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One Pill Makes You Boy, One Pill Makes You Girl

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ABSTRACT

Psychoanalysis has been confronted with the conundrum of integrating the use of psychotropic medications with the talking cure, with understandable concern about the substitution of a pill for working through. This paper addresses a unique situation in which the "pill" constitutes hormone-blocking drugs or cross-sex hormones to treat transgender youth. Clinical material of a 16-year-old transgender female is presented and followed by a review of several aspects of transgender hormone treatments. Winnicott's construct of the True and False Self is then used to argue that the True Gender Self of transgender youth is not the gender assigned to them at birth but the gender they experience themselves to be. The paper concludes by suggesting that if hormone blockers and cross-sex hormone therapies facilitate the strengthening of a youth's authentic gender self, the administration of those drugs is in the best interests of the transgender youth's healthy development. Copyright © 2009 John Wiley & Sons, Ltd.

Key words: transgender youth, psychotropic medications, hormone-blocking drugs, cross-sex hormones, True Self/False Self

> When is it my turn to be a boy?
>
> – A little girl who longed to be a boy (Smiley, 2007)

At age nine, this little girl went on to become a boy named Marty. When Marty approached puberty, Marty took a hormone suppressing drug, putting a halt to female puberty that would be the want of his female body. Later, Marty will begin cross-sex hormone treatment that will allow him to go through the puberty of the gender with which he identifies – male. Whether he will go on to elect sex reassignment surgery to match his genitals in accordance with the gender with which he identifies remains to be seen.

Megan is six years old. She has a long blond single braid that cascades down her back. She also likes to wear boys' clothes and is delighted when people

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mistake her for a boy. Yet she is not ready to say she *is* a boy. Instead, she describes herself as a Prius, a hybrid – boy in the front, girl in the back. Drew is Megan's father. He is sitting in my office with his wife in our first consultation together. Suddenly, he explodes in angry tears, "Don't talk to me about hormones and making my daughter take things that we don't even know what they'll do to her. I can't let that happen." No one had been talking about hormones at all, but the horrific possibility was an ever-present torment for Drew.

For Marty access to hormone treatments was seen as a blessing, for Megan a potential curse. Marty and Megan are part of a growing cohort of children who, at ages as young as three or four, announce that they do not accept or are discontent with the gender assigned to them at birth. These children and their families challenge us to rethink our theories of gender, and along with it, our stance on the use of gender-changing chemical interventions in childhood. When the mothers and fathers of child psychoanalysis laid the groundwork for a structural model to both comprehend and analyze the challenges of childhood, medical science had yet to present them with the conundrum of alternative biochemical routes to cure: mood stabilizers, rather than interpretations of primitive anxiety, to treat manic outbursts; stimulants, rather than a transference container, to treat impulsivity, crankiness, and distraction; anti-depressants, rather than a residential holding environment, to treat childhood depression or suicidality. Now it behooves us to reflect on yet another form of treatment ushered in by the advances of neuroscience and endocrinology: gonadotrophin-releasing hormone analogues to suppress puberty and cross-sex hormones to treat childhood gender dysphoria, allowing youth under the age of 18 to transition from the gender assigned to them at birth to the gender with which they identify. Proponents say that the treatment saves children from the anguish of continuing to develop into a gender with which they do not identify while giving them the opportunity to be their genuine gender selves (cf. Brill & Pepper, 2008). Opponents argue that children should be helped to accept the gender assigned to them at birth (cf. Zucker & Bradley, 1995), and are not yet emotionally (Di Ceglie, Sturge & Sutton, 1998) or cognitively capable of making such life-changing decisions; one medical professional has gone so far as to call such treatments "a modern form of child abuse" (Smiley, 2007).

The issue of allowing children to take hormone blockers and cross-sex hormones to alter their birth gender is quite complex and involves important ethical, legal, and psychotherapeutic questions. In what follows, I would like to discuss the perspective on the use of birth gender-altering drugs for children and youth that I have come to as the result of my work as a psychoanalytic researcher and clinician immersed in the culture of gender variant children and their families.

I am going to first present my conclusion, and then unfold the process of getting there. A number of cases present themselves in which youth have either expressed a desire to be the opposite gender since early childhood, have already lived as the opposite gender for some time, or, upon entry into puberty, disclose,

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sometimes with great urgency, that they have never identified with the gender assigned to them at birth and are horrified at the unwelcome bodily changes showing their appearance. In those instances, the use of puberty-suppressing medications with the later potential for cross-sex hormone treatment may be in the child's best interests; further, to deny this medical treatment could cause undue suffering and poor outcome for these transgender youth.

I came to this conclusion from several sources: my own clinical work with children who go against the gender grain, along with meetings with their parents; my self-education as a non-medical professional on the nature of these treatments; my study and collaboration with other mental health professionals, medical professionals, and health and community educators working with gender variant children and their families; post-modern psychoanalytic gender theory; and my review of Winnicott's writing on the True and False Self. I start from the premise that the concept of Gender Identity Disorder-Childhood that appears in the DSM IV-TR (APA, 2000) is invalid and harms myriad children who have no disorder but are simply seeking their true gender identity. I would argue that Gender Identity Disorder-Childhood should be removed from the manual and replaced with the construct of gender dysphoria: the conflict or suffering of an individual due to serious conflicts about his or birth or self-identified gender. My thinking is further informed by the theory that gender runs along a spectrum and is a fluid choreography over a lifetime between the human organism and the environment (cf. Corbett, 1993, 1996; Dimen, 1995, 2003, 2005; Goldner, 1991, 2003; Harris, 1991, 2005). In that context, there appears to be a small subset of people who will tell you, if you listen, that a colossal mistake has been made – their brain tells them that they were born into the wrong gendered body. It is the children in that subset who I will be addressing here, children who are teaching us that the locus of gender identity lies not between our legs, but between our ears.

PILLS AS AN ANSWER TO A CRY FOR HELP

To situate my thoughts about the use of hormonal treatments with transgender youth, I would like to start with two vignettes. One is from my own clinical practice; the other from a published report.

When Sammi first came to me, she was Sam. Sam had just turned 16. A late developer, Sam looked in the mirror and noticed the beginning of peach fuzz on his face. So did his parents, and began publicly acknowledging, with pleasure, the physical signals of his budding, albeit somewhat late, transition to manhood. Rather than feeling buoyed up by his parents' glowing praise, he was wracked with agonizing anxiety. He silently contemplated suicide. Instead, in a state of desperation, panic, and turmoil, he confided in his mother that he did not want to become a man; he was actually a girl. For years prior to this startling announcement, Sam had hid in his room painting his nails, looking in the mirror, and envisioning his girl self. He had known since preschool that he was "different,"

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but mostly kept it from view, particularly in the context of the strict Catholic school he attended. His parents noticed some of the behaviors, such as his interest in dolls, and simply told him that he could not do those things because he was a boy. As he grew older he became a social isolate and began to act out at school. By the time he entered high school he was showing signs of major depression, spending most of his time in the basement doing chemistry experiments or locked in his room surfing the web for transgender sites and joining chat room discussions with other transgender youth.

The onset of puberty catalyzed Sam's disclosure to his mother. Before that, behind closed doors, he could live out the fantasy of his girl self. Now his body was betraying him and destroying his dreams. This is not an uncommon experience for transgender youth, with puberty experienced as a nodal point of trauma rather than a celebratory transition to adulthood. Samantha, another transgender teen, reported that "Puberty threw me into an enormous depression. Becoming more masculine felt so wrong. Sometimes I'd secretly pray to God to make me into a girl" (Booth, 2008).

Marty, the child who as a little girl asked when it was her turn to be a boy, had already been living as a boy for about three years when he began to notice the first signs of puberty. When his second breast bud popped up, he ran to his mother and cried in distress "Mommy, feel this lump. You have to do something!" Once Marty's parents heard his calls of distress, they arranged for their child to take a hormone suppressing drug that halted female pubescence (Smiley, 2007).

Sam's parents, like Marty's, also did something. They took him to a local clinic for an evaluation by a psychiatrist, a gender specialist who assessed Sam as transgender and then referred Sam to a pediatric endocrinologist for consideration of puberty-suppressing treatment and to me for psychotherapy. Sam's parents went through their own therapeutic process to come to terms with the fact that their son was now going to be their daughter. The endocrinologist started Sam on Lupron, a commonly used drug to halt puberty. Three months later Sam returned to school after winter break as Sammi. A month later Sammi started taking estrogen. She is looking forward to sex reassignment surgery, which has already been scheduled during the twelfth-month anniversary of her living as a female. She detests the "thing" down there, the penis that betrays her and signifies to her that she is not yet a card-carrying member of the female gender. She anxiously awaits the time when her genitalia and her gender identity will be one.

UNDERSTANDING TRANSGENDER HORMONE TREATMENTS

The problem for transgender youth is that the experience of full biological puberty based on sex assigned at birth can seriously interfere with a child's development, if a child is firm in his or her stance that his or her gender is other than that stated on the birth certificate. To handle this problem, endocrinologists in several Western countries, after careful and exhaustive evaluation to

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confirm a child's transgender status, have begun administering gonadotrophin-releasing hormone analogues to put a temporary arrest to puberty. This treatment, originally designed in the 1970s to suspend precocious maturity, is fully reversible – puberty typically will resume its natural progression about six months after the termination of the medication. To date neither side effects nor changes in fertility have been reported; similarly, no drug-related increase in birth defects in the offspring of transgender persons has been observed. The main known downsides to the treatment are that the child will become a "late bloomer," typically smaller than his or her age peers, and cognitive development may be impacted since ordinary brain changes associated with puberty will not yet have occurred. Ideally, the treatment is administered during Tanner Stage 2 of puberty, when early signs of sexual maturity – breast buds in girls, testicular growth in boys – become evident. The drugs work by preventing the pituitary gland from sending signals to the ovaries and testes to produce estrogen and testosterone. The drugs are administered through injections, nasal spray, or annual implant. In addition to avoiding the trauma of experiencing an unwanted puberty with irreversible results (such as body size), the use of puberty-inhibiting drugs allows families to buy some time in which children can grow to fuller emotional and cognitive maturity and, with the help of their parents, make more informed life decisions about their gender identity and expression. Requirements for the treatment typically include (1) parental consent; (2) a mental health evaluation documenting psychological stability and assessing long-standing gender dysphoria and evidence of an increase of those symptoms with the onset of puberty; (3) a gathering of medical history and physical screening, including bone age and bone density scan, overall blood panel, tests for hormone levels; and (4) in some clinics, the child living in accordance with his or her stated gender identity prior to administering puberty-inhibiting hormones. In the US the five- to six-hundred dollars per month cost of this drug is prohibitive, and is not covered by insurance (Adams, 2007; Brill & Pepper, 2008). To date, therefore, it remains a treatment for those with financial means.

In contrast, hormone treatment is relatively less expensive, somewhere between 25 and 75 dollars per month (Adams, 2007; Brill & Pepper, 2008). It is administered either in tandem with the puberty-inhibiting medications for those youth who have already begun a regimen of hormone blockers, or as the only form of hormone-related drugs for youth who could not earlier afford the prohibitive cost of the hormone blockers or for transgender youth who are first considering hormone-altering medications well after the onset of puberty, at which point the hormone blockers are no longer effective to stop the effects of a birth gender puberty. A biological female takes testosterone, a biological male takes estrogen.[1]

[1] It should be noted that the estrogen transgender females take is at doses two to three times higher than the amount recommended for postmenopausal women taking hormone replacement therapy (HRT). This is of particular concern given the potential health risks that have already been flagged for women taking the much lower levels of estrogen used in HRT.

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The drug treatment produces the desired secondary sexual characteristics, including facial and body bone structure, muscle tone, voice pitch, breast growth, increased height, and the growth of facial and body hair (Brill & Pepper, 2008). Those adolescents who do not receive such treatments and nevertheless live a transgender life may undergo numerous surgeries in adulthood (mastectomies, electrolysis, facial reconstruction, and shaving of the Adam's apple, among others) that could have been avoided if access to hormonal treatments during adolescence had been available. They may also find themselves stigmatized by their ambiguous gender presentation in which features of both sexes are still visible and their desire to have the world see them as the gendered-self they are is severely frustrated. As one endocrinologist said to me about his adult transgender female patients, "Let's face it. If they don't get to me by puberty, when I open the door to the waiting room, all I see is Tootsie, and there's not much I can do about it." The hormones are not without side effects or untoward outcomes: increased risk for venous thrombosis and depression for estrogen treatment; increased risk for cardiac stress, cerebral vascular accidents, and polycystic ovarian disease in testosterone therapy (Moore, Wisneiwski, & Dobs, 2003). Fertility is also compromised, and because of the risk factors, life expectancy may be foreshortened. Yet, as one 23-year-old transgender male explained to me, "I know I may be shaving off some years of my life by taking testosterone, but when I considered the alternative of living my entire life miserable and depressed, it was an easy choice." In other words, living a shorter and authentic life that matches one's true gender identity is far preferable to enduring a longer, futile one.

THE TRANSGENDER TRUE SELF

I would now like to explore attaining one's true gender identity with a regimen of hormone-altering treatments through the lens of D.W. Winnicott's concept of the True Self and the False Self. The True Self is the authentic core of one's personality, from which spontaneous action and a sense of realness come. 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 holding on the part of the caretakers, in which the adults allow the child's self to emerge through accurate attunements and reflections about the child's states. The False Self is the part of the personality that accommodates to the demands of outer reality and functions to shield the True Self from annihilation. Within family life, this means that the child, through the False Self, will develop the capacity to comply with the parents' expectations about who their child is and how they expect their child to be. 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, both within and outside the family. 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

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and demands of the environment. The aim here is the preservation of the individual in spite of abnormal environmental circumstances (Winnicott, 1960).

I would like to suggest that a transgender child's experience of gender dysphoria, that is, a sense of alienation from his or her birth sex, correlates with just such a point along the True Self–False Self spectrum. The abnormal environmental circumstances begin with both a medical sex assignment at birth that will not match a child's evolving inner sense of him or herself and a response of the environment thereafter to that child matched with the assigned gender at birth but mismatched with the gender that child feels him or herself to be. Traditional psychoanalytic and gender theories posit that gender dysphoria is caused by parental shaping or environmental experiences, and indeed, we have evidence of cases in which this appears to be so. Yet I am proposing that these cases may be aberrations rather than norms. Particularly with gender variant children, there is ample evidence that in the vast majority of circumstances the child shapes the parent far more than the parent shapes the child. Repeatedly in my clinical interviews with parents and in reports from others, parents describe a history in which their gender variant child just comes to them that way, typically somewhere in the second or third year of life, which is the exact age when children first cognitively grasp the concept of gender:

> 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. (Report from a mother, in Green, 1987, p. 116)

> Even before her son turned two, Sherry Lipscomb noticed that he wasn't like other boys. When she took him shopping, he would go gaga at sparkly dresses. He would toss his baby blanket around his head like a wig and prance on the balls of his feet. (As reported by John Cloud, in "His name is Aurora," *Time*, September 25, 2000, p. 90)

These parental accounts are corroborated by children's reports, at a later age: as long as they can remember, they always felt there was something different about them, and they often call on God, parents, doctors, or fate to fix the mistake that seems so visible to them but so invisible to others. As one little boy told me, "Why can't Mommy put me back in her tummy and make me come out a girl?" Another little boy echoed this longing for gender reincarnation, "I want to die and go to heaven and come back a girl." I would like to suggest that these children are expressing not a wish for re-birth but rather the original kernel of the True Self that has existed since birth, whether as a result of genetics, biochemistry, prenatal environment, or some yet to be explained phenomenon.

In Winnicott's theory, it is the parent–infant dyad that is critical in setting the stage for the expansion of that early kernel of the True Self by allowing the child's spontaneous expressions to unfold rather than imposing the parent's will and personality on the child. The facilitation of the True Self's emergence is accomplished through the process of mirroring – reflecting back to the child the child's image rather than imposing the parent's.

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I would like to situate Winnicott's mirroring within the constructs of gender development. The first designation a child is given upon birth is its sex. This appears to be universally true across human cultures. From here on in the parents typically respond to the child in accordance with their gendered conception of their child. According to Irene Fast (1999), it is not the child, but the parents who hold the child's gender during the first year of life. A newborn or small infant has yet to develop a gendered sense of self. Yet by the end of the first year of life the baby will be in the process of developing a self-identity as boy or girl (or other – in the case of intersex children, for example) as a result of the parents' gender-specific ministrations to the child. What happens if the parents have it wrong? The parents see a child of one gender, typically based on sex assigned at birth, and mirror that image back to the infant. Referring back to the growing cohort of transgender children, as this little child matures, his or her brain sends itself a gendered image discordant with that received from its parents. If the mother or father sees a boy, but the baby sees itself as a girl, there is a mismatch: mirroring has failed. What is the child to do under those dissonant circumstances? A likely outcome is that the child, in conforming to the cultural demands, develops a False Self based on gender assigned and reflected back to the child but not on the gender experienced within. In those cases, the True Gender Self remains unrecognized and unacknowledged while the False Gender Self attempts to comply with these gender-discordant social demands.

So where does the True Self go in this gender-enigmatic situation? According to Winnicott, "[w]hen the degree of the split in the infant's person is not too great there may be some almost personal living through imitation, and it may even be possible for the child to act a special role, that of the True Self as it would be if it had had existence" (1960, p. 147). If we apply this approximated True Self functioning to transgender development, we might find it evidenced in the little male toddler who with consistency and intensity dresses in his mother's jewels and sparkles, or in the little female toddler who insistently wears boy pajamas and adamantly stands facing the potty to urinate, just like Daddy. As early as the second year of life, the child may hold on to his or her True Self by expressing cross-gender behaviors and preferences. These actions will be plumbed from early identifications with parents and observations of culturally-defined gender-specific behaviors, activities, and accoutrements. Such gender expressions on the part of the child will have as their driving force the emerging internal recognition of self as other than the gender that everyone else thinks he or she is – maybe opposite, maybe a gender-hybrid "Prius". As these children grow, they may continue to find compromises in their gender expressions, living in accordance with the sex assigned to them at birth but finding gender fluid combinations in dress, activities, or behavior, or hiding their "true" gender selves behind closed bedroom doors. I would like to suggest that these "compromise formations" are evidence of the False Self, troubled attempts to conform to the culturally hailed sex assigned at birth, allowing the True Self, the gender with

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which the child identifies, to exist as a potential and to be afforded a private, and occasionally public, life.[2]

Some gender variant children are not given this opportunity to partially express their authentic gender identities through imitation, special role functioning, or cross-gender behaviors, either because of cultural prohibitions ("Boys don't play with dolls") or psychological inhibitions ("People will make fun of me if I play with dolls because they expect me to act like a boy"). In that case, the children may find themselves at the most extreme end of the True Self–False Self spectrum, where intense but failed efforts by the False Self to shield the True Self from annihilation may result in the child's desire to die or be destroyed, especially when despair over the True Self never having a chance to emerge becomes unbearable. At this point, according to Winnicott:

> The False Self has as its main concern a search for conditions which will make it possible for the True Self to come into its own. If conditions cannot be found then there must be reorganized a new defence against exploitation of the True Self, and if there be doubt then the clinical result is suicide. Suicide in this context is the destruction of the total self in avoidance of annihilation of the True Self. (Winnicott, 1960, p. 143)

A wish for death of the whole self to avoid living a false life that forecloses any chance for authenticity may be the very experience of the transgender youth confronting the body changes of puberty. In this circumstance the young adolescent may be horrified at the potential decimation of the True Self, the inner gender identity, by the False Self, the gender that presents itself to the world based on (1) the child's assigned sex at birth, (2) the treatment of the environment accordingly, and (3) the emerging inevitable and seemingly unstoppable

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[2] Another way to understand these gender compromise formations involves a synthesis of Irene Fast's theory of gender development (1984, 1999) and Winnicott's concept of potential space (1970). According to Fast's theory of gender differentiation, in earliest life the child thinks he or she can be everything – boy, girl, boy/girl, girl/boy. Then, coincident with the Oedipal stage, the young preschooler comes to the sobering reality that you cannot be both; you can only be one and have to give up the other, typically based on your gender assigned at birth. Transgender and more generally, gender variant children, defy the traditional dyadic categories of gender by continuing to be gender-hybrid, gender fluid, or cross over from one gender to the other. In addition to the organic predispositions that might lead a child in that direction, we might also say that these children are maintaining themselves at the cusp of two eras and two areas of experience – one founded on an early subjective experience of psychologically shaped gender and the other on the "reality-based" understanding of gender located in sex assignment at birth gleaned from body presentation. In that case, their developmental "achievement" is in being able to creatively maintain a suspended state between body (reality) and psyche (fantasy), a place that Winnicott (1970) labeled potential space, hovering between inner and outer and designated as a critical component of a lively human experience. Referring to potential space, Winnicott asks, "Can we gain some advantage from an examination of this matter of the possible existence of a place for living that is not properly described by either of the terms 'inner' or 'outer'?" (1970, p. 106). When we look at gender variant, cross-gender, and gender fluid children, could we not say that this suspended state both evidences and keeps the child's True Gender Self alive?

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markers of a mature post-pubertal (wrong) gendered body. Prior to puberty a child can more easily play at the margins of gender through hair styling, clothing choices, and activity preferences. Except for genitalia, body presentations still remain fairly androgynous. Clothes may make the man, but may not be enough to allow a young child to continue to live in the gender with which he or she identifies once puberty sets in. When the clothes come off, and even with them on, the young adolescent is left with the reality of new indelible and highly visible gender-specific body presentations that may forever imprison him or her within the False Gender Self. To understand what that might feel like, imagine waking up one morning to find that an elephant trunk had grown where your nose used to be and that was to be the body with which you were to spend the rest of your life. The horror of such an imaginary body transformation can be likened to the actual dread and panic described by transgender youth when confronted with unwelcome facial hair, breast buds, and so forth. To quote Winnicott, "Whereas a True Self feels real, the existence of a False Self results in a feeling unreal or a sense of futility" (Winnicott, 1960, p. 148). It is my assessment that this exact sense of futility and unreality leads some transgender adolescents to contemplate or even attempt suicide as they helplessly watch the seemingly unstoppable advent of an unwanted puberty, which for them marks the death of any chance for the True Gender Self to emerge.

Dr Norman Spack, director of the Clinic for Gender Variant Children at Children's Hospital Boston, Massachusetts, is a proponent of the use of hormone blockers and cross-sex hormones for transgender adolescents to allow them to live in their "correct" gender, the one with which they identify, and reports that of the 200 adolescents treated at the clinic with these drugs, not one later regretted his/her choice (Adams, 2007). In support of hormone treatments for transgender youth Dr Spack said on National Public Radio: "You start to realize what's really important in this world. . . . And I don't think there's anything [more important than] . . . who you are" (Spiegel, 2008, p. 5). If the True Self can be equated with "who you are," and if we apply the authors of *The Transgender Child's* definition of gender identity as "a person's internalized deeply felt sense of being male, female, both, or neither" (Brill & Pepper, 2008, p. 4), we can accurately say that drug treatment for transgender youth is a facilitator of health in which the False Self recedes and the True Self is allowed to flourish in living a gender-authentic life.

There is one caveat, however, in considering this prescription for gender health. When a child or youth expresses cross-gender preferences and identity, how are health and mental health providers to discern that this is actually an expression of the True Self rather than a manifestation of gender confusion or gender chaos? When distressed gender variant children want to call God for help, they are actually dialing the wrong number, and should instead have their parents phone a gender specialist. At the same time, gender specialists should not be in the position of playing God. As in any situation of attempting to reliably predict adult outcomes from child experiences, we must be humble enough

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to recognize that we can never know for sure if a child who says he or she is transgender is expressing a stable, permanent lifelong identity. When a particular boy says he is a girl or a particular girl says she is a boy, that child may simply be on one leg of a long journey with twists and turns that could have any number of authentic outcomes, only one of which would be a transgender identity. A cross-gender preference on the part of the child may be a manifestation of some other internal turmoil having nothing to do with gender. Further, is it ethical or psychologically warranted to skew a child's evolving sexual body with hormones or hormone blockers before that child has had an opportunity to explore his or her sexuality within the body that has housed him or her since birth? Lastly, there is a larger existential question: Should it be the role of the health and mental health provider to change or support the change of a young person's embodied self rather than help that individual accept the body given at birth?

To answer the first question – discerning the True Gender Self – protocols are being developed and clinical observations synthesized to offer guidelines to discriminate gender clarity from either gender confusion or gender chaos. Although not an exact science and certainly open to human error, these measures have been reported to be accurate in screening youth for evidence of a stable and cohesive transgender identity prior to embarking on any medical interventions (Spiegel, 2008; Cohen-Kettenis & Pfäfflin, (2003). I also mentioned earlier that if one really listens, with an open clinical ear, the children themselves will tell you. The transgender children provide a consistent narrative over time in which they report that their real self is not determined by their genitalia but how they perceive themselves – a girl in a boy's body or a boy in a girl's body. The child suffering from gender chaos generally has no such cohesive narrative. For example, one youth I see in weekly psychotherapy changes his gender narrative from session to session: one week he is "transy"; the next week "gay"; the next week "bi"; the next week "gender queer"; the next week a "fem heterosexual." Internally his gender seems to exist not along a spectrum (to which I referred earlier) but rather more like being stuck in the spin cycle of a washing machine.

When children with consistent and cohesive narratives about their gender are allowed to match their gender expression with their inner gender identity, they relax and appear better regulated in most if not all aspects of life. This has important diagnostic implications. If prohibited from matching their gender expression with their inner gender identity, they become agitated, depressed, or even suicidal. The same does not appear to be true for the child suffering from gender chaos or confusion, who sometimes appears even more agitated, rather than less, if allowed the opportunity to express him or herself in a cross-gender way or to change gender identity.

To underscore both the ethical and existential dilemmas related to drug interventions for transgender youth, consider the reflections of Peter Lee, a professor of pediatrics. He came to understand the ethical correctness of moving forward with medical treatments for transgender youth upon recalling an

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experience two decades earlier, when hormonal treatments were not available for patients under 18. A biological female, self-identified as a male, came to him in late adolescence with "so much pain and agony in her development in the 'wrong direction' that she later committed suicide" (Booth, 2008).

Lastly, in response to the concern about artificially altering the progression of a child's sexual development before the child has had the opportunity to fully explore his or her sexuality, I would raise the opposite concern about denying a youth his or her sexuality if culturally obliged to live with the post-pubertal body that matches birth gender but not gender identity. Suspending an adolescent in a protracted period of gender dysphoria in which he or she is forced to live with the realities of a distressing and repudiated pubertal "not-me" body may become an identity disruptor in which the youth, defensively attempting to preserve the True Self, remains arrested in a latency, pregenital, or asexual state, blocking any opportunity to explore adolescent sexuality within the identity that feels correct, true, and authentic – the Transgender Self. That was precisely how Sam experienced life before becoming Sammi at age 16.

CONCLUSION

The rates of depression, suicide, and hate crimes are higher among transgender youth than in the general population as a result of social stigma, familial aspersion, and internal turmoil when one's gendered body and brain are out of sync with one another. Playing with nature by switching the tracks of an individual's physical gender development through drug treatments or surgery admittedly generates anxiety in all of us as it challenges the heretofore basic premise that one's biological sex is immutable bedrock in the human condition. Yet it should not be the stance of the psychoanalytic community to therefore dismiss this approach to transgender experience but rather analyze our own discomfort and evaluate the limitations of our own theories in the face of these children's needs. As clinicians, it is not for us to bend twigs, but to recognize when a twig has been unwittingly twisted and help get it untwisted. With that said, I began this paper with an answer and I would now like to finish with two questions. If a course of drug treatment can significantly reduce extreme risk factors for transgender youth, why wouldn't we? If a goal of development is to allow the True Self to unfold and a drug treatment proves instrumental in facilitating that process for transgender youth, why wouldn't we?

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