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Attachment and Shame in Gender-Nonconforming Children and Their Families: Toward a Theoretical Framework for Evaluating Clinical Interventions

Robert Wallace
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ABSTRACT. There is currently no consensus over how best to approach work with gender-nonconforming children and their families. We turn to attachment theory to develop a framework for assessing the impact of two different approaches, suggesting that new understandings of links between shame, shame proneness, depression, and identity might provide key questions to consider in developing services for these children. We outline arguments from both sides of the debate, highlighting the work of 2 leading clinicians. We suggest that supportive approaches are more consistent with an attachment-based framework while approaches aimed at correcting gender-nonconforming behavior risk increasing attachment dysfunction.

KEYWORDS. Attachment, gender dysphoria, gender identity disorder of childhood, gender-nonconforming children, gender variance, shame, transgender children

In the field of theorizing about and treating gender-nonconforming children,¹ there are, in general, two polarities. Menvielle notes that although united in the goal of optimizing the child's functioning, there is a divergence of opinion about the specific goals of treatment (Byne et al., 2012). One approach aims at reducing gender dysphoria and decreasing cross-gender identification in order to prevent persistence into adulthood. Here we find figures like Stoller (1985), Rekers (1977), and Nicolosi (1997). These clinicians see gender variance as pathological and as resulting from pathological processes—perhaps from attachment failure, or some disruption in the psychosexual develop-

ment of the “normal” child. On the other side are those who “remain neutral with respect to gender identity and . . . have no therapeutic target with respect to gender identity outcome” (Byrne et al., 2012, p. 763). Their goal is to support the child and family as they navigate social structures that might put the child's self-esteem at risk and, so, cause harm. On this side of the debate stand clinicians like Lev (2010, 2004), Ehrensaft (Ehrensaft & Ayers, 2011), Menvielle and colleagues (Hill & Menvielle, 2009), and Spack (Edwards-Leeper & Spack, 2012). Seeing gender variance as healthy diversity, they focus on how to engender the development of attuned and supportive responses to the child by their families

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and communities (Lev, 2010, 2004; Ehrensaft & Ayers, 2011; Hill & Menvielle, 2009; Edwards-Leeper & Spack, 2012). Hence their work shifts away from a focus on fixing the child to fixing the system that pathologizes them and on developing strategies to mitigate the injuries of that system. Dreger (2009) describes these as either “therapeutic” or “accommodating” approaches. In the hope of moving this polarized debate forward, we will attempt to develop a theoretical framework for evaluating intervention that supersedes particular approaches and draws upon attachment theory for guidance about the goals of intervention. We argue that attachment theory is relevant because intervention with children must inevitably impact the attachment relationship between parents and their children, either for good or ill, because by the nature of the theory, it is designed to impact how the parent responds to the child’s experience of cross-gendered identity as a part of self (Zucker, 2008). We also turn to the emerging literature on shame to understand how intervention in the attachment relationship can risk engendering shame if the child’s self-perceived identity is challenged and negated by intervention. This is a particularly important issue because gender-nonconforming children are already vulnerable to being shamed through ostracism by their peers and others (APA Task Force on Gender Identity and Gender Variance, 2008; Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Zucker, 2005a; Zucker, Owen, Bradley, & Ameeriar, 2002; Zucker & Bradley, 1995). We will also argue that where shame emerges as a dominant and/or unrecognized dimension of experience for gender-nonconforming children, there are risks that it can become the organizer of identity and amplify later life vulnerability to shame proneness, a shame-based identity, and depression.

To accomplish this task, we will begin by broadly defining shame, summarizing current thinking about how attachment problems between parent and child engender shame, thus creating a vulnerability to shame proneness and later depression. We also consider how attachment theory takes up issues of identity formation and resilience in the face of stigma, both sensitive areas in the development of gender-nonconforming children. We hope this discus-

sion may provide a theoretical lens or framework for assessing the effects of intervention. We then return to the question of how theory specifically informs work with gender-nonconforming children by positing three evaluative questions that can be used to assess any intervention with these children and their families. Finally, we use these evaluative questions to assess the potential impact of the “accommodating” and “therapeutic” intervention styles as exemplified by the work of two prominent clinicians, each representing one approach. We suggest that strategies that affirm rather than redirect gender behavior are more consistent with an attachment-based approach. Let us begin by considering in broad strokes some current thinking about the relationship between shame, attachment, identity, and depression. Having established a theoretical foundation, we will return to specific impacts on working with gender-nonconforming children and their families.

THE DYNAMICS OF SHAME AND ATTACHMENT

Understanding the relationship between attachment and shame can shed light on what must be attended to in any intervention with children and their parents. In order to make this relationship clear, however, it is important to first understand the nature of shame. There is general consensus that shame is a social affect requiring a sense of self, a cognitive awareness of social standards, and an ability to compare self and other as causal agents (Izard, Ackerman, Schoff, & Fine, 2000; M. Lewis, 2003). Shame’s emergence is therefore generally seen as arising between the ages of 1.5 and 3 years (Cole, Luby, & Sullivan, 2008; Herman, 2007; Kim, Thibodeau, & Jorgensen, 2011; M. Lewis, 2003; Luby et al., 2009; Mills, 2005; A. Schore, 1996, 1994). Phenomenologically, H. B. Lewis (1987) describes shame as “a negative experience of the self: it is an ‘implosion’ or a momentary destruction of the self in acute self-denigration” (p. 95). Subsequent theorists such as Herman (2007) agree. In her summary of attributional theories of shame, Mills echoes Tangney, Wagner, and Gramzow’s (1992) argument that shame “is elicited by

a global self-attribution of failure, essentially an experience of the global self as undesirable, unworthy or fundamentally flawed" (Mills, 2005, p. 30). As a self-conscious moral emotion (Izard, Ackerman, Schoff, & Fine, 2000; M. Lewis, 2003; Tangney, Stuewig, & Mashek, 2007), shame regulates or influences social and interpersonal relationships (Herman, 2007) and regulates social ranking as a submission or appeasement response (Gilbert, 2000; Herman, 2007; Kim et al., 2011) to socially threatening environments (Gilbert, Allan, & Goss, 1996; Irons & Gilbert, 2005). Herman, following in the tradition of others such as Scheff and Retzinger (Retzinger, 1995; Scheff & Retzinger, 2000), further argues that it is a master affect that "generalizes to become an emotion that serves to regulate peer relationships, social hierarchy, and all basic forms of social life" (Herman, 2007, p. 8).

As an inherently social emotion that regulates interpersonal relationships, we might expect some consensus that shame and attachment are linked (Bowlby, 1978a; Consedine & Magai, 2003; Gross & Hansen, 2000; Herman, 2007; A. Schore, 1994, 1996; J. Schore & Schore, 2008). For example, Brumariu and Kerns's 2010 review of 55 studies conducted between 1984 and 2008 suggests that attachment insecurity in combination with parental rejection leads to a "depressogenic inferential style . . . attributing negative outcomes to internal global and stable factors' cognitions of failure and low self worth" (p. 197). This echoes Tangney, Wagner, and Gramzow's (1992) definition of shame.

We will now shift our attention to attachment theory to explore the link between shame and attachment. At its simplest level, attachment is a behavioral signaling system by which the vulnerable infant signals need for caregiver proximity in times of danger or distress (Bowlby, 1978a, 1988). However, the dynamic between infant and mother is reciprocal and contingent, with each bringing what Bowlby (1978a) calls "initial biases" (p. 402) into the relationship, which evolves into a process of mutual dialogue and adaptation. By the first year, the interactional patterns become characteristic (Bowlby, 1978a) and are organized into Internal Working Models (IWMs) or representational models of self, other, and the interaction between the two (Bowlby,

1978b). Bowlby (1978b) argues that "in the working model of the self that anyone builds, a key feature is his notion of how acceptable or unacceptable he is in the eyes of his attachment figure" (p. 236). Thus, Bowlby describes shame as an outcome of attachment difficulties: where a child's primary caregivers find the emerging self unacceptable, shame will become a keystone of the child's model of the self.

This relationship between shame and attachment is developed by A. Schore. Like others (Fuendeling, 1998; Herman, 2007; Kerns, Abraham, Schlegelmilch, & Morgan, 2007; Matos, Pinto-Gouveia, & Costa, 2013; Mikulincer, Shaver, & Pereg, 2003; Wells & Hansen, 2003), A. Schore argues that attachment is an emotional regulation system (J. Schore & Schore, 2008) and that unrepaired shame is central to the development of insecure attachment (A. Schore, 1994, 1996). This is an argument echoed by others (Gilbert et al., 1996; Mills, 2005). In secure attachment, A. Schore (1996) argues, the infant develops the capacity to modulate internal distress through a recurrent and predictable process of dyadic attunement, misattunement, and reattunement by the caregiver. Where reattunement is unreliable, the child develops a sense that the caregiver cannot be counted upon and that the self is unworthy of love and comfort (A. Schore, 1996). The child learns to self-regulate through disengaging or through avoidance. When the parent persists in trying to engage the child in ways disconnected from the child's cues, the child does not learn to regulate excitement and rather than experiencing shame exhibits high negative affectivity (anxiety). He concludes that "these early unregulated shame experiences lie at the core of various developmental psychopathologies" (A. Schore, 1994, p. 248). Thus, A. Schore establishes a web of relationships between shame, attachment patterns, the model of self in the IWM, and depression. The convergence of these four constructs has influenced the framing of research questions. Much research has supported a positive relationship between shame and depression in children (Brumariu & Kerns, 2010; Hughes, Gullone, & Watson, 2011; Kim et al., 2011; Luby et al., 2009). This has also been demonstrated in adults (Blum, 2008; Irons & Gilbert, 2005; Matos &

Pinto-Gouveia, 2010; Matos et al., 2013; Mills, 2005; Pinto-Gouveia & Matos, 2011; Tangney et al., 2007; Tangney et al., 1992; Thompson & Berenbaum, 2006). Similarly, many studies have examined the correlations between internalizing symptoms of depression, anxiety, and insecure attachment in children and adolescents (Brumariu & Kerns, 2010) and shame, insecure attachment, and depression among adults (Matos & Pinto-Gouveia, 2010; Matos et al., 2013; Pinto-Gouveia & Matos, 2011).

If attachment style, shame proneness, and depression correlate, then we might also ask whether these influence how children experience social behavior outside the family. Gilbert's foundational work on social rank, depression, and shame (Gilbert, 2000; Gilbert et al., 1996; Irons & Gilbert, 2005) is relevant here. Arguing that perception of status or social rank influences mood (Gilbert, 2000), he and Irons examine the relationship between attachment dysfunction, shame, and depression in adolescents, finding that insecure attachment, both avoidant and ambivalent, "sensitizes individuals to become focused on the competitive dynamics of groups, the power of others to shame, hurt or reject, and the need to defend against these possibilities" (Irons & Gilbert, 2005, p. 325). In other words, parent-child attachment problems increase the child's susceptibility to shame and depression when encountering stigma in the external world. Thus, any intervention that impacts the parent-child attachment relationship needs to be attentive to this risk.

ATTACHMENT AND IDENTITY FORMATION

Attachment processes have also been linked to identity formation. Zucker (2008) argues that gender atypicality is seen by the gender-nonconforming child as a part of the self. Thus, if something experienced as intrinsic to identity is devalued and organized around shame, this might disrupt the attachment relationship and impact how the child comes to experience self. To explore this, let us return to Bowlby's concept of the IWM.

At the heart of attachment theory lies Bowlby's concept of the IWM with its embedded

model of self. The IWM anticipates the idea that attachment entails the self's experience of identity and poses the question of whether identity can be informed by or intersect with attachment style and shame. As we have seen, shame is an organizing affect for insecure attachment. Studies have considered this relationship in adult populations. For example, in their study of 811 Portuguese adults, Pinto-Gouveia and Matos (2011) found "expressive and positive correlations between the centrality of the recalled shame experiences to one's identity and life story and depression, anxiety and stress" (p. 287). In another study of 90 adults, they and Costa found that when traumatic shame memories occur in relation to attachment figures, the relationship with depression is directly experienced as shame. Thus attachment impacts how shame memories become part of autobiography (Matos et al., 2013). They argue that this conclusion "is in line with our hypothesis and previous research that showed shame memories that function as traumatic and central memories to one's identity and life story are associated with psychopathological symptoms, particularly depression" (Matos et al., 2013, p. 159).

The relationship between shame, identity, and attachment difficulties is also supported in research on lesbian, gay, bisexual, and transgender (LBGT) populations. Wells and Hansen (2003) found that 317 American lesbians reported higher levels of shame than similar heterosexual populations and that "shame scores decreased as lesbian identity integration increased. Likewise, high levels of secure attachment were associated with less shame while high levels of fearful and preoccupied attachment were associated with greater shame" (p. 93). In a successive study of 100 European-American self-identified lesbians, Wells also found a relationship between attachment style and internalized shame. Secure attachment was associated with lower levels of shame; insecure attachment was associated with higher levels. She also found that attachment styles accounted for 43% of the variance in internalized shame (Wells, 2004). In an online study of 286 American LGB men and women, Sherry (2007) found that secure attachment negatively correlated with shame, internalized homophobia, and guilt, while there was a positive correlation between shame and both fearful and pre-

occupied attachment. Brown and Trevelthian's (2010) study of 166 Australian gay men also found a strong relationship between insecure attachment style, shame, and internalized homophobia. These findings lend credence to Sedgwick's (2009) argument that shame is central to LGBT identity because it adheres to who one is rather than what one does: "Queer, I'd suggest, might usefully be thought of as referring in the first place to . . . those whose sense of identity is tuned most durably to the note of shame" (p. 63).

In summary, we suggest that there is an intricate relationship between the problematic emergence of shame for the child and the child's attachment relationship with the parents. We argue that unrepaired, shame can function as an organizing emotion in the process of identity formation. We have posited that this creates particular vulnerabilities to stigmatization, especially for gender-nonconforming children who, as we know, experience high levels of social exclusion. The result can be significant proneness to shame and depression. We therefore posit that difficulties in the central relationships of gender-nonconforming children's lives risk leaving them particularly vulnerable to subsequent shaming experiences and to depression. Hence we argue that useful interventions in the lives of these children must attend to protecting and enhancing the bond between parent and child and to minimizing shame within that bond. We therefore argue that intervention in the lives of gender-nonconforming children could usefully be evaluated in terms of three core questions: (a) How might a particular intervention style negatively impact attachment processes between parent and child? (b) In what ways might it impact the child's experience of shame around their gender variance? (c) What risks does treatment pose for engendering shame proneness, a shame-based identity, and susceptibility to depression?

DR. KENNETH ZUCKER'S APPROACH IN RELATION TO SHAME AND ATTACHMENT THEORY

We chose to consider the work of Kenneth Zucker because he has written extensively in the field of childhood gender identity disorder (GID) since the early 1990s. He has also had

considerable influence on the field through his involvement serving on various influential bodies including the American Psychiatric Association Sexual and Gender Identity Disorder Work Group, which he chairs and which published a critical review of the literature about GID in 2012 (Byrne et al., 2012). Zucker is the editor of the *Journal of Sexual Archives* and the director of the Gender Identity Service in the Child, Youth and Family Program of Toronto's Centre for Addiction and Mental Health.

We will begin by providing an overview of Zucker's work, recognizing that his understanding of GID has evolved considerably over more than 20 years and that there have been significant changes in his understanding of etiology and treatment. We use the term "gender identity disorder" rather than "gender-nonconforming" when describing Dr. Zucker's work since this is the term he uses himself. We acknowledge that this term will likely change when the *DSM-5* is approved. In general, Zucker sees gender atypicality as in itself evidence of disorder or pathology. He and his colleagues use "a multifactorial model that takes into account biological factors, psychosocial factors, social cognition, associated psychopathology, and psychodynamic mechanisms" (Zucker, Wood, Singh, & Bradley, 2012, p. 375). He acknowledges the problematic lack of empirical knowledge in this field: "There is a large empirical black hole in the treatment literature for children with GID. As a result, the therapist must rely largely on the 'clinical wisdom' that has accumulated in the case report literature and the conceptual underpinnings that inform various approaches to intervention" (Zucker, 2008, p. 359).

Zucker has identified possible psychological factors contributing to GID which are associated with parental deficiencies, focusing on parental support for a child's GID behaviors (Zucker, 2004, 2008; Zucker & Bradley, 1995), on maternal encouragement or tolerance for feminine behaviors in boys (Zucker, 2008; Zucker & Bradley, 1995), and on maternal psychopathology (Owen-Anderson, Bradley, & Zucker, 2010; Singh, Bradley, & Zucker, 2011; Zucker, 2008, 2005a, 2005b; Zucker & Bradley, 1995; Zucker et al., 2003; Zucker et al., 2002). While his 2012 paper is careful to avoid generalizing, the focus on maternal psychopathology remains evident in

his case studies and suggests disturbances in the attachment relationship with the child.

This focus is consistent with Zucker's understanding with respect to the child's attachment process. Among other clinicians, he argues that GID in children can arise from a fantasy solution "that becoming a member of the other sex would somehow resolve internalized distress" (Zucker, 2008, p. 359) by maintaining a position of psychological safety in relation to attachment figures (Zucker, 2008; Zucker & Bradley, 1995). In his coauthored 2012 paper, this perspective is embedded in his case study of Rose, a young girl whose mother had been murdered. Zucker proposes that the fantasy of being a boy allowed her to think there was a way she could have protected her mother and could protect her adoptive mother in the present (Zucker et al., 2012).

Zucker also specifically attributes etiological influence to dysfunction within the attachment relationship with the mother (Singh, Bradley, & Zucker, 2011; Zucker, 2008, 2005b; Zucker & Bradley, 1995): "It has long struck me as important to think about their [signs of GID] genesis within the context of early attachment relationships" (Zucker, 2008, p. 360). In relation to girls, he relates GID's onset to attachment failure with the mother and the child's adoption of an avoidant attachment type (Zucker, 2005b); with regard to boys, he notes a study by Birkenfeld-Adams that 75% of boys with GID had an insecure relationship with their mothers while unpublished data suggest a similar attachment dysfunction in girls with GID (Zucker, 2008). In a 2010 study, he and his coresearchers found that "mothers of boys with GID displayed significantly higher percentages of a pattern characterized by borderline or high emotional over-involvement and low criticism" (Owen-Anderson et al., 2010, p. 341). For reasons that are unclear, this perspective is not explicit in his 2012 paper; however, it is not clear whether that is because it is background to his arguments or because he no longer sees it as a significant variable.

Given the established links between attachment difficulties and the experience of social exclusion, we must also note Zucker's conclusions regarding repeated findings that gender-

nonconforming children are victims of social ostracism. The distressing effects of bullying and victimization on children are well known (Chan, 2009; Gilbert et al., 1996; Irons & Gilbert, 2005; Malti, Perren, & Buchmann, 2010). For example, in their literature review on victimization and bullying, Bernstein and Watson (1997) report studies that suggest that children who are victimized tend to be anxious and insecure, have low self-esteem and tend to be withdrawn and socially isolated. This constellation of symptoms closely mirrors Zucker and Bradley's (1995) conclusion that boys diagnosed with GID tend towards internalizing symptoms of depression and anxiety (Singh et al., 2011; Zucker, 2005b).

Much research shows that GID children experience a very high level of social rejection from peers (Cohen-Kettenis et al., 2003; Zucker, 2005a; Zucker et al., 2002; Zucker & Bradley, 1995). Zucker acknowledges that poor peer relations correlate with and amplify the distress of GID children more than any other variable. However, he tends to perceive the child's distress as an effect of gender atypicality rather than the sequelae of ostracism itself: "When children with GID are socially ostracized by their peers, it is their overt behavior that elicits negative reactions, not an abstract label. There is considerable evidence that, even in normative samples of children, cross-gender behavior is appraised negatively by the peer group, and more so in boys than in girls" (Zucker, 2006, p. 548). In a 2009 paper, Zucker and his colleagues therefore dispute Hegarty's (2009) argument that the dysphoria of children diagnosed with GID could be the outcome of stigma, concluding that "one could argue that, even in the most accepting of social environments, the disjunction between one's psychologic gender and somatic sex . . . has an inherently distressing component" (Zucker, Bradley, Drummond, & Peterson-Badali, 2009, p. 906–907). In his 2012 paper, however, he notes the possibility that co-occurring pathology in GID children may result from ostracism (Zucker, Wood, Singh, & Bradley, 2012).

Since he considers gender nonconformity disordered or pathological, Zucker seeks associated influences, which then become the targets of change together with the behavior itself. In

2008, Zucker identified two foci of treatment that involve working both from the “inside out” and the “outside in.” The first involves individual work with the child diagnosed with GID “in which efforts are made to understand the factors that fuel the fantasy of wanting to become a member of the opposite sex and then to resolve them” (Zucker, 2004, p. 563). He argues that fantasy mediates unconscious conflicts to maintain connection to internalized figures (Zucker, 2008). This objective becomes more ambiguous by 2012. Here, therapy with children is designed to enable them “to discuss and play out their gender identity issues” by affording “an opportunity to make sense of their representational world, and, in general, to master various developmental tasks with which they may be struggling” (Zucker et al., 2012, p. 383).

Parents are the second focus of treatment. In 2008, Zucker states that the initial focus of parental work may need to focus on resolving parental ambivalence:

In these more complex clinical situations [in which parental support for cross-gender behaviors is related to systemic/dynamic factors], one must attend to the underlying issues and work them through. Otherwise, it is quite likely that parents will not be comfortable in shifting their position. (p. 361)

In his 2012 paper, he argues again that parental investment may be a perpetuating factor in GID and that “when parents have significant reservations about setting limits on the child’s cross-gender behaviors and to provide alternate activities, this requires considerable discussion” (Zucker et al., 2012, p. 388).

ZUCKER’S FRAMEWORK VIEWED FROM THE PERSPECTIVE OF ATTACHMENT THEORY AND SHAME

We will now consider how our questions, emerging from the shame and attachment literature, might inform an evaluation of Zucker’s approach. At heart, Zucker’s framework is organized around constructs of pathology: There

is something inherently disordered about a child opting for an identity that makes him “uncomfortable in his own skin” (Zucker et al., 2012). The child’s behavior is potentially stigmatized, and the attempts to change that behavior can transmit a judgment that something is wrong. Both of these risk impacting attachment in a negative way. Given that the child is self-identifying with the behaviors of the other gender (Zucker, 2008), we are concerned that intervention attempting to stop these behaviors risks amplifying global shame (A. Schore, 1994; J. Schore & Schore, 2008) by conveying a “not OK” message to the child, which is carried forward by the parents. Is it possible to convey unconditional regard when a dimension that the child experiences as part of self is the object of change? How can parent and child reattune after this limit setting when cross-gender behaviors express something the child considers core to their sense of self? Our concern is that without a positive reparative response the child will experience shame as a global attribute of the self, as part of identity, and will therefore be at elevated risk of depression.

There may also be risk in stigmatizing the parents, who are held to have responsibility for engendering the child’s identity or for supporting the behavior’s continuation. In his 2012 article, Zucker and colleagues give two case examples that formulate GID as a response to two kinds of maternal pathology: a mother’s “pathological gender mourning” (Zucker et al., 2012, p. 382) over the birth of a boy rather than a girl and the child’s use of fantasy solution to maintain relatedness to the mother. In describing the clinical work, rather than focusing on buttressing the attachment relationship between mother and child, Zucker seems to focus on underlying parental pathology or “parental factors in the genesis and maintenance of GID” (Zucker et al., 2012, p. 388). However, is there a risk of engendering shame in the parents about their responsibility for contributing to and supporting pathological processes in their child? Thus, we are concerned that this treatment approach may tend to increase shame in both parent and child, thus potentially impacting negatively on successful attachment and increasing the risk for depression. Finally, questions arise about

the potential impacts of these interventions on the child's experience of social ostracism. If Gilbert and his colleagues are right in arguing that attachment difficulties amplify the impact of shaming messages external to the family (Irons & Gilbert, 2005; Gilbert, 2000; Gilbert et al., 1996), then interventions which risk embedding shame in the child's attachment relationships also risk amplifying the child's vulnerability to the shaming effects of social exclusion.

With reference to our three questions, Zucker's framework does not appear to focus on enhancing the attachment relationship between parent and child. Nor does it specifically address the shame children may feel about their gender nonconformity, particularly in response to social ostracism. In the absence of both, there appears to be an enhanced risk of fostering proneness to shame, a shame-based identity and vulnerability to depression.

DR. EDGARDO MENVIELLE'S APPROACH IN RELATION TO SHAME AND ATTACHMENT THEORY

We turn now to the work of Dr. Edgardo Menvielle, a clinician whose focus is on supporting the child and family rather than decreasing cross-gender identification. Menvielle was chosen because his program, the Children's Gender and Sexuality Advocacy and Education Program, has been running at the Children's National Medical Center in Washington, DC, a prestigious U.S. hospital, for many years and has been well-documented and researched. Menvielle has authored or coauthored at least eight papers on gender-identity-related issues in children and, like Zucker, is a member of the American Psychiatric Association Task Force on the Treatment of Gender Identity Disorder. We will look at fundamental assumptions of the program and at actual interventions to examine our three questions: How might a particular intervention style impact attachment processes between parent and child and so engender shame? In what ways might it impact the child's experience of shame around their gender

variance? What risks does treatment pose for engendering shame proneness, a shame-based identity, and susceptibility to depression?

We have argued that beginning from an assumption of disorder has certain consequences: if gender variant behavior is pathological, then we must inquire into its etiology and do what can be done to prevent and to treat it. The program at the Children's National Medical Centre asserts that there is nothing inherently pathological about gender variance: "Our assumption is that GID in children represents a normal developmental variation" (Menvielle, 2012, p. 363). This perspective on gender variance as diversity, not pathology, is reflected throughout his work. Perhaps the very first contact a family has with the clinic would be its flyer for parents, available on the Internet, wherein they assert that "some experts used to believe that gender variance represented *abnormal* development, but today many have come to believe that children with gender-variant behaviors *are normal* children with unique qualities—just as children who develop lefthandedness are *normal* [emphasis in original text]" (Tuerk, Menvielle, & de Jesus, 2003, p. 3). They also see this stance as an accurate reflection of current cultural mores:

In contrast to how parents might have reacted in the mid-twentieth century, seeing their child's gender presentation or identification as psychopathology and in need of correction, these "millennial parents" felt that their child's predicament in the world made them wiser and better persons and challenged them to accept their gender outlaw children. (Hill & Menvielle, 2009, p. 268)

This position is consistent with the new Standards of Care position that "being transsexual, transgender, or gender nonconforming is a matter of diversity, not pathology" (World Professional Association for Transgender Health, 2011, p. 4). If we examine this clinic's assumptions about the nature of gender and gender identity, we find a related set of concepts. This program does not subscribe to a conception of gender identity as something simple or fixed but sees both complexity and

variability. Menvielle (2009) argues that “gender identity can be experienced as either a constant or something more fluid, more evolving over time, or changing with circumstances” (p. 365). Far from attempting to correct gender variance so that the child may grow up to fit within a binary conception of gender, matching their natal sex, the clinic sees a broad spectrum of adult-gendered possibilities as healthy and desirable: “The idea that is communicated is that [there is a range of] viable and valid options among which the patient can choose, and that the patient should make the best decision for themselves, free from external pressures to conform to gender ideals” (Menvielle, 2012, p. 365).

What might be the impact of these fundamental principles on children, parents, and their relationship? If there is a broad range of healthy gender identities and gender-variant behaviors are not a result of malfunction, whether biological or social, then the goals of the clinic shift from treatment to support. When parents believe that gender-variant behaviors indicate that something is wrong with their child, may this not itself have an impact on their attachment? They may have a wide range of feelings, from worry and compassion to embarrassment or even revulsion, but any of these reactions seem likely to interfere with providing the unconditional acceptance that underlies solid attachment. The clinic reports a parent as saying:

Your child needs one thing in the world and one thing only, which is a supportive environment from their parents and their family, who tells them that they’re okay and there’s nothing wrong with them. And everything else takes a back seat to that. And if you can’t give them that then you’re not doing the right thing. (Hill & Menvielle, 2009, p. 265)

As we have noted previously, faulty parenting is often seen as the cause of gender variance in children, both by the culture at large and by many clinicians. Menvielle and his colleagues adopt a different framework, addressing the concept of shame directly in its role as form of gender-policing: “A frank discussion about the role of

shame in keeping people within the confines of gender-appropriate behavior often offers relief regardless of whether shame has been brought up by parents” (Menvielle, 2012, p. 359). Rather than adding to the parental burden of shame with diagnoses of parental pathology and templates of corrective parenting structures, the program uses its power as a source of professional, licensed knowledge to buttress the parents’ ability to resist shame. Menvielle (2012) writes,

Emotional reactions about present or past responses and actions, such as guilt for having felt sadness or anger toward the child, or past efforts to normalize the child into gender-conventional behavior that are now deemed misguided, may be presented to the clinician. A nonjudgmental response that acknowledges the social imperatives that drive such feelings and actions reassures and soothes distressed parents. (p. 359)

Menvielle and his colleagues ground their position in an understanding of stigmatization. The child suffers stigma but so also do the parents, indeed, the entire family, including siblings and extended family. He writes,

The stigma of gender nonconformity, the “spoiled identity,” is, thus, borne not just by the child but also by all those associated with the child (Goffman, 1963/1986). The usual mechanism by which stigma by association is avoided, through the disavowing of the stigmatized person, is not possible here except in the extreme and rare cases of physical or psychological abandonment. (Menvielle, 2012, p. 360)

The isolation this can produce for siblings as well as parents is another source of family stress which, he implies, impacts attachment:

The threat of straining or losing important relationships is an important contributor to some parents’ inability to suspend judgment about, let alone embrace, gender variance in their child. Families embedded in communities with commitments to

certain religious or cultural traditions may experience a version of this, complicated by the threat of other losses of a symbolic nature. (Menvielle 2012, p. 361)

By focusing on reinforcing and building familial strengths, Menvielle avoids the difficulties posed for Zucker in tending to possible parental pathology. Zucker's position directs him toward engaging the parents in a process of targeting the child's gender-nonconforming behaviors for change, posing the problem of how this can be done without rupturing the relationship with the child, who presumably experiences that behavior as part of self. By dismissing pathology as an issue, the potential for this negative impact disappears. On the other side, however, a lack of focus on actual parenting dynamics could mean that attachment problems that are present as covariables are missed.

One of the main interventions of the program, the peer-support group offered to parents, provides an antidote to this stigma-produced shame:

The program provided a supportive community where the child's gender variance was not marginalized but rather valued and respected, ultimately creating a different understanding of their child and themselves. The experience also afforded parents a much better appreciation of the social mechanisms through which they are made to feel inadequate and regard their child as deviant. (Menvielle & Hill, 2011, p. 120)

Though Menvielle and colleagues do not take up this argument, we might compare the parent support group to structures developed by many marginalized groups resisting discrimination, and its accompanying shame, particularly in the late 20th century. The act of gathering together those who suffer from the same form of discrimination can provide a form of support that is different and perhaps more impactful than any other. When I can see from the outside another person struggling with issues like my own, then my own struggles can be illuminated. When another participant reports exclusionary behaviors, that injustice can be clearly visible to

me, where similar behaviors I have experienced myself can leave me too flooded with shame to see clearly. This perspective is reflected in Menvielle's (2012) statement that "[t]aking distance from their own circumstances and analyzing the situations in a more dispassionate way allows parents to better resist sanctioned discourses and social mechanisms that cast them as enforcers of gender difference. This shift in perspective can be liberating and transformative" (p. 359). Menvielle and Hill (2010) report one parent's comment that "[y]our most important mission [as a parent] is to create an environment where your child says 'I'm ok.' Maybe that didn't quite articulate itself to me until I saw all these other parents, and then it made me more [certain] that that's exactly the mission: to [let] him know that he's ok" (p. 119). Support groups, both in person and online, are also seen as a mechanism for providing families with access to others with similar concerns, thereby building community and providing an antidote to isolation (Menvielle, 2012).

The clinic pays careful attention to minimizing the child's experience of shame. In preparation for the first visit, parents are encouraged to "communicate to the child that they wish to learn how to help the child feel good about herself or himself and to get along and to be successful with peers" and to assure the child that he or she will not be pressured to answer difficult questions—they may simply play while their parents talk to the doctor:

Sparing no effort to put the child at ease is critical to obtain the child's cooperation, particularly with children who already feel very self-conscious or ashamed of their difference. Some children with gender issues are exquisitely attentive to potential disapproval and are conditioned to expect it. (Menvielle, 2012, p. 364)

The "play and socialization group" for children, that includes siblings, provides another route to break out of isolation, to lose that terrifying sense that no one else in the world is like me and, thus, to minimize shame. A parent reports, "He loves it. He loves feeling like he has a place where he can be himself around other kids who

are just like him . . . so I think it shows him that there are other boys that do this and you're not alone with this problem," while two children reportedly comment, "When I go to the group I feel like I was in a cage and then I'm set free" and "When I go to the group I feel like I don't have to explain anything to anybody . . . it makes me feel really good" (Menvielle & Hill, 2011, p. 112).

It is apparent that Menvielle and his colleagues focus on supporting the parents' affirmation of the child. Although not stated in terms of attachment theory, the goal of intervention is to build positive relations between parent and child by directly attending to the impact of stigma and shame on the parent-child relationship. Returning to our three questions, then, it would appear that this intervention may minimize unrepaired shame as an influence on the attachment relationship and on the child's construction of identity. In doing so, it may reduce shame proneness and susceptibility to depression either in childhood or later on.

Although it would appear that this approach seems likely to lead to more positive outcomes in terms of attachment and the reduction of shame's potential impact, there is as yet no clear evidence about its effectiveness. Further research might explore the impact of affirmative strategies on attachment security between parent and child, on vulnerability to shame and shame-based identity, and on depression. Menvielle does not appear to assess attachment relationships upon intake with new families. Thus we cannot know what impact intervention has had on attachment. Other lines of study might include whether affirmative interventions reduce the impact of social ostracism and increase resiliency in the face of stigma.

CONCLUSION

Through the course of this article, we have argued that attachment dysfunction can emerge from persistent unrepaired shame in the parent-child relationship. Where this occurs, there is risk that identity will be organized around the experience of shame and lead to persistent shame proneness and to depression, both in

childhood and in later life. With this argument in mind, we developed three key questions that might be asked of any approach to working with gender-nonconforming children: (a) How might a particular intervention style negatively impact attachment processes between parent and child and thus engender shame? (b) In what ways might it impact the child's experience of shame around their gender variance? (c) What risks does treatment pose for engendering shame proneness, a shame-based identity, and susceptibility to depression? We have applied these questions to the approaches taken to working with gender-nonconforming children by clinicians from opposing sides of the debate about whether to correct the child's cross-gendered identification or provide support for and affirm the child's experience of gender, whatever its manifestation. We have considered the difficulties the application of this framework poses to Zucker's approach, which is geared toward changing the child's gender identification; we have also considered the ways in which Menvielle's more affirming approach avoids some of the potential problems inherent in corrective strategies because it appears to support the parent-child relationship and attempts to minimize shame. However, we have noted the areas in which supportive interventions lack evidence to support them. We conclude by suggesting that supportive interventions are more likely to avoid harm by buttressing the attachment relationship and so reduce the risk of engendering shame as a core element of identity. We argue that they are also less likely to put children at risk of depression and that this occurs, in part, because secure attachment relationships seem to reduce the impact of stigmatizing shame for children who are gender-nonconforming. That said, much work remains to be done to test whether these linkages are verifiable. Thus, we encourage research that looks closely at the attachment patterns established between gender-nonconforming children and their parents, at whether there are correlations between attachment patterns and vulnerability to shame, and whether persistent shaming does correlate with depression and a heightened impact of the social ostracism these children experience as they attempt to construct an identity that is

self-affirming rather than shame based. Most important, however, is the need to test the efficacy of intervention in terms of these domains.

NOTE

1. There are a variety of terms to describe children whose gender expression does not fit the expectations of those around them, including “gender creative,” “gender independent,” “gender-nonconforming,” and “gender variant.” In this article we shall use these terms interchangeably.

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