision to choose this identity, rather than coming into the world with it as the kernel of the true gender self? Like with any child, gender creativity is not the end product, that is, the gender identity and expressions, but rather the act of putting together the wardrobe of the affirmed true gender self, both literally and symbolically.

PRIMER OF TRUE GENDER SELF THERAPY

TGST has a simple goal: helping a child build gender resilience and explore his or her authentic gender identity while acknowledging social constraints that may work against its full expression. Whether working directly with a

child, or indirectly through the parents, an objective is to facilitate acquisition of a psychological tool kit 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 that regard, the therapist will need to differentiate the false gender self as a conscious artifice under the child's control from the false gender self as an embedded and constricting aspect of the child's personality, unavailable or resistant to conscious control. To minimize the need for either of those two self-constructions, it behooves the therapist to actively work not only with families but also with the community to facilitate transformations from an "abnormal environmental circumstance" (Winnicott, 1960b) to a supportive holding environment for the gender nonconforming or transgender child, so that Jeremy, for example, would be free to waltz into class in his red velvet dress.

Just as there is no infant without a mother (Winnicott, 1960b), there is no gender nonconforming child without an accompanying family or family substitute when it comes to treatment. Parents or caretakers bringing a gender nonconforming or transgender child to a therapist will come with two potentially opposing socialization tasks: allowing the child to unfold to be his or her healthiest and most authentic self; ensuring that the child is safe in the world. In TGST, there is no one formula for the appropriate balance between these two demands, except to say that the overriding principle is to foster the child's authentic gender. When parents deem it too dangerous to allow a child to fully express him or herself in certain settings or are themselves not psychologically ready to allow such expression, the function of the therapy is to ensure that a child externalizes rather than internalizes the potentially negative valence of those proscriptions. When parents find it necessary to ask a child to employ a false self presentation, when the family itself is not a safe environment for the child to fully express him or herself or when the child has actually been ejected from home because of a gender identity or presentation, ego-building will be a strong component of the therapeutic work. In these situations, the therapist can explore with the child the self-protective false gender self constructions that have evolved not because his or her inner self is bad or damaged, but because there is an external world that is not yet ready to receive it. This is a resiliency model facilitating the child's development of empowering responses to negative reactions from peers at school that are common and chronic occurrences in the lives of gender nonconforming children (Toomey, Ryan, Diaz, Card, & Russell, 2010).

This true gender self model does not give a free pass to a child's self-determined gender expressions and identities without assessment of the possibility of gender nonconforming presentations and ideations as a symptom of some other underlying psychological problem or a gender self that is not yet formed. To the contrary, every true gender self therapist will need

to recognize that a child's gender is a developmentally unfolding process for which we must be able to suspend ourselves in a state of ambiguity and not knowing and understand that both the developmental unfolding and the therapeutic journey will be a process that takes time and careful and thorough explorations on the part of the therapist. Failure to accept this ambiguity would violate the very premise of the true gender self, for authenticity in these symptomatic cases may lie not in gender transformations but in sorting out other conflicts of self that express themselves through the portal of gender.

My own clinical experience is that in the vast majority of gender non-conforming children, there is no history of trauma or attachment disruptions. They come from stable families in which the most distinguishing features of their developmental histories are the parents' reports that their child just presented him or herself that way, typically in the second year of life, but even occasionally as early as nine months to one year of age (cf., Brill & Pepper, 2008; Ehrensaft, 2007, 2009). Yet, I have seen cases in which gender dysphoria was the manifestation of internal psychological disturbances rather than reactive behavioral distress in the face of societal stigma and prohibition or mismatch between assigned and affirmed gender. However, these are the exceptions rather than the rule. A key indicator of gender as a symptom of another underlying disorder or conflict, such as trauma, anxiety, social communication disorder, or psychosis, or a more global disorder of the self is when there is a more generalized disorganized, unintegrated sense of self, filled with anxiety and reflecting a lack of stable psychic structure. As described by Corbett (1996), the child's gender presentation is reflected in a nearly hysterical performance that is an overlay to chaotic states or regression or psychic pain. In other situations, rather than a consistent pattern over time, there is a sudden interest in gender bending or gender transformation, perhaps following a major psychological event in life and, perhaps, as a magical solution to life's challenges. The challenge for the therapist will be to differentiate the child who suddenly exhibits gender nonconformity with no preexisting history as an attempt to solve some other life or emotional problem from the child who has been suffering from what I would label a repressed true gender self that abruptly manifests itself with no forewarning. The latter is most often seen in children who are approaching puberty and are faced with a sudden trauma that forces to consciousness the horror that they are living in a body that is totally at odds with the gender they know themselves to be but which has been kept securely underground. Such youth are in gender crisis and need to be attended to immediately, with an evaluation for puberty blockers that will serve to temporarily stop the progression of the pubertal development with its unwanted secondary sexual characteristics and allow time to explore the true gender self in the light of day.

An example of gender as symptom of other problems is a young woman who implored her analyst to assign her a diagnosis of Gender

Identity Disorder and recommend top and bottom surgery for her. Her intent was to remove her breasts and sew up her vagina, to create a body that would repudiate any signs of sexuality altogether. She was not looking for a gender transformation, but rather a sex-neutered self-identity, driven by a frantic psychotic retreat from sex that had become equated with psychic and physical horror. An example of a gender response to a life event is the little boy who, after surviving a car crash in which his mother died, suddenly announced he was no longer a boy and would, henceforth, be living as a girl. This could be interpreted as a desperate attempt to retrieve his mother by embodying her. In this special case, this child's urgent wish to transition to a girl is a manifestation of traumatic attachment loss. A less dramatic example of a gendered response to a life event is Lucy. She returned from her first week at kindergarten suddenly announcing she would no longer wear girls' clothes, wanted a boy's haircut, and wanted a boy's name. Previously, she had been all about pink, frills, and Barbie dolls. The precipitating life event was the daily march to the principal's office because of disruptive behavior in class. She observed that some of the boys acted just as rowdy, but their behavior seemed more acceptable to the teacher. She concluded that boys had more leeway to act up in class, but girls got in trouble for the same behavior, ergo, she would switch to boy. She maintained a transgender façade for two years, at which point she announced, "I'm tired of pretending to be a boy." Lucy's transformation was not an expression of her authentic gender, but a magical solution to avoid school detentions. Other examples of magical gender solutions to psychological conflicts include the young man demanding cross-sex hormone treatment because of fears of his own repressed rages and desire to be a kinder and gentler human being; the molested girl who equates a change in gender with an escape from sexual predators; the teenage boy diagnosed with Asperger's Syndrome who demands transition because he has observed that girls are much better at making friends and being in relationships, believing that once he starts wearing dresses people will like him better and he will finally have friends.

There is often a simple *ex post facto* test that differentiates the child searching for his or her true gender self from the child who embraces gender nonconformity as a shibboleth to overcome psychic distress. The child who implores the world to listen to his or her pleas that the world has gotten it wrong and he or she is in the wrong gender or the child who is not allowed to express gender in the way that feels right to him or her often shows signs of stress, distress, or behavioral disruption. Once allowed to transition, these children typically relax and the signs of stress, distress, and disruption dissipate, if not disappear altogether (Interview with Dr. Norman P. Spack, as reported in Spiegel, 2008). In contrast, the child who has been mistakenly assessed as transgender will often get worse if precipitously allowed to transition to a pseudo true gender self and psychic distress escalates. Although not a universal phenomenon, one simple rule of thumb is that

if the assessment is correct, the child shows signs of getting better; if the assessment was incorrect, the child gets worse, or at least no better.

CANDIDATES FOR TRUE GENDER SELF THERAPY

Not only is it difficult to separate gender as symptom from gender as journey toward an authentic self, we also have to differentiate the many different kinds of gender nonconforming children who are working toward a true gender self and who may benefit from therapeutic supports.

The rate of development moves much more swiftly in children than in adults and therefore children can go through many changes in a very short period of time. With that said, as in any situation of attempting to reliably predict adult outcomes from child experiences, we must be modest enough to say that we can never know with absolute certainty if a child who says she or he is transgender is expressing a stable, permanent lifelong identity or is just on a temporary stepping stone. Although not an exact science and certainly open to human error, better measures that are not binary biased are needed to decipher whether a child is truly gender nonconforming and may be suffering from gender dysphoria. Yet, until that time, I think the best means is simply listening to the child, attending not just to their words, but to their actions. Gender nonconforming children typically provide a consistent narrative over time in which they report that their real self is not determined by their assigned gender or the social expectations for that gender, but how they perceive themselves to be. A transgender child will most often declare, “I *am* a (child of the other sex than the one on the birth certificate),” whereas a gender nonconforming, but not transgender, child will more often make a statement, “I *wish* I were a _____” or “I *feel* like a _____.” When allowed to match their gender expression with their inner gender identity, both transgender and gender nonconforming children relax and appear better regulated in most if not all aspects of life. If prohibited from matching their gender expression with their inner gender identity, the children become agitated, depressed, or even suicidal.

As a way to think about the myriad of children who may qualify for TGST, I have generated the following evolving categories for presentations of gender nonconforming children, with the caveat that these categories are somewhat reductionistic and potentially brittle if taken too literally or used inflexibly:

- *Transgender Children* affirm that the gender they are is opposite to the gender assigned at birth. They typically say they are a girl (boy), not that they want to be one. They represent a very small minority of gender nonconforming children.

- *Gender Fluid Children* do not abide by the binary norms of gender prescribed by the culture but instead flow along the spectrum from male to female, but not necessarily with a cross-gender identification or identity.
- *Gender Priuses* think of themselves as hybrids—half boy, half girl, or some combination thereof (e.g., “I’m 60% girl, 40% boy”).
- *Gender Tauruses* are similar to Gender Priuses, except they assert they are one gender on top, another on the bottom—a creative solution to a mismatch between genitalia and the mind’s messages to the child about his or her authentic gender.
- *Protogay Children* play at the margins of gender in the beginning stages of their gay development. They may remain gender fluid throughout their lives, or as they establish a gay identity may realize that earlier theories, like loving a boy means having to become a girl, are untrue and that boys can love boys and girls can love girls. In early childhood, they do not say that they are a boy (girl), but that they want to be a boy (girl).
- *Prototransgender Youth* first come out as gay or lesbian but then later discover that they are transgender. This is more common in female-to-male transgender than in male-to-female transgender youth and young adults.
- *Gender Queer Youth* defy all categories of culturally defined gender altogether and prefer to identify as gender-free, gender-neutral, or outside gender at all.
- *Gender Smoothies* Like gender fluid youth and gender queer youth, they metaphorically take everything about gender, throw it in the blender, and press the “on” button, creating a fusion of gender that is a mix of male, female, and other.
- *Gender Oreos* are layered in their gender, perhaps presenting as one gender on the outside, but feeling like another on the inside. These are the children who illustrate most poignantly the true gender self and false gender self in dialectical tension with each other.

This list is no doubt incomplete and will expand as my skills as a gender specialist grow.

WHO TO TREAT

Perrin, Tuerk, and Menvielle (2005) have provided a succinct summary of the reasons to treat a child who falls in any one of the categories above:

Most [gender nonconforming] children will respond to parents’ acceptance and encouragement. Referral to a mental health specialist is appropriate if the child is anxious, depressed, or angry, exhibits self-destructive behavior, or experiences significant isolation—especially if

these problems do not improve with short-term counseling. Children who are victims of bullying can benefit from therapeutic approaches that teach skills to respond more effectively and provide strategies to reduce the impact. Children who are very shy or have difficulty making friends may benefit from training to improve social skills and reduce social anxiety. (p.3)

Even under the above circumstances, the bulk of the work in TGST may be not with the child, but with the parents in a parent consultation model. I would also include children in need of an evaluation for medical services, including consideration for hormone blockers or cross-sex hormones, children in need of a care letter to be placed in their permanent files and carried by parents, and children in need of assessment in legal disputes related to gender (typically custody battles) as candidates for services.

I start from the premise that a child whose main presenting problem (as reported by parents or others) is that he or she is gender nonconforming may be no more in need of treatment than the child whose main presenting problem is that he or she is gender normative. Yet, there are specific challenges to being a gender nonconforming child, and the challenges often fall most directly in the parents' laps. Work with parents gives them an opportunity to work out their own feelings, conflicts, and confusions about their gender nonconforming child, without depositing them into their child's psyche. The consultations also give parents time to adjust their parenting to the child they have, mourn the child they thought they had, and explore options for supporting the child they do have. While receiving their own emotional supports, the parents also become facilitators, taking ideas and emotional equanimity home to help their child, who may never know that a therapist exists and who can continue in the tasks of childhood without being put under the microscope of a "shrink," an experience that may lead the children to think that there is something wrong with them. The role of the therapist in the consultations is not to dictate what parents do, but to help them get their child in focus; deal with their own pain, suffering, and confusion, when evident; work through conflicts for parents who disagree about their child's gender presentation; and make a plan for their child that optimally will be gender enhancing rather than gender crushing. This necessitates starting where the parents are, not where the therapist hopes them to be; listening, but also knowing when to step in as the expert offering information about the developmental paths and risks for gender nonconforming children.

TGST work starts with parent consultations, with the exception of work with older adolescents, who may need to be seen alone first. Whether or not to see a child individually is decided collaboratively with parents. If a child asks to be seen, that should be reason enough. Other indications include signs of stress, distress, confusion, anxiety, depression, or social isolation

that persist despite parent interventions and increased social supports both at home and at school; a nonsupportive environment that seems impervious to change or is characterized by warfare between disputing parents. Work with the child can last anywhere from a few sessions to years, weekly or intermittently, depending on the child's needs, and for some the therapist can become the child's consultant over the course of development, not seen regularly, but only as issues arise.

Rather than trying to describe TGST, I will let the work speak for itself through excerpts from the case of Brady/Sophie. I have specifically chosen the case of a very young child evaluated as transgender since these children give most therapists the greatest pause in deciding between allowing a child so young to change gender versus waiting and exploring for an indefinite period of time.

Philip requested a parent consultation about his four-and-a-half-year-old child whom he suspected was transgender. He and his wife, Amy, provided the following history. Four months earlier, at Christmas, their child, Brady, announced that he wanted to be called Sophie all the time and that he felt like a girl on the inside and a boy on the outside (gender Oreo). Before that, Brady had given himself the nickname, Rainbow Love Heart. Philip had tried to talk more to Brady about his gender feelings, but Brady was resistant, saying only that he felt he was a girl, but could not be, because he had a boy's body. Soon after, Brady described himself as a girl with a penis and a boy's voice. Even before that Christmas, Brady had been longing for girls' clothes for some time. At age 3, Brady told his parents that he wanted to be a woman, not a man when he grew up and he asked if he cut off his penis, would it hurt. Amy and Philip were both concerned that Brady might actually try to cut off his penis to achieve his goal. During that same year, Brady saw a girls' shirt in a store and begged his mother to buy it for him, but Amy said no, that shirt was for girls and he was a boy. A year later, Amy had done reading on gender nonconforming children and felt more comfortable buying Brady the girls' clothes.

Amy and Philip came for several consultations; we decided together that Brady was showing enough signs of stress and discomfort to warrant individual sessions. He was presently attending a preschool where he only wanted to play with girls, but had few friends. He wished to let his hair grow long, but wear boy clothes and longed to be a princess. Most of the time Brady seemed steeped in his own internal world, and both parents described him as having a bit of an Asperger's quality. Brady strongly identified with an animated car in a Pixar film that he identified as Girly Girl, a car with boy paint but a girl engine. He had created a new category: Merman, a male mermaid. He was picking at his skin and generally seemed agitated. Amy and Philip saw Brady in turmoil about his gender identity. They wanted help from a professional to figure out what would be the right thing to do for Brady to ease his angst and give him a better go in life. They had a hunch

that the answer was to allow him to express himself as a girl, but they did not want to do anything precipitous that might harm him.

Brady arrived at our first session in unisex clothes—a tie-dye tee shirt, shorts, and sandals. Almost the first thing Brady said to me when he met me was “I’m half and half. Half boy, half girl. A boy on the bottom (he points to his waist down), a girl on the top (he points to his waist up)” (gender Taurus). I asked, “What name should I use for you?” “Sophie. My nickname is Brady, but in kindergarten we’ll sign me up as Sophie and I’ll want everyone to call me ‘she.’” Noteworthy, but not understood by me at the time in terms of Brady/Sophie’s gender creativity, much of the play in that first session involved fierce aggression on the part of a giant sandworm who scares people and then eats them. After the first visit with me, Philip called to report that Brady declared, “I don’t want to have to go to school if they have to call me Brady.”

In a subsequent session, my patient arrived fully decked out as a girl, with a headband, girls’ shirt, and multicolored sandals, and announced, “I’m all girl now—Sophie. It just happened real fast. I’m not half and half anymore.” I asked Sophie where the boy half went. “Somewhere else.” Throughout the session Sophie kept sucking in her tummy, in an attempt to make herself more girl on top. When asked, Sophie refused to do Draw-A-Person or a self-portrait, but she was eager to draw the car named Girly Girl. She assigned Girly Girl the number 53, which she explained is a girl’s number. Her old number used to be 95, which is a boy’s number: “8 is a boy’s number, 76 is a girl’s number, 6 is a boy’s number, 70 is a girl’s number.” Later, I made a note that there is no gender fluidity for this little person—gender is as binary as a number system for her, just reversed.

In a later session, Sophie announced excitedly, “Did you hear? There’s no more Brady. I threw Brady in the garbage, and Brady couldn’t get out because the garbage can’s too high, and then all the garbage got thrown on top of him. But Brady climbed to the top and still couldn’t get out. Then Corky [their dog] came and ate him. Actually, Mom fed Brady to Corky. He tasted good, like a human. But a dead human, because Brady was already dead when Corky ate him.” I simply listened and made a mental note about Sophie’s creative, albeit gruesome, whimsical solution for consolidating a transgender identity. Sophie wanted to draw new portraits. A colorful mermaid replaced Girly Girl (mermaids appear as a common self-representation or identification figure for assigned male gender Taurus and transgender little girls, which has an internal logic—a long-tail-y self on the bottom, a beatific, long and silky haired flow-y self on the top). In her play, not Brady but little mermaids were chased by a shark who tried to eat them, symbolizing the yet shaky consolidation or acceptance of her female self.

Sophie spent numerous sessions working through her feelings about her transition from Brady to Sophie. Sometimes I interpreted, but mostly I listened. In the last session, Sophie and I had the following conversation:

Sophie: You know what? Sophie is calm when she wakes up in the morning. But Brady, who got eaten, was wild.

D.E.: Does your mom know that?⁴

Sophie: I don't know.

D.E.: Should we ask her?

Sophie: No, I just want to tell Dr. Ehrensaft. But if you weren't Dr. Ehrensaft, I wouldn't tell you.

Later in that same hour, Sophie explained that Brady has never shown up again since Corky ate him. Throughout this session, Sophie clutched her penis over her shorts, having told me that when someone from preschool says she used to be a boy, so she can't be a girl, she just gets quiet and doesn't say anything. (Earlier, I had advised her parents to help her come up with language for responding to other children.) I reflected that she could be a teacher to others, because she knows more about this than they do. She asked how I knew that. I tell her because she was the expert of herself. She responded by expounding, "I have 8 baby dolls and 19 race cars." Through her play, I bore witness to her own unique gender web, which presently consisted of threads of nurturing baby doll play and violent racecar mayhem.

Over the course of these sessions, I met regularly with Amy and Philip, who reported Sophie's experiences both at home and at school. After a period of reflection, they had decided, with the school's acceptance, to allow their child to go to preschool as Sophie. The teachers reported that her behaviors now made more sense to them and that she was, for the first time, jumping right into the play, rather than anxiously clutching a baby doll carriage and literally freezing whenever a boy showed up in her vicinity. She now had her first real friend, a girl named Gina. One boy was giving her a hard time, telling her he was only going to call her Brady, and would not call her Sophie. Sophie's response: "Well, that's okay, but if you do, I'm not going to answer you."

During the initial transition period, Sophie's mother would set out three sets of clothes: girl clothes, tie-dye clothes, and boy clothes that Sophie had been wearing as Brady. Sophie consistently chose either the girl clothes or the tie-dye clothes. The first few days when she presented as a girl, her parents reported she was somewhat agitated, but then she seemed to settle down. Now that she was allowed to be Sophie all the time and wear girl clothes whenever she wanted, she reported, "I'm the happiest I've ever felt in my life."

As Brady transitioned to Sophie, she asked her parents if she would grow up to have "nomies" (breasts) like Mommy. Her parents wondered whether they should tell her about body change options—either surgical or hormonal. They had their doubts about whether this might be overwhelming or frightening information for a child as young as Sophie, and I confirmed

those doubts when they brought them to me in our parent consultation. Together, we came up with a more age-appropriate response: “There are many ways to be a boy or a girl, and no, if you are born with a penis, you won’t grow breasts on your own.” They would then wait to see what Sophie, who is a very scientifically minded four year old, would do with that information.

The following summer, between preschool and kindergarten, I had completed sessions with Sophie but was available for parent consultations as needed. The parents reported that Sophie was adjusting to life as a girl and seemed to be enjoying herself, although she was showing some signs of stress, particularly fingernail biting. She worried that people would find out she used to be a boy or think she was a boy. She also feared that people who knew her before as a boy would not be accepting. On the other hand, she beamed with pleasure when she was acknowledged or recognized as a girl, as when a parent at the playground said to his own child, “Careful, there’s a girl already on the slide,” or when a young salesgirl commented, “I like your hair. It’s cute.”

As Sophie successfully settled into kindergarten with no apparent worries, my work with the family was finished for the time being, but was capped by the carry letter that I wrote for Sophie at the parents’ request:

To Whom It May Concern:

I am writing this letter in regards to Sophie X, who has been in my care since xx. I am a clinical psychologist and gender specialist who is working with Sophie and her family, for the purpose of helping her clarify her gender identity. Sophie was assigned a male gender at birth but has shown signs of gender fluidity from early life. Under her care with me, Sophie (Ne. Brady X) has expressed both to me and to her parents that she is an affirmed female. With the support of her parents, Sophie is now living fully as a female and self-identifies as such. To promote her well-being 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. In school settings and the community, this would include such things as bathroom use, participation as a female in sports activities or any other programs that might be designated as “girl” activities, and so forth. Both of Sophie’s parents have supported Sophie in her transition to an affirmed female gender identity and are in full agreement, as am I, that her well-being and mental health will be best served by recognizing and acknowledging her as a female.

Philip sent an E-mail thanking me for the carry letter, in which he shared that they had attended a picnic with other transgender children and their families. Some of the children were boys who had transitioned to girls. Others were girls who transitioned to boys. Afterward, Philip asked Sophie

what she thought of the other children. Her reply: “They were okay, but I was the only girl.”

CONCLUSION

There is now a little person named Sophie enrolled in kindergarten as a girl and by parent and teacher reports she is doing quite well. As Sophie grows older, she will have to decide, with the help of her parents, whether and to whom to disclose that she had once been Brady; whether to take hormone blockers; whether to take cross-sex hormones; whether to have surgery. In a fluid journey whose endpoint we can never fully predict, Brady may also make a reappearance, miraculously resurrected from the bowels of Corky. If that should occur, it will be imperative that Sophie feel free to express her desire to possibly switch back to male, rather than feel compelled to conform to the female gender that others have now supported and expect but who Sophie may no longer feel herself to be. If it should ever come to pass that Sophie would want to return to Brady, not making room for that transition back would simply be substituting one false gender self for another. To date, we have no research studies that indicate that a child who transitions gender and later transitions back in a gender fluid process rather than a frenzy of gender chaos or confusion suffers any damage to his or her psyche, and my own clinical observations are that such a process does indeed occur with no harm if the surrounding environment is accepting of the changes. Whatever course Sophie’s life takes, it will continue to be the function of TGST to help Sophie and others like her tap into their gender creativity to establish, over time, the gender that will be true to them.

NOTES

1. Presently, many gender theorists and practitioners use the term *gender variant* to refer to children and youth who function outside binary gender norms. Others, including myself, have replaced gender variant with the term *gender nonconforming* for the reasons that *nonconforming* is a less pathologizing term and that *variant* has connotations of deviation rather than difference. Throughout this article, gender nonconforming will be used but is interchangeable with gender variant in its referents.

2. In the present terminology of the transgender community and some gender theorists and specialists, *affirmed gender* is used to denote the gender an individual asserts him or herself to be, perhaps more accurately to mean self-affirmed gender. Throughout this discussion I will be using the word *affirmed* to allude to an individual’s assertion of his or her declared gender.

3. *Genderist* refers to a systematic belief system in the binary dichotomy of male/masculine, female/feminine as the only true, natural, or correct gender identities and expressions.

4. Amy was in the room with Sophie. Many parents of transgender or gender nonconforming children understandably are hesitant to leave their child alone with a therapist, either as a result of previous bad experiences with therapists who cast blame on them and tried to “repair” their child or in light of general mistrust of the mental health community’s aspersion on children who do not fit their gender norms.

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