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RESEARCH ARTICLE

A "hard question": Gender affirming care and gender distress in a social world

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Abstract

Gender affirming care for youth is currently under political attack across the United States. Critics of affirming care often leverage a biological and fixed notion of gender as assigned at birth, which is at odds with how gender has been theorized academically for decades. Yet for some feminist clinicians, the popularized version of SOCIAL CONSTRUCTION present within rhetoric about the purpose of affirmative intervention also seems to undercut the legitimacy of care. In this article, I track how the difficult problems of the origins of gender itself, problems seemingly exposed by the invocation of the SOCIAL CONSTRUCTION of gender, are managed within the field of gender affirming care. I show how by drawing on the narrative power of very young gender expansive people, and by orienting clinical care away from identity towards DISTRESS, medical providers can align themselves both with feminist desires to change how gender ideology functions in the social world, and with the need to provide interventions that allow youth to embody the gender they desire.

INTRODUCTION

Rita is about 15 years old when I meet her for the first and only time in the exam room of Dr M, a pediatric and adolescent doctor who specializes in transgender medicine. The appointment is not Rita's first, nor will it be her last; rather, it is a regular part of her care, as she decides, in conversation with her guardians and providers, what kinds of medical interventions are right for her and when the right time to try them might be.

Rita seems close with her Mom, who is here with her today. They make jokes to each other that Dr M and I only smile blankly at. Near the beginning of the appointment, Dr M and Mom start discussing how now that Mom has a trans daughter, she thinks about gender differently.

Mom says to Dr. M,

'Gender is a SOCIAL CONSTRUCT.'

Dr M muses back,

'is it, though?

It's a core part of the self. But it can't express itself in a vacuum.

It's irrelevant –

but it's totally relevant.'

With a small smile, Rita interjects, to say

'You're both TOO OLD.'

The question of the SOCIAL CONSTRUCTION of gender is inescapable in the world of gender care, much as it is inescapable in the world of feminist theorizing. In this scene, Dr M[1] shows her ease at negotiating this question, which is as common in her professional life as the clinical director of a gender identity clinic as it is in my life teaching gender studies. In many ways, Dr M is far more practiced than I at negotiating the complicated, contradictory views on gender that her patients, their families, and her professional colleagues often present; in other words, the gender she describes as "irrelevant" but "totally relevant" to the practice of medicine.

While Dr. M and Rita's Mom might have been satisfied to speculate for hours about the meaning of gender itself, the reason for their engagement with the concept is, in this case, a "speaking subject" (Stryker, 1994)—one that interrupts their speculation, and dismisses both the question, and the askers, as TOO OLD. I take Rita's interjection to be a form of critique (perhaps a complaint [Ahmed, 2021]) against upholding a culture which uses trans people to perform theorizations of gender while neglecting their material conditions and political circumstances (Namaste, 2008). In the clinical space, her teasing redirects our attention, changing the scene from one where adults speak about young trans people to one in which those same youth challenge the frameworks they have been handed to make sense of their lives.

Rita's comment has stayed with me, shaping how I have approached the perennial curiosity about the etiology of gender identity, and the perpetual struggle over what, exactly, gender affirming care should treat, as related ethnographic phenomena. In this article, I describe how

the popularized theory of gender that SOCIAL CONSTRUCTION often indexes is one that has material implications for the way that gender affirming care is made sense of and provided. Mostly simply, the invocation and recitation of SOCIAL CONSTRUCTION usually carries an unspoken critique along in its wake—if gender is a social category, why should it be treated through medical means?

I show how the threat this critique seems to pose to the medical treatment of gender has been managed in the field in two overlapping ways. First, I describe how providers look towards the past, and the existence of very young trans people as key figures which enable a more essentialist view of gender identity. This is a view which even feminists committed to SOCIAL CONSTRUCTION of gender can embrace, despite how it seems to contradict prior understandings. Next, I show how the focus on treating gendered DISTRESS—the broad name for the constellations of thoughts and symptoms that likely brought someone like Rita into the clinic in the first place—over gender identity, theoretically enables medicine to offer affirming care without directly concretizing gender categories. The focus on DISTRESS also shifts attention to the future in moments where a patient's history of gender seems less clear. For adolescents, especially those who may not have had a clear trans identity in childhood, their trans futures are secured not by an appeal to their infancy but by attending to how their experience of their assigned gender causes DISTRESS. Yet as I argue, even this experience is haunted by the circulation of questions about the relationship between DISTRESS and current social expectations of how one should look, behave, and live in accordance with patriarchal and heterosexist norms.

Living as a gendered body with a gender identity that does not match it is largely understood to be the source of DISTRESS that gendered medicine attempts to treat. In a very simplified manner, there are three locations which intervention could target as a way of ameliorating this DISTRESS.

$$\text{gender identity} \neq \text{gendered body} \rightarrow \text{DISTRESS}$$

$$\text{gender identity} = \text{gendered body} \rightarrow \text{No DISTRESS}$$

The first point of intervention could be gender identity itself, which is the goal of reparative therapy that attempts to align people with the gender they were assigned at birth. This care has been explicitly banned in some places and is, at the very least, considered to be harmful by most medical institutions[2]. The alternative to reparative care is affirmative care, known as such because it affirms identity; that is, this is a model of care which does not take the identities of youth as a place for intervention. Instead, most care takes up the gendered body as that which can be changed. But the last place that could theoretically be a place for intervention is the sense of matching itself, which, for constructionists, stems from the social world, and the social expectations that give most individuals the sense that the gender identity they hold aligns with the body they inhabit.

Mapping out the different ways that interventions find their objects matters, especially given the history of the medical treatment of gender. Historians have argued that as a concept, gender developed to legitimize and stabilize sex. Starting in the 1950′s, clinicians and scientists were increasingly made aware of how sex categories were less binary and less coherent than imagined, causing them to look for further interior sources of sex differentiation (eventually settling, for a time, in genetics [Richardson, 2013], though neuroscientific explanations are also increasingly popular [Wang, 2022]). In the cases of the treatment of intersex and trans people, the concept of gender rose to prominence in part because it validated medical experts' desires to reinforce normative identities that aligned with social expectations;

expectations which some experts argued were more critical than any biological characteristic (Gill-Peterson, 2018; Meyerowitz, 2009).

Scholars have broadly argued that medical institutions function as normalizing and regulating forces (Canguilhem, 1978; Foucault, 1977), which historians have shown to be especially apparent in the case of gendered medicine (Gill-Peterson, 2018; Repo, 2015; Meyerowitz, 2009; Velocci, 2021).Yet rather than re-articulate the clinic as a "technology of inscription" (Stone, 1992), here I argue that the contemporary treatment of gender reveals ongoing negotiations about the social significance of gender identity and the relation such an identity has to gender as it is materially enacted and embodied. Clinicians in my fieldwork often knew and critiqued the medical history of treating gender. Many of them were also deeply impacted by the interventions of a lineage of feminist scholars who used the concept of gender to make the case against using essentialism, particularly biological essentialism, to justify the oppression of women. These clinicians were therefore disinclined to see gender as a biological category, and yet also found themselves wary of how appeals to SOCIAL CONSTRUCTION might be used to further disenfranchise trans people.

Questions about what impact an understanding of gender as social should have on the practice of gendered medicine, therefore, resist any easy resolution, and instead, must be taken as a part of the conditions which set the terms upon which gendered medicine can exist. My intention here is not to adjudicate SOCIAL CONSTRUCTION as a theory, but instead, trace how medical providers operate within a context shaped by the polarization of gender as either SOCIALLY CONSTRUCTED or biological. I do so because despite Rita's critique—that this circular obsession with what gender *is*, is simply, TOO OLD—it is far from abstract. Access to gender care is being stripped away across the United States. Globally, fascists gathering under the banner of feminism are allying with those attempting to protect normative gender ideology in myriad attempts to eradicate the possibilities for transgender life. Understanding these dynamics is a necessary part of building new ways of justifying and evidencing the value of affirmative intervention—ways built not from a desire to settle the meaning of gender once and for all, but instead, shored up by commitments to bodily autonomy—and by an understanding that the social world is always coterminous with the material one. Only then might we be able to adequately theorize how protecting the right to change how gender is embodied is a necessary part of any possibility of re-signifying gender itself.

"SOCIAL CONSTRUCTION" AND SOCIAL CONSTRUCTION

The concept of SOCIAL CONSTRUCTION that Rita's Mom and others like her invoke in the clinic does not neatly track on to a specific theoretical body of scholarship. Rather, I use small capitals in part to distinguish the use of SOCIAL CONSTRUCTION in its casual, unelaborated form from the specific theories and theorists of "social construction"[3]. Even though the power of SOCIAL CONSTRUCTION in the clinic and in popular discourse draws from its relation to "social construction" in the academy, here I allow the concept to remain "black-boxed" (Latour, 1999). That is, I draw attention to how the invocation of SOCIAL CONSTRUCTION often grants stability and coherency to the concept, rendering it already known and agreed upon.

Within the academy, social construction is used in widely varying ways, as the philosopher Ian Hacking (1999) has shown. Hacking argued that claims about social construction are generally used to show up to three things about an object or concept *X*: "*X* is not inevitable"; "*X* was a bad thing" and "the world would be a better place without *X*" (p 19). These purposes are generally implicit, rather than explicit. Furthermore, it is not always necessary for these purposes that the object or concept *X* be consistent across its uses, which is certainly the case when it comes to the relationship between gender and SOCIAL CONSTRUCTION. Along with

the three claims above, invoking SOCIAL CONSTRUCTION in the world of gender affirming care might index political liberalism, a feminist history, a criticism of medical power, or an understanding of gender itself as malleable, culturally dependent, and most definitively, not biologically predetermined. Yet in most instances, it remains impossible to identify exactly which aspect is intended by the speaker, and which is taken up by those who overhear.

Gender is a SOCIAL CONSTRUCT

- Rita's mom

Rita's mom makes such a statement because "social construct" holds such a central role in conversation about the meaning of gender in her particular social world. Yet, the focus on "social construction" as the ur-theory of gender has a tense history within the study of transgender medicine. The academic lineage of social construction is a way of seeing gender that makes clear the ways that "woman," especially, is a category linked to forms of social oppression (Haslanger, 2000, Rubin 1975), and is linked in the social sciences to the ethnomethodologists of the 1970's (Kessler and McKenna 1985), as well as to sociologists West and Zimmerman (1987) notion of gender as "doing" and later, Judith Butler's (2006) repurposing of the linguistic phenomenon of "performativity" to understand the meaning of gender and sex as rendered through repeated citational acts, where interiority is a fiction created through the actions which take it to be so.

In many instances, scholars have read transgender medicine as mistakenly reinforcing normative gender values and regressive political ideologies, and thus reduced the meaning of trans identity itself to the interventions which provided trans embodiment (such as in Hausman [1995] and Raymond [1980]—see Bettcher and Garry [2009] for further discussion of this lineage). The anthropologist David Valentine (2012) has argued when academics question the legitimacy of gender affirming genital surgeries by asking after the "politics of *that*," they problematically erase the agency of the scholar from the practice of determining agency itself, as well as re-naturalize the normatively gendered body. That is, he demonstrates how, by focusing on trans people's choice to pursue genital surgeries, the responsibility for the entirety of the sex-gender system becomes rhetorically displaced onto already over-burdened trans people. Choice becomes legible only in the context of trans embodiment, and the many actions cisgender people take to sustain their own gendered legibility within social worlds (including *not* pursuing genital surgery) are naturalized as outside of both politics and gender ideology. This, despite the fact that it is primarily the choices of cisgender people, the vast majority, which do the most work to uphold and maintain structures cultural notions of gender and sex.

Feminist anthropologists have also provided insights into the ways that inequality embeds into gender systems across cultures (Ortner 1972, Strathern 1988), and done critical work to expand our sensibilities towards what gender could be. When it comes to investigations of the gendered "other," offerings from anthropological perspectives have typically been taken as providing evidence for one of two claims. The first, that gender is highly culturally specific, as showcased through ethnographies of Indonesian waria (Boellstorff 2004), Thai toms (Sinnott 2004), or Brazilian travesti (Kulick 1998), among many others. The second orients towards the near-universal existence of gender categories other than the expected Western binary of male and female, sometimes drawing upon the historical and archeological record to make claims that transgender identities have "always" existed (Everhart, 2022). However, these claims have not been enough to substantively impact the way that theories of "social construction" are often seen to theoretically delegitimize individual claims to gender identity. Nor have these anthropological perspectives effectively disrupted the ways that gender is often re-binarized

as either rooted in biological systems— which medicine would be appropriate to treat—or social ones; where treatment through medicine is at best misguided, and at worst, to blame for sustaining problematic gender ideologies.

In my work with gender affirming care for youth in the United States, I encountered the ways that arguments about the social nature of gender seemed magnified in the presence of childhood and adolescence. Recent scholarship has described the ways that race and privilege shape how trans youth are able to access spaces and care (Travers, 2019), how parents shape youths' gender experiences (Meadow, 2018), and questioned how Western medicine interiorizes gender as a part of the self (Sadjadi, 2019). In public conversation in the United States, trans youth have become emblematic of larger concerns about the solidity of gender itself, as well as gender as a social category. Gender affirming care for youth is therefore a site where negotiations about gender happen in both abstract and concrete ways—and where those who provide or receive care often attend to the ways that doing so requires reassessing their own understanding of the meaning of gender.

"THIS DIDN'T DEVELOP": GENDER AND SOCIAL IDENTITY

"I'm probably like more essentialist than like your average feminist" said Ingrid, an academic research psychologist, in an interview with me about her work. Ingrid has decades of experience analyzing, constructing, and implementing gender measures that attempted to understand and justify the use of gender affirming interventions. She was not the only one who explicitly invoked a "feminist" understanding of gender when describing her understanding of gender in relation to her work. Sarah, a clinical psychologist several states away, also told me about how she "had always identified as a feminist," telling me, "really probably for a while, I really thought of gender identity as being totally socially constructed."

For Sarah, as for Ingrid, they position their theoretical and "feminist" understanding of gender in partial contrast to the understanding of gender they have developed doing gender affirming care, particularly, interacting with very young gender expansive people. Despite being a clear minority of the patient population, as exemplary cases these youth stand out in popular narratives (consider Jazz Jennings, first made famous at 6 years old by her 2013 interview with Barbara Walters), and in the field itself. Take Jenny, whose mother and I talked on the phone after we had met one day in clinic. Jenny's mother told me how before Jenny was even 5 years old, she had used an old camcorder, a relic of her parents she liked to play with, to record herself asking to be called girl, not boy.

> [Jenny] brought it to me in the morning and said 'I want you to watch something really important'. And then she ran off and hid. So I watched the video and she came back and said, 'do you see why it's important?' and 'I said, I do honey'. I said, 'I do'. I said, 'do you, are you feeling like you want to be a girl?' And she said, 'no, I am a girl, I am a girl'. And I said, 'Oh'. I said, 'well, you know boys can wear whatever they want to, and like girly things', and then she said, 'but I'm not a boy'. And I said, 'okay, okay'. So at that point I was like, [she laughs a little] I had never heard of, you know, like a child that young expressing any sort of – anything like that.

This became the last in a string of events that, taken together, indicated to her parents that "something" was going on. But even though they weren't surprised at her wanting to be "called girl," based on her tastes and interests, they still weren't sure what to do with this admission. So, they went to the place they hoped would have answers—the doctor's office.

The "Littles," as patients like Jenny were often called, are often centered in narratives that attempt to protect the legitimacy of gender affirming care from the rarely spoken, but often implied critique that medical intervention for gender merely concretizes and biologizes a category, gender, which should not be. Although neither Ingrid nor Sarah outright describes the way that their previous understanding of gender may have come hand in hand with a critical stance towards the way that affirmative care was provided, their way of telling their personal history in the field shows the ways that such a theoretical understanding of gender could limit their ability to see the importance and legitimacy of the work that they now do.

Ingrid, who trained in adolescent development psychology, told me how she always thought that "like sexuality," knowledge of gender—if it was different than the gender one was assigned at birth—would be formed in the teenage years, by way of experimentation and experience (neither of which are associated with prepubertal youth.). At the same time, Ingrid admitted that she didn't really think too hard about these young people until they appeared at one of her first focus groups. She went on to tell me about two youth, with similar narratives: how they started carrying "boy" clothes to school and changing on their way, how their teachers called home asking after "your son" only to be correct to "my daughter", but most importantly, how these children were happy when she met them. She told me, "… meeting those two kids was just eye-opening for me. Ok, these two kids had gender, this didn't develop as an identity, this is something that was just there. And then it was expressed. It was well before anyone was really talking about publicly, in the United States, really talking about identity that way."

As Ingrid went on to say, "even though I'm like incredibly feminist in my thinking… I think because of my work with trans stuff I feel like a lot of gender is like, people bring it with them, when they're born, I just hear that so much, that I can't, I can't think that it's not true… that there's not some truth to it. That some people are just physiologically, they just act, in a more masculine and feminine ways." She laughs, and tells me, "I guess I've just seen too many two-year old's, like [laughing] you know, there's just no way that there not some element of that that comes from the body, right?"

When Ingrid invokes the notion that "people bring [gender] with them," part of what she constructs is an origin story of gender identity that roots gender in the body. Whereas Ingrid sets this feeling apart from her own "feminist" training, many theorists, particularly those in Britain and France, have argued for gender as an essential sense of self, as something which precedes social and cultural experiences[4]. Yet unlike those who now co-opt aspects of these theories to insist that trans people, especially trans women, should be excluded from any gender except the one they were assigned at birth, Ingrid cultivates a vision of gender that is essential enough to be clinically used to support young people's access to gender affirming interventions. That is, by seeing gender as something that comes "with" a person, rather than something that "develops" through social interaction, Ingrid protects youth from the pressing clinical concern that gender identity in youth is something that might change—-specifically, that may revert to their gender assigned at birth (see Steensma et. al, 2013; Steensma and Cohen Kettenis, 2018; and Temple Newhook et. al, 2018 for more about the persistence and desistance debates). The Littles, therefore, become intensely important narrative figures which help legitimize early intervention through the embodiment of an origin point for gender, one that can seem less socially influenced than claims made by older children and adolescents.

In my clinical observations, only a handful of patients I met were under the age of six or seven. But like Ingrid, I sometimes felt that what I learned from them was qualitatively different than what I would learn from teenagers, who were often sharply articulate about how things like INTERNALIZED MISOGYNY might be shaping their gendered desires, and

questioned if medical intervention would truly ease their discomfort. The Littles, on the other hand, might be accompanied by parents with similar concerns, but would not express such needs themselves. Instead, young people like Riley, whom I met in clinic with Dr M, often expressed their investments in embodying gender directly, and with little concern for finding the sources or explanations for their desires.

When I met her, Riley was in Dr M's office and becoming impatient with her parents' recital of her gender history. After 10 or 20 minutes of watching her get increasingly fidgety, I gave up writing fieldnotes and quietly sat down on the floor. It felt a shame for a family that had crossed three state lines to be here, after months of waiting, to split their energy between watching a bright and busy 4-year-old and talking through a vast set of anxieties about their kid and her future. From my current position, I could help with only one of those things.

Riley had already unwrapped a handful of new toys, selected from a substantial box that Dr M kept for this purpose. Still, it isn't much fun to play with yourself. Boxed in by the knees of her parents on one side and those of Dr M on the other, I quietly took one long piece of green waxed string, curling it up into a spiral with a little tail. Underneath the clouds of PUBERTY SUPPRESSION and HER BATHROOM ISSUES and WHEN WE TOLD MY PARENTS, that hovered above us, I say to her, in a low voice,

look.

it's a snail.

Riley likes this, so I make her glasses, a bicycle, a tightrope to hang things from, all out of the flexible, waxed string in muted yellow, purple, blue, red.

can you make me another one?

sure.

I fold one end of the string in tightly and begin to roll.

do you want to try it?

We half-whisper to each other, with lint gathering on my pants and my loose shirt, the one that masks some of my own gendered attributes, and likely contributed to some earlier confusion. After Dr M had disappointed Riley by saying that she "doesn't actually make vaginas", Riley had asked, "how does HE do it?" looking at me, while I wrote furiously and missed the question entirely. Dr M had laughed, told Riley "HE is not a surgeon either!" and, "you know, it's NOT A VAGINA THAT MAKES YOU A GIRL."

now you have no eyes!

and you have to answer a hard question!

oh!

I close my eyes. One of the ropes has caught the bicycle. To free it, and regain my sight, I have to answer Riley's trick question. She makes them up on the fly, seemingly pulling from what is around her to recreate something that sounds familiar.

> what has …. is round and has three legs and is a door?
>
> a lunch box?
>
> ye-es! alakazam…

She waves her wand, also made of waxed string

> now you have eyes again!

This game Riley and I play on the floor is an ordinary kind of "worlding" (Haraway 2013), a term I use to connect these "string figures" to the many other forms of SF—science fiction, speculative fabulation—that offer ways to theorize possibility. This also lets me read Riley's game, which plays on some of the tropes present in the clinic, as a space of imagination as well as enactment. Riley takes my eyes, and gives them back, if only I can provide the correct answer. Lucky for me, she wields her power benevolently, but the game mimics to me the ways that our "hard questions" about gender are impacting her capacity to envision the future with the body she wants. Where the reminder that IT'S NOT A VAGINA THAT MAKES YOU A GIRL sits as a representation of the SOCIAL CONSTRUCTION of gender, but the desire to "have a vagina" nonetheless remains.

Riley wants to know how to make a vagina, but Dr M, and Riley's mom, want to make sure she knows that "being a girl" isn't tied to her anatomy. Within the field, Riley's desire both functions as evidence for something beyond socialization that creates desire for certain gendered recognition, as well as troubles some other (especially adult) desires to make gendered experience available to more people, regardless of their anatomy. It also complicates the form of "trans therapeutics" that others have described. For example, anthropologist Eric Plemons (2017) has described in his work on facial feminization surgery, where the visible traits of the face are prioritized over the largely invisible genitalia, and where gender transition is taken as successful when individuals are able to be recognized as their gender in daily life. But what really concerned families and providers I observed was not where on the body gender was located, and what bodily trait was targeted for intervention, but the fact that the body was the primary site of intervention at all. For example, as Sarah put it,

> you know, that just that whole argument of 'if society was more accepting of, you know, men doing more feminine things and women doing more masculine things,' like would people feel that need to be transgender, you know, people still, bring that up. Definitely like in the early, early days, [I had to] grapple with that a little bit just because I'd come from such a feminist perspective, like sort of like gender being socially constructed and 'blah, blah, blah, whatever.'

By tying in her own early views, ones she comfortably understands as "a feminist perspective," Sarah illustrates the tension between what gets captured by SOCIAL CONSTRUCTION and the desires of youth seeking to reshape their bodies in gendered ways. This tension, though difficult, is also what produces the narratives which justify and explain contemporary

gender affirming care for youth. Some clinicians and advocates see commitments to the SOCIAL CONSTRUCTION of gender as potentially harmful because it is assumed that if SOCIAL CONSTRUCTION indeed reveals the absence of a bodily truth of gender, then bodily treatment of gender is both inadequate and inappropriate. Thus, the "Littles" emerge as evidence of a more "essential" gender nature, one legitimately met by supportive biomedical intervention.

Not only does the tension between SOCIAL CONSTRUCTION and the desire for gendered embodiment often push providers into rethinking their carefully held beliefs, but it resonates with the diagnostic and clinical changes that have shifted what gender affirming care is meant to treat. Most affirming providers I met openly criticized the ways disciplines like psychiatry historically worked to normalize gendered embodiment and behavior. It is unsurprising then, that in the last decades while this impulse nonetheless persists, there have also been substantial revisions to how gender care is justified outside of simply maintaining hegemonic gender categories. One of the most meaningful ways this has happened is through the shift in the object that gender care treats, from the category of gender itself, to the feelings of DISTRESS associated with experiencing oneself as a gender in a social world that does not recognize you accordingly. In this shift, and in the negotiation over what it means for the field to focus on the category and necessity of DISTRESS, the relationship between gender and the social world once again become difficult to categorize. Here, instead of the origin stories possessed by the Littles that ground gender as legitimately treated by medicine, it is the quality of experienced DISTRESS.

FROM IDENTITY TO DISTRESS

In the narratives I have just shared, the Littles are emblematic of an idea of gender that "doesn't develop" but which is "just there," and which protects them from the threat SOCIAL CONSTRUCTION and seems to pose to the medical treatment of gender. But even so, many clinicians are loathe to contribute to the solidification of gender norms, many of which are unequally felt to be problematic, especially in children, and tend to re-entrench femininity as a problem more than mere gendered misalignment (Sedgewick, 1991). As Dr M was fond of saying, NO ONE IS RUNNING TO THE DOCTOR BECAUSE THE CHILD THEY THINK IS A GIRL WANTS TO WEAR PANTS.

Some feminist clinicians, especially those sensitized to see gender through the lens of SOCIAL CONSTRUCTION and with an eye towards gender inequity, regularly critique how diagnoses related to gender identity are often linked to the performance of gendered expectations—that boys should like "rough and tumble play" (American Psychiatric Association, 2013) and girls should be drawn to dresses and dolls. The inadequacy and normativity of these expectations is often what gets captured by the gloss of SOCIAL CONSTRUCTION. The field has also become more explicit that expansive and trans gender identities are not themselves pathological, but rather a normal part of human diversity (Cuypere et al., 2010; F. Beek et al. 2016). This makes clear that being trans or gender expansive is not necessarily wedded to medical intervention. Instead, what medical professionals have become increasingly attuned to is the way that intervention should be aimed not at treating or consolidating identity itself, but at treating the DISTRESS that can accompany gendered misalignment.

This change is apparent in the 2013 revision of "gender identity disorder" to "gender dysphoria" in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association). Though many social gender expectations remain central to the diagnostic apparatus, especially for youth, the revision revealed a growing need for the field to grapple

with an uncertainty that I suggest is resonant with the uncertainty introduced by academic attention to SOCIAL CONSTRUCTION. By establishing that it is not gender identity which is being corrected, but rather clinically severe DISTRESS, a space opens for medicine to participate in the *de*-pathologization of gender diversity without forgoing the necessity of gendered medical intervention.

Yet not all institutional orientations towards DISTRESS were the same, which was especially clear during negotiations between insurance and providers about the necessity of intervention. Although such negotiations often happened behind closed doors and through months of email and fax exchanges, they were also commonly referenced during the staff meetings I regularly attended.

During one weekly meeting, Dr M sets her glasses in front of her on the table, as she reads aloud, palpably irritated, from a denial she recently received on behalf of a patient seeking coverage for facial feminization surgery.

> …our reviewer has determined your features are within the normal range for females…

Others around the room started to grumble under their breath, raising the importance of

> mental health need

Rachel, a therapist and social worker, says DISTRESS under her breath. A doctor, who may or may not have heard her, more loudly repeats that

> WPATH says it's really about DISTRESS.

The conflict exhibited here is both about what gender affirming interventions should produce (a "normal range" of features or a reduction in DISTRESS[5]) and over whose authority should be followed. For while insurance companies in the United States hold immense power in determining what procedures are actually available to patients, drawing upon many different resources to make their determinations about medical necessity, Rachel and others at the table cite the importance of the World Professional Association for Transgender Health, commonly known as WPATH, as the more relevant experts.

WPATH is the current iteration of the organization founded in 1979 as the International Harry Benjamin Gender Dysphoria Association, and it is most well-known for the collective authorship of the "Standards of Care for the Health of Transgender and Gender Diverse People" (SOC) (Coleman et.al 2022, WPATH, n.d.). Currently in its 8th version, the SOC is a contentious document, in turn critiqued, looked to, and ambivalently adopted (shuster, 2016). The SOC itself does not provide a diagnosis. Rather, there are two main diagnostic standards used in transgender medical care—the DSM, and the International Classification of Diseases, put out by the World Health Organization (n.d.). What WPATH-along with many other advocates and professions- has done is question whether gender affirming care needs to be justified through an appeal to a diagnosis at all. WPATH weighed in on this issue of diagnostic necessity most visibly during the development of the DSM 5, when working groups suggested that "gender dysphoria" be used in place of "gender identity disorder" as "the diagnostic criteria should focus on distress, not identity" (Knudson et al., 2010, 116)—despite the fact that DISTRESS itself is a highly ephemeral, vague category, and that a separate working group questioned the clinically utility of a DISTRESS requirement given the difficulty of recognizing if the source of DISTRESS was internal gendered misalignment, or some other external factor (Bouman et al., 2010).

This is both continuation and return to the dynamic which has plagued experts attempting to clinically capture gender. The very first published Standards of Care defines "gender dysphoria" as "that psychological state whereby a person demonstrates dissatisfaction with their sex of birth and the sex role, as socially defined, which applied to that sex, and who requests hormonal and surgical sex reassignment" (WPATH, 1985). This initial definition centralized the request for intervention as a key marker of the experience while also including an understanding of the sex role as "socially defined".

DISTRESS continues to emerge in moments where provisions and standards attempt to articulate what, exactly, about being trans is inherent. In the 2022 SOC guidelines, in a section entitled "Diversity versus Diagnosis," the SOC notes that symptoms such as psychological distress "are socially induced and are not inherent to being TGD [transgender or gender diverse]." (S7). This aligns with the current ICD-11 classification of gender incongruence, which makes no reference to DISTRESS as a necessary experience for receiving gender affirming care. Both claims make apparent a growing professional consensus that being trans should not be considered to inherently cause DISTRESS, and that gender identities themselves do not need clinical treatment. Rather, it is embodying gender within a gendered world that can create DISTRESS, which is treatable through clinical and medical interventions.

Despite these clarifications, in the absence of an etiological explanation for gender which concretizes identity as a pre-social, essential characteristic, DISTRESS often continues to be used to distinguish between those for whom gender affirming interventions are indicated, and those who should not receive them. Especially when navigating the uncertainty of the future, DISTRESS was considered a necessary component of the DSM-5 diagnosis. As the WPATH subgroup tasked with reviewing the DISTRESS criteria described, requiring "severe" and "persistent" DISTRESS as a prerequisite for treatment will lower the risk of treating patients who may come to "regret" intervention in the future (Bouman et al, 2010, p. 104), despite any evidence that this is the case.

While some clinicians may look to the Littles to find a version of gender that escapes the critique that affirming interventions merely concretize a flexible aspect of social life, in the absence of such a story the experience of severe and persistent DISTRESS helps to make the future seem more predictable. DISTRESS both provides an alternate object for gender affirming care to treat, one which can be resolved (unlike gender itself) while also providing an additional form of evidence that that individuals will hold their gender identity into the future. Diagnosing and treating DISTRESS itself, though, suffers from many of the same difficulties as diagnosing and treating gender. Rather than resolve these difficulties, treating DISTRESS has seemed to repackage the same concern with what can, or should, be treated—in other words, the self, or the social world.

BEYOND DISTRESS

While the diagnostic centering of DISTRESS over gender itself has seemed to displace some of the concern with *what* is being treated in the course of providing gender affirming care, the current focus on also recognizing DISTRESS as not inherently a part of a trans experience but rather a condition of living as trans in a social world, once again surfaces the old questions about how medicine should be seen to intervene upon inequitable social forces. Not only was this dynamic apparent in the standards of care, but during my fieldwork observations with a large clinical research study as well as at interdisciplinary conferences.

The study—a multi-sited, longitudinal investigation into the impact of early medical intervention for youth such as puberty blockers and hormones—had already been in progress for

several years by the time that I had arrived to do my fieldwork. As a part of my research, I witnessed a series of conversations about revising some of the survey items for the next wave of the project.

During one such meeting, Max, one of the principal investigators, sat at the head of the table, railing against the general "asshattery" of the world, the kind which prevents trans people from simply living their lives the way they desire. This was in response to the need, raised by many on the team, to account for the way that social conditions of transphobia shape the DISTRESS experienced by many trans people—especially when it comes to some of the primary outcome measures, like suicidality and depression, which are often used to justify intervention. In other words, project coordinators and others on the team, others who were often also trans themselves, had been pushing for the study to better account for the impact social and contextual factors had on wellbeing measures.

While Max and other authorities were sympathetic towards this desire, Max also worried that focalizing the social experience of being gendered also held the power to undercut the necessity of physiological intervention. "Parents say to me, 'well, if there's more acceptance, everyone would be fine,'" Max grumbled, clearly disagreeing. "I don't want us to get to this place of 'if we get to gender utopia…'" Without explicitly describing it, Max presents a fantasy that with enough social change, no one would actually want to change their physiological embodiment of gender, and therefore there would be no need for gender affirming medical interventions.

This is the fantasy which I argue shadows the invocation of SOCIAL CONSTRUCTION as the answer to the hard questions of gender, whether what is identified as the problem is gender itself or the experience of DISTRESS. What this fantasy does is implicitly subsume trans people and desires for gendered embodiment under a logic of false consciousness, and re-invigorate a version of feminist thinking which largely saw trans people as victims, and sometimes perpetrators, of gender ideology and oppression. This fantasy suggests that a child—like Riley—could use her creative imagination not to make up puzzles about wheels and doors, but to re-signify her gender in relation to the genitals she has and the ones she wants. But this emphasis both continues to moralize the bodies that do not take part in medical gender affirmation as more desirable (an ultimately transphobic stance), and fails to understand material processes of embodiment as sources of pleasure, enjoyment, and, potentially, as mechanisms through which new social norms might be made.

Focusing on DISTRESS enables some to shake off this fantasy, like Rita does with her indictment of the question of social construction as TOO OLD, pushing such a curiosity aside as irrelevant to practice. Focusing on DISTRESS also cultivates a sense of urgency, but as I have shown, simply shifting focus does not exactly address the underlying problems with this logic of care. The pushback on the necessity of DISTRESS diagnostically and clinically, however, has provided opportunities for providers to demonstrate the other values that ground and legitimate gender affirming care.

In 2019, I attended a conference session entitled "How Much Distress is Enough?" led by two therapists, Darlene Tando and Aydin Olson-Kennedy. The room is packed, one of the fullest sessions I attend. The session begins with an overview of how distress has been used clinically to differentiate between children who are "gender expansive" and those who are "transgender." In this case, "transgender" refers to those who may be appropriately served by more medicalized interventions but also implicitly invokes a distinction between youth who will continue to express a gender identity different than the one they were assigned into their adult lives and those for which their gender diversity is limited to childhood. DISTRESS has been a part of the clinical project of distinguishing between those groups of youth, as a way of limiting access to interventions with more physiological

effects, as opposed to merely permitting youth to play with other toys or wear other clothes, a kind of social intervention that most providers encourage parents to allow all children access to.

When it comes to the experience of DISTRESS, both Darlene and Aydin are critical of what it does to the practice of affirmative care to hinge it so heavily on the experience of distress for youth. In the workshop, Darlene asks the assembled crowd,

> why would we want DISTRESS from anyone?

A few minutes later, she says, in reference to timing intervention if not waiting for a prescribed level or type of DISTRESS,

> how do we know when the right time is?

And someone from the crowd calls out

> when they ask for it!

The presenters laugh.

> we keep planting you in our audiences!

Distinguishing between youth who will be transgender long into the future, and those who might not, has long been the emphasis within the field of transgender care. Although adult care was similarly built upon a desire to provide medical transition only to those who seem the least likely to regret their choice, based on their capacity to fit within cisgender norms (shuster, 2021, Stone, 1992, Velocci 2021), in recent years, this mode of gatekeeping has been reduced. However, among youth, the desire to differentiate between youth who might reliably be transgender adults, and those who might not, still often grounds how standards are developed, and care provided.

Even though this desire would seem different than the etiological desire to understand where gender comes from, in practice, these threads are intertwined such that when providers like Ingrid and Sarah begin to blend their feminist training with a more essentialist model of gender, they are protecting the field from both modes of critique. That is, understanding gender as something that "doesn't develop" is a way of both situating medical intervention as appropriate and youth as something beyond the malleable, not-yet-formed persons they sometimes are seen to be; a different form of "plasticity" than the one that Jules Gill-Peterson (2018) has described as enabling the development of gender affirming care in deeply racialized ways, ways only available to young people who could exhibit the proper biological flexibility—tied to Whiteness—taken to ensure their eventual successful integration in the normative gender order.

The kind of malleability that seems to threaten youths access to intervention is not a biological one, but an understand of a self that is not yet settled, and thus shouldn't be the basis upon which individual people can access intervention which reshapes the body. For if youth are seen as simply responsive to social pressures, many of which are recognized by feminists as problematic, then gender affirming medicine becomes inaccessible until youth are considered fully socialized and in possession of a fully developed independent identity[6]. Taking young people seriously enough to offer them interventions now, even faced with both an uncertain future and an unknowable origin, however, challenges the concept of child as the embodiment of the abstract political and racial future (Edelman, 1996, Berstein, 2011),

and helps reorient towards children as real subjects who may be explicitly "growing sideways" (Stockton, 2009).

But this is a difficult ask, so for many, the turn towards DISTRESS is an easier move, which nonetheless underscores the necessity of providing intervention even without the security of origin stories. Yet there are those who refuse the seduction of the easier answer of DISTRESS, who accept that as Darlene says in the session, "it's true, that if you offer options, your kid might take you up on it."

"Maybe because it's right for them."

In this way, what Darlene and Aydin offer is a practical reorientation towards both certainty and towards youth themselves. What grounds their work is the assumption that a trans life, a trans future, is not one which is only turned to in the event of crisis but instead a valued, and valuable, way of living in the world. As Aydin has said elsewhere about the DISTRESS requirement, "It is not okay that we are asking young people to feel unsafe in their bodies. That is unacceptable" (Webberly 2020). By refusing to play into the rhetoric that pits DISTRESS against regret, or even to emphasize essentializing discourses (Schilt, 2015) in order to legitimize gender identity itself, Aydin and Darlene remind all those in the room and all those listening that young trans people are not asking for answers to old questions about gender itself. Instead, they are asking to be seen as they are, and asking those around them to recognize how living an embodied, gendered life, in the social world, is a valuable part of being a person; one which they deserve access to.

CONCLUSION

Gender affirming care for youth is under wide scrutiny, particularly in the United States and other countries where a surge of conservative investment into gender assigned at birth is being translated into legislative attempts to sharply limit or outright ban affirmative care. Given this context, it is unlikely that questions about the origin of gender and the relevance of DISTRESS are going to disappear anytime soon. Instead, Riley's game—her play at taking, and what she asks for in return—are repeating at scale, only this time, the hard questions asked of youth are ones which seek to solidify both a past and a future. In the process, narratives about the right kind of gendered origin narrow, and possibilities for gendered futures are more tightly wedded to the experience and performance of the right kind of DISTRESS.

Though I have narrated the ways that the invocation of SOCIAL CONSTRUCTION has been seen as a threat to the legitimacy of medical intervention, not all providers located the problem in the framing of SOCIAL CONSTRUCTION itself. As Dr Y, another TYC physician, told me, the error was often how such a claim was leveraged to make gender seem less important, less critical. But as he said, "actually, it's a SOCIAL CONSTRUCT that means everything, every day, in every setting, to everyone." To see gender as this kind of a SOCIAL CONSTRUCT enables him to hold multiple truths, together—that gender could be social, yet claimed individually; that gender could be internally experienced and made meaningful through social relations; and most importantly, that the importance of gender affirming care does not need to be built on reinscribing the role of gender as a biological category. Furthermore, even reasserting the importance of the physiological shouldn't entail casting out the social, given that, as the theorist Grace Lavery has written, "biology exists on the terrain of culture: that biology can be changed and indeed is continually being assigned new meanings; and that it is indeed infinitely negotiable by any number of regimes of bodily modification, chosen and unchosen (p. 146, 2019)." Instead, what matters is remembering what Darlene and Aydin say; that the best way to know what might be right for a young person is to ask them.

ETHICS STATEMENT

All participants, including patients, completed informed consent and assent procedures and HIPPA waivers. This research was approved by the IRB of the University of Chicago and the IRB of the clinical research site.

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ENDNOTES

[1] I refer to most clinical providers and all patients with pseudonyms to best protect their confidentiality and privacy. Outside of my primary clinical site, some clinicians have consented to the use of their real name and are recognized accordingly.

[2] See the Human Rights Council "Resources" for a collection of Policy and Position Statements on conversion and reparative therapy at www.hrc.org/resources/policy-and-position-statements-on-conversion-therapy.

[3] In my work I use small capitals for concepts and phrases that are simultaneously endowed with uncertain meaning and taken to be understood between those I was speaking with or observing. I do so as a method of ethnographic re-presentation which seeks to acknowledge in its form the way that my partial perspective undoubtedly misses much of the meaning, and to hold on to the poetics of everyday speech (see also Davis 2012, Lepselter 2016).

[4] However, the French sociologist and feminist Christine Delphy has argued that the school of thought many US academies characterize as "French Feminism" – highlighting writers such as Hélène Cixious and Julia Kristeva—does not exist in France as such, given that many of these figures disavowed feminism themselves. Instead, in her own analysis of the "social construction" of "French Feminism," Delphy argues that English writings on these scholars focusing on topics such as the psyche which stands apart from society, and the universal distinction between the masculine and the feminine, is an imperial project which functions to legitimize views on essentialism (Delphy 1995). This history is not the same as, but certainly related to the contemporary movement of "gender criticals." Not all theorists agree here - see also Grace Lavery's (2019) important essay on the relation biologically essentialist claims have to free speech, which includes her own brief nuancing of "essentialist" French feminists (p. 139).

[5] See also Plemons (2017).

[6] An objective which itself has been critiqued as a particularly Western ideology of self (Sadjadi 2019).

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