

Caring for Gender:  
Sisters, Psychiatrists, and Gender Crossing

Deirdre McCloskey

Economics, History, Poroi

I was sitting in my livingroom as a man, in cowboy boots and unshaven face, giving an interview to a reporter. Because you can't change gender in private, I noted, I would speak to reporters. The story of my proposed gender change was buzzing in the university and whether or not I told my side the newspaper story was going to appear. I didn't want anyone to think I was ashamed. There's politics in it, I said. Self-respect.

The interview had just begun when someone knocked hard on the front door. The schnauzers barked hysterically, and my wife answered it. *Probably some delivery*, I remember thinking. But two sheriff's deputies in brown uniforms came in.

"Sir, you have to come with us. We have a warrant."

“A what?!”

“A warrant for your arrest for mental examination.”

*Good Lord, my sister's done it.* I turned to the reporter: “Please, please don't print this!” The reporter said he wouldn't, but reporters report. The next day the Cedar Rapids *Gazette* printed its scoop on the front page, “Professor Seized by Police.” Donald McCloskey, the University of Iowa professor of economics and history who has declared that he wants to be a woman, was taken in handcuffs yesterday by Johnson County sheriff's deputies to the University of Iowa Hospital's mental health facility to be tested for insanity.

My sister Laura, a professor of psychology at the University of Arizona, together with a former colleague of mine at the University of Chicago named Galenson, had used the civil commitment designed to stop people from jumping off bridges. The bridge this otherwise normal-seeming man was jumping off were operations scheduled a month later. A nose job; a smaller voice box. Not *the* operation. My sister and Galenson wanted to save me from myself. He's gotta be crazy. Danger to himself. Stop him.

They were being caretakers, loving and courageous. I think of the virtues as five (plus two on the side):

*Courage Temperance Prudence Justice Love (Faith Hope)*

These cardinal virtues are the four “pagan” virtues in Greek philosophy (thus Casey 1990) plus the three “theological” virtues of faith, hope, and love added by Aquinas. Adam Smith arranged the five virtues as I have for a commercial society. An ethics of the virtues plays on the scale of seven, and I prefer the Scottish pentatonic scale of five.

At the hearing the next day the judge took a seat, and around him a secretary and the assistant district attorney, and my sister. As I sat down a few feet from her, my sister spoke.

“You know, Donny, I’m doing this for love.”

“Yes, dear. And Hitler loved Germany.”

My lawyer Sharon Mellon loved the crack. As men are I was stupidly pleased to amuse a woman. Grace under pressure, my father used to say, in the words of the stoic Saint Hemingway of Key West. Later I would plod forward with the Hitler thought: Love, after all, is not an excuse for everything. I was studying the history of ethics that year, and saw my own situation in tomes by Aristotle, Aquinas, Adam Smith, and modern theorists of the virtues. If the love is exercised without prudence or temperance or justice, I wrote, it is dangerous and

productive of wickedness. Years afterwards my sister could not get the point. She repeated as a talisman: "You know, Dee, I did it for love. For love." Yes, dear, I know.

And the second time she did it, in the Palmer House two weeks later, using the law in another jurisdiction, I was taken in a paddy wagon from a conference session honoring my academic work to the madhouse at the University of Chicago. When we got to the rambling hospital the policemen were uncertain where to take me. I knew the hospital from my time at the University, and the three of us consulted here and there, me talking amiably to the policemen. That way? No, I don't think so. Must be down here. Look, there's a sign. The emergency room. When the policemen were to leave me, after I had been searched and put into a locked room--a danger to myself--one of the policemen asked, puzzled, "Is this about money?" He meant: you obviously are not insane; is your sister trying to get you declared insane in order to take over some inheritance?

"No. It's about love." The policeman sighed and left with his partner.

My sister had the love for sure, and courage, too, obsessing on her project of Saving Him for months, calling around for sympathetic psychiatrists, flying to Iowa City or Chicago, courageous in conviction. But those other virtues? Temperance, prudence, justice? The political scientist Joan Tronto writes in her

*Moral Boundaries: A Political Argument for an Ethic of Care* (1993, pp. 127-136)

that good care must involve attentiveness, responsibility, and competence by the giver and responsiveness by the receiver. All of these are checks on care that hurts. My sister was “attentive” in one sense, but the attention was absorbing, not listening. She would not come to Iowa to check her theory about her older brother formed a thousand miles away that “He’s manic, not transsexual.” She was competent, but in aid of a manic project of her own. She was “responsible,” too, but again in excess, and would not listen to the victim’s responsiveness.

Mary Midgley said in *Wickedness: A Philosophical Essay* (1984) that wickedness is a disproportion in positive capabilities, not some Essential Evil that would get most of off the ethical hook. Evil? Moi? Iago’s mad envy of Othello is such that “all other motives have given way to it, . . . all attempts at inward balance. . . ceased. . . . There are no more conflicts. When this happens, we generally reckon people as in some sense insane” (p. 147). And short of mania the lack of balance in the virtues makes for a bad caregiver.

I think an ethic of care should take its first note as Love and then complete the chord with Prudence, Temperance, and Justice, with Courage a grace note to defend all these together. Instead of trying Plato-style to define the essence of care it would be better to try Aristotle-style to see care as love in the

presence of a balanced set of other virtues. The virtues cannot be reduced one to the other (though they *can* be traded off, which is what ethical choice is about). What makes for wickedness is the reduction of all virtues to one--the monsters of Prudence in utilitarian economics, for example, or monsters of Love in pathologies of caretaking.

The Aristotelian approach, for example, makes it easier to understand why caretaking cannot be universal. It's Hume's paradox, that we care more about a little mirror of our own that gets broken than a house burning down in far China. We cannot care for everybody (which is not an argument for caring for nobody). A "principle of unrelenting caring" would drive anyone mad (Dower 1993, p. 281). But if we as humans have more than one virtue to serve then an excess in caretaking can be made good by the demands of other virtues. It is just to care more about ones own child than about a poorer child in Pakistan because local caring is part of the contribution to community that justice demands. It is prudent to care more for our own than for strangers, for what, prudentially and practically speaking do we know of the needs of these strangers?

And putting care within an Aristotelian ethics of the virtues makes it easier to connect individual caretaking to the community. We want people around us who are prudent, loving, just, and so forth, but balanced in these--temperate,

self-controlled. Maximum care is no better as an ethical goal than maximum prudence (self-interest). A community of moral saints, as Susan Wolf has argued, is not habitable. A perfect carer is an imperfect citizen, and a terrible bore.

But my sister and Galenson did more than care for me by themselves. They compelled me, by calling in the state. There's a difference between voluntary imprudent care and compulsory imprudent care. Compelling women to be sterilized (thus a recent scandal in Sweden) is different from suggesting it or offering it. The difference is the threat of legitimate (I mean legal, not justified) physical violence. What makes caregiving political is the involvement of police and locks and judges.

I would say at the outset that it is not enough that treatment X be good for you for you to be justly compelled. Otherwise one adopts an extreme utilitarianism, and would assign police to stop people from eating that Big Mac or reading the classic comic book. I take rather the other view, that an adult must be respected: offered help, but not compelled to take it. The psychiatrist Thomas Szasz has long outraged his colleagues by arguing that "involuntary psychiatric interventions rest on coercion, voluntary psychiatric interventions on dependency. It is as absurd to confuse or equate these two types of psychiatric relations as it is to confuse or equate rape and mutually desired sexual relations" (1997, p. 488).

When I was brought for my own good to the madhouse in Iowa I thought that I was going to be given a chance to explain, and to show on the spot that I was not crazy. *The craziness is my sister's and Galenson's, I thought. Surely this is all silliness, and a competent doctor will see it immediately. Gender crossing is not illegal, or evidence of craziness. I am going to have a nose job. There is no "danger to myself," that elastic cover for psychiatric thuggery. Surely the psychiatrist will let me go home after this.*

I did not realize that the doctor who was about to see me had been plotting with sister. I did not realize that I was about to experience illiberality. In such a civil commitment the psychiatrists never let the victim go, regardless of how reasonable he or she proves to be. The ceremony of examination is empty, a cover against liability. It's not the liability from false detention that worries the psychiatrists anyway, but the other side: I mean, what if he walks out of our hospital and shoots himself? In Iowa and many other states (it's harder in California, and impossible in Holland) the law provides that someone seized in this manner can be held for three days for observation--it works out usually to five days, because the courts that can free the victim are not open on weekends. In my case the psychiatrist decided without telling me to recommend holding me for

eight days. The feelings or condition or evidence or convenience or reputation of the victim are given no weight.

Psychiatrists do not like this civil commitment for observation. It is messy, and is often employed by abusive husbands to keep their wives in line--if the wife acquires in this way a "mental record" the husband can threaten plausibly to get the kids taken from her by Social Services if she misbehaves, like not getting up quickly enough to get him another cold one. The tactic is quite common, a major abuse of the statutes of caring. (I heard of another tactic, a woman in Iowa who had her boyfriend committed for observation, and in the days thus afforded emptied their bank account, sold their trailer and contents, and moved to Illinois with a new boyfriend.)

It's not much of an exaggeration to describe the legal situation as this: the victim has no civil rights, especially if poor and unable to hire a vigorous lawyer; nothing she says is to be credited; no penalty of perjury or civil liability attaches to the people initiating the seizure if their testimony proves to be false or even perjurious; and the psychiatrists do everything to avoid the liability from *not* keeping the victim, are cowardly about taking responsibility to let someone go, and in effect are exempted from liability for the consequences of a false seizure and an unreasonable detention. In Iowa as in many states (such as Illinois) any

two people who claim to know the victim can have him or her committed for observation if they can lie effectively to a judge. My sister was willing to lie to a judge to save her much-beloved brother. Anything. Love and courage.

I admit, as May Sarton points out, that “every middle-class ‘safe’ person should have to go to prison at some point to find out what the locked world is like.” Or to a madhouse. In both Iowa and Chicago I spent only one night, which was terrifying at the time, because on neither occasion did I know if I was every going to be let out, but was in retrospect educational. My upper-middleclass income permitted me to spend the \$8000 in legal fees to get an appropriately brief education in the locked world. It is not for myself that I complain but for my fellow victims without large incomes and secure employment and bourgeois self-confidence in the face of illiberal bureaucracies.

That one evening in Iowa I was interviewed by numerous psychiatrists, Dr. this and that, students and faculty all curious to see the gender-crossing professor. None of them knew about gender crossing, though all claimed to be expert. *They can hold me forever*, I thought in terror, *but they don't know what they are talking about*. The legal question was whether I was competent to sign the surgical permissions in a month to have a nose job. The psychiatrists seemed to be confused about this, and inquired irrelevantly into my sexual

practices. *Huh? What do my gender crossing or sexual practices have to do with the major mental illness that would make me incompetent to sign?* I noticed that the psychiatrists were humorless. My little jokes about the absurdity of the situation got nowhere, so I stopped making them. I slept that night uneasily, but hid it, pretending to sleep when awake, because the psychiatric nurses check for sleeping disturbances every hour. In the cuckoo's nest you develop a protective paranoia, if you have your wits about you.

A week after the Iowa commitment I went over to the hospital, as the court had ordered, to be interviewed by a psychologist, a young man who had had some experience at the program for gender crossers at the University of Minnesota. *Oh, oh*, I thought, *one of the American university programs following Johns Hopkins*. My opinion of Johns Hopkins' program was already low and became lower. It had once, when run by endocrinologists and surgeons, been a help for gender crossers, but long ago had been taken over by psychiatrists who wanted to "cure" them. Hormones and surgery could help the gender crosser, by carrying out his or her harmless desire. No gender crosser has ever been cured by psychiatry--about as many, I would venture, as the religious right has cured of homosexuality. Yet the Johns Hopkins psychiatrists kept on racking their patients. Help or medieval cure.

Both the good and the bad approach to gender crossing, the help or the rack, suppose that it is a “disease,” but the choice between the two depends on which metaphor of disease you use. Is help for a gender crosser like plastic surgery after a disfiguring auto accident? Or would giving such “help” on the contrary be an unprofessional indulgence, an approval for insane and immoral cosmetic surgery, and should one therefore help the patient by hurting him, jailing him, delivering a painful cure for a silly delusion? The Johns Hopkins way. *Vee have vays of “curing” dat.*

The young psychologist was apparently amiable, and better informed than his colleagues. *Watch it*, I reminded myself. *Amiable or not, he’s not your friend.* But then in a feminine way, or maybe just the self-involvement of a man, I forgot my caution, and talked too openly. After an hour or so we were joined by the psychologist’s boss, the chair of the Department of Psychiatry at Iowa. For some reason, probably his M.D. degree in the doctor-mad environment of a big hospital, he was to be involved. The Department of Psychiatry appeared to be terrified by the case.

The psychiatrist swept into the little room with the air of a man cutting through all the nonsense to the core.

“Are you a homosexual?” he demanded, without sitting down.

“Uh, no.” *Good Lord*, I thought, astonished, *doesn't he know the difference between homosexuality and gender crossing, who you love and who you are? Yiddish syntax: This is a psychiatrist? Not so funny. Watch out.*

“Have you ever had a homosexual experience?”

“No.”

“Do you wish to *become* one?”

Pause. “No, I’ve never wished to ‘become’ a homosexual,” I replied as nonchalantly as I could.

The psychiatrist stood astonished. “Well, then: *why are you doing this?!*”

I thought, *my God, the Chair of Psychiatry at the University of Iowa has the religious right's theory of homosexuality, as something you decide like style in clothing. He regards homosexuality and gender crossing as the same thing--gay men want to be women and gender crossers are in it for the sex. Don't say any of this. Don't.*

I regarded the psychiatrist with alarm, but did not reply. The young psychologist, seemingly embarrassed by this showing of his boss' ignorance, changed the subject. The two of them wrote a finding for the court, which admitted that I was competent to have the surgeries, the legal point at issue. And

then they expressed disapproval of my plans to become a woman, urging the judge stop me for a year. By force. State power. Policing gender.

Psychiatrists are structurally incapacitated to help gender crossers. They have no prudential interest in respecting the autonomy of people. Nor, unlike surgeons, do they need professionally to exercise courage. So they become, if they are not already, cowardly and authoritarian. Against a social taboo like gender change they are helpless.

My surgeon in San Fransisco called the psychiatrist in charge at Chicago, that second episode of my sister's caring behavior. The psychiatrist's letter about me had been ambiguous in its last paragraph, and my sister had tracked me to San Francisco and now was at the last moment trying to stop the nose job by threatening the hospital with suit. The Chicago psychiatrist's letter was not good enough to satisfy the lawyers for the hospital: it read like more of the self-protection which seemed to be the main object of psychiatric practice.

My surgeon later told me roughly what he had said to on the phone to Chicago:

“Do you think Deirdre is competent to sign the consent form and be operated on?”

“Yes.” The psychiatrist had said the same to me a couple of weeks earlier.

“That’s wonderful! Could you write that down, in the same words? You can send it to California by fax.”

“Uh. . . . My typist isn’t here.”

“You can write it on a sheet of paper and fax it. You know how to write, don’t you?”

“Umm. I don’t know how to operate the fax.”

“Turn it on and I’ll tell you how to do it over the phone.”

“The cord’s not long enough.”

Nothing worked. The psychiatrist wouldn’t do it, wouldn’t say in print what he had said twice and what he believed. *He’s afraid*, I said to myself. *He half believes my sister’s theories about me waking up and regretting it all and going crazy. He doesn’t want to be responsible. Psychiatrists don’t. Professional cowards. Unlike surgeons, who must decide now, psychiatrists can always wait. “Let’s see how she looks after a month in a madhouse. A year.”*

The psychiatrists are involved in gender crossing because there is a medical “protocol,” called the Benjamin Standards, not because there are in fact laws. Protocols are customs among doctors, which in their opinion protect them

from claims of malpractice and give them a sense of knowing what they doing-- often when they do not (the erroneous treatment of tonsillitis, for example, was a protocol, as was the practice of radical mastectomy and the casual use in the 1950s of lobotomy and electric shock therapy). The Benjamin Standards, which require that psychiatrists sign off on a gender changer, were formulated thirty years ago without scientific evidence and have not been changed since in the light of new evidence.

Even in tolerant Holland, where I fled for a year, the Benjamin Standards ruled. I needed hormones, and got them from the largest program on gender crossing in the world, at the Free University Hospital of Amsterdam. They wanted a psychiatrist to interview me, though it seemed to me pointless. I was not officially in the Free University program, which for political reasons has to extend the transition to two years of agony between genders, following the Benjamin Standards. But I needed the hormones, and so couldn't risk standing up for patient rights. Anyway I like the Free University program. It's good, a lot better than the few hospital programs in the United States, dominated by the example of Johns Hopkins.

The young woman psychiatrist asked me the usual questions, running down a checklist in her mind of the gender-crossing illness. "When did you first

want to be female?” “Were you effeminate as a child?” I could see the psychiatrist’s eyebrows rise when she got an answer that didn’t fit the conventional "diagnostic" list thrown together for the *Diagnostic and Statistical Manual of Mental Disorders* out of junk science. I thought, *She does not realize how silly the list is.*

*So what? Does it matter? Can she hurt me? Can she stop my prescription of estrogen, or tell my potential surgeon in Australia I’m not "really" a gender crosser?*

*Damned right she can.*

*Time for action.*

I started lying. We all do it. A psychiatrist proposes to withhold a desired and harmless life from a free, sane adult on the basis of no scientific evidence and no intelligent empathy for the patient and no understanding that the DSM’s list of symptoms rewrites the society’s myths about gender. We need to examine you. For two years. Wait, wait. Pay, pay. We might not ever approve you. Chances are, we won’t. I know a gender crosser from Galesburg, Illinois, an otherwise normal if workingclass person, who after two years and \$2,500 of “therapy” from a local psychologist was still being delayed: You have more issues to work on. You will *always* have “more issues to work on,” dear. It’s therapy for

the therapist not for the gender crosser. Daphne Scholinski, a female-to-male gender explorer, described the psychiatrists sicced on her in 1981: "They're not interested in what you think. They want you to give them the right answer so they can walk away smiling, pleased at the progress they have instigated."

Of course the gender crossers lie. They can read the DSM just as well as the psychiatrists can. Pat Califia, who wrote the book on it, notes, "None of the gender scientists seem to realize that they, themselves, are responsible for creating a situation where transsexual people must describe a fixed set of symptoms and recite a history that has been edited in clearly prescribed ways in order to get a doctor's approval for what should be their inalienable right."

"Oh, yes," I said earnestly to the Free University psychiatrist, "I've always had these desires. Oh, yes, Doctor, ever since I can remember. Oh, yes, it's *just* like being a woman in a man's body. Oh, yes, I *hate* my penis." *Oh, yes, Doctor, whatever your dopey list says.* The psychiatrist's eyebrows returned to normal.

It was my last encounter with psychiatrists--except trying a year after I returned to Iowa to get the Department of Psychiatry to take out the 30 pages of medically misleading notes from my file. I pointed out that every doctor who saw my file at the University of Iowa Hospital would see the wedge of "psychiatric

information,” and that I could be misdiagnosed as a result. *Maybe I already have been*, I thought suddenly. *It might account for the casual way my physician brushed off my attempts to get Blue Cross to pay for the second operation on my vocal cords. Maybe he thought, “Look: it says here she’s nuts anyway.” Probably not. But more nonsense to worry about.* I made an appointment with the chair of psychiatry, the same who had asked, “if you’re not homosexual, then why are you doing this?”

Now he was resentful and uncooperative like a bad boy who had been caught in a lie. He didn’t want to fix the damage that he and his department had been tricked by my sister into doing. As a result the lawyers at the hospital had to be whined at for months to do the little they said they would do. They would “sequester” the psychiatric parts of the file. But when I went to look at my file to check to see if they had done what they promised there was a large notice “ONE OF TWO FILES” and no assurance I could trust that doctors could not get access to the “sequestered” set. Back to the lawyers. Anyway the curiosity of even one judge would make all the sequestering irrelevant. I finally gave it up, and resigned myself to being misdiagnosed in future at the University of Iowa Hospital as having “mental” disorders when I in fact had physical ones. Welcome to womanhood, dear.

There's no case for letting psychiatrists get at a gender crosser.

People say, "Wait a minute. It's an irreversible step. Better check it out." But the psychiatrists don't know how to check it out. They know nothing about it, and are not interested in learning. To make them assess gender crossers is like making a brain surgeon do open heart surgery. It's not in their competence. The excitement these days in psychiatry is about drug treatment of psychoses. It's wonderful that some clinical depression and even schizophrenia can be helped with drugs. But gender crossing is not a psychosis, and there is no medical evidence that it is associated with psychosis in any form. We might as well have psychiatrists check out people with brown hair or people with cheerful dispositions or people who like to visit Venice as often as they can. Just to make sure.

And The Step is not irreversible. When I make this point people get indignant. They at least know *that* much. "What are you talking about? Someone cuts off his penis and you say it's *reversible*?!" Please, listen. Operations--not that *The Operation* is the essence of it all--can be reversed, sometimes. For example you can take out cheek or breast implants. True, with current techniques reconstructing a penis is very expensive. That's the only advantage that male-to-females have over females-to-males in cost and effectiveness: because it's easier to remove than to make, their male-to-female operation is a fifth the cost of the

female-to-male one, a compact, low-end car instead of a Mercedes. But so what? Forget about reconstructing the penis. Many men do not have penises, on account of war or accident or disease. This does not for most purposes make them less men. A man is a man because of his look and behavior, not because of what is secretly in his pants. And beyond the content of pants, ones behavior and dress can be changed back. The hormones, too, have partly reversible effects. If I stopped female hormones and started testosterone, in five or six months I'd be acting like a jerk again. (This joke works best if there are lots of other women present.)

Anyway we need to ask whether we want to invite psychiatric caretakers to have power over all the comparably important business of life. Having a baby is well and truly irreversible, more so than gender reassignment. A new human being is brought into the world. Well, shouldn't everyone have many years of psychological/psychiatric counseling before having a child? And getting married, though reversible at some cost, like cheek implants, is pretty serious, too. So likewise is choosing a career, or buying a house, or taking up golf. If these were treated the way gender crossing is treated we would need for each a certification from psychiatrists achieved through hours and hours of expensive conversation; maybe some drugs; or if nothing else works hitch 'em up to the

house current. Such certification and treatment would be absurd for the reasons it is absurd for gender crossing. The psychiatrists don't know anything worthwhile about having a child or buying a house or being a gender crosser, as most psychiatrists admit.

And even if they did know, in matters not affecting other people's rights we regard ourselves as free individuals. The freedom question is: Why not? There's no case for a special enslavement of gender crossers to the psychiatrist, except that there are so few of them that no one troubles to care.

Gender crossing is called in the DSM-III "gender dysphoria," Greek for being uncomfortable with your birth gender. Being uncomfortable with, say, poverty or brown hair or lack of fluency in French is not labeled a "disorder." Drunk and disorderly. A threat to order, the order that gender is irrevocable. A gender crosser I know in Iowa City lives under threat by a psychiatrist at the University of Iowa Hospital that if she appears there for treatment of her mild, easily-treated depression (having nothing to do with her gender crossing) she will be sent to the state madhouse for three months. She has posted on her door a sign: "If you are coming to take me to a hospital, take me to Mercy," the local Catholic hospital--anything but the University of Iowa and its crossphobic psychiatrists.

I have been surprised that psychiatrists have allowed themselves to be cast as gender police. Nowhere in the literature, I repeat, has a “cure” been reported for the “disorder,” except the cure of letting people be who they wish to be, which has done its work for tens of thousands. But when the psychiatrists get the chance they lock people up; and if they don’t have locks they deny permission. The patients wait, and go slowly mad, which then confirms the prior judgment of unsuitability. Doctor sickness.

The world’s anxieties about gender support the psychiatrists’ presumption. For God’s sake don’t let him do *that*. The residual crossphobia in the DSM justifies parents on the religious right in sending their children to jail camps to butch up the boys and femme down the girls, scaring them straight. “After all,” the parents say, “whatever the allies of Satan claim, homosexuality is not an identity or a biological fact. It’s a choice of life-style, a sin and sickness you can cure. Why, not long ago even the liberal psychiatrists thought of homosexuality as a ‘disorder,’ not a trait of character. And gender crossing, right there in the book, this ‘gender identity disorder,’ it’s the same thing, isn’t it? The liberals still think *that’s* a disorder. Darn right. No son of mine.”

A resolution was passed on August of 1997 at the annual meeting of the American Psychological Association, in Chicago, a quarter of a century after

homosexuality was guiltily removed from the *Diagnostic and Statistical Manual*. Homosexuality “is not a mental disorder and the American Psychological Association opposes all portrayals of lesbian, gay and bisexual people as mentally ill and in need of treatment due to their sexual orientation.” Most American gender crossers want the same liberation from psychiatric torture. They want gender identity “disorder” removed from the list of madnesses, and another sentence added to the resolution of 1997: “The same is true for gender crossing and crossgendered identification.” The Canadian gender crossers object, because under their national health service they get money for the operation as long as the “disorder” is in the DSM. Consistent Canada. *Merci bien*.

There are, in short, two versions of love and caring. One is absorbing, taking the beloved or the cared-for into the personality of the lover or caretaker. When economists, who for the most part are simpleton utilitarians, are challenged to admit that love exists in the world they say, “No problem. Just make altruism into a good. That is, write your utility function as  $U_{Me}(Me, Thee)$ .” The point is that Thee becomes a part of Me. Thee only has identity as contributing to the Utility of Me. A mother who loves her child as a contribution to her own wellbeing, not for the child’s own sake, is behaving like the monster of prudence the economist favors. In a fine essay on “Reasons for Altruism” the philosopher

David Schmitz, a colleague of my sister's at Arizona, insinuates identity into the economist's tale. "There is this advantage in having a principled character," he slyly remarks to the economist standing by watching for arguments from Prudence Alone. "We become selves worth struggling for" (p.171). But a love that acknowledges the identity of others, and not merely their utility functions, is one that respects persons. It is a non-absorbing care. "Paternalism . . . is a form of altruism--an expression of concern for the welfare of other people--that overrides one's respect for their expressed or implied preferences" (p. 174). Bad caring is paternalism.

Or perhaps we should call it sororism, or psychiatrism, or just the pathology of care.

### Works Cited

Califa, Pat.

Casey, John. 1990. *Pagan Virtue: An Essay in Ethics*. Oxford: Oxford University Press.

- Dower, Nigel. 1993. "World Poverty." Pp. 273-83 in Peter Singer, ed., *A Companion to Ethics*. Oxford: Blackwell.
- Midgley, Mary. 1984. *Wickedness: A Philosophical Essay*. London and NY: Routledge.
- Nodding, Nel. 1984. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley and Los Angeles: University of California Press.
- Schmidtz, David. 1993 (1996). "Reasons for Altruism." In Ellen F. Paul, F. D. Miller, and J. Paul, eds., *Altruism*, reprinted as pp. 164-175 in Aafke E. Komter, ed. *The Gift: An Interdisciplinary Perspective*. Amsterdam: University of Amsterdam Press.
- Scholinski, Daphne. *The Last Time I Wore a Dress*.
- Tronto, Joan C. 1993. *Moral Boundaries: A Political Argument for an Ethics of Care*. NY and London: Routledge.
- Wolf, Susan. 1982 (1997).. "Moral Saints." *Journal of Philosophy* 1982, reprinted as pp. 79-98 in R. Crisp and M. Slote, eds. *Virtue Ethics*. Oxford: Oxford University Press.