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MOURNING THE BODY AS BEDROCK: DEVELOPMENTAL CONSIDERATIONS IN TREATING TRANSSEXUAL PATIENTS ANALYTICALLY

This paper introduces the concept of massive gender trauma, a clinical syndrome arising at the onerous intersection of the misgendering of transgender patients and the subjective, anguished experience of the natal body. Analysts have become increasingly aware in recent years of the complex interactions between psyche, soma, and culture. Consequently, the field is increasingly hospitable to considering the psychic risks inherent in misgendering. However, patients' body dysphoria is often left unaddressed even by analysts who seek to work within their analysands' gendered experience. Through a detailed, in-depth account of work with a five-year-old trans girl (female-identified, male-bodied), the developmental implications of the natal body's not becoming sufficiently mentalized in the course of treatment are tracked and explored. Attention to unconscious fantasy and its transformations shows the importance of helping transgender patients whose bodies are a source of suffering to be able to psychically represent their pain as a critical step in the process of a psychologically healthy transition.

Keywords: gender, misgendering, body dysphoria, unconscious fantasy, transgender, trans child, gender variance

My six-year-old patient Jenny and I worked together in analytic play therapy two or three times weekly for a year and a half before she was able to share with me something I had known all along

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from her parents: Jenny had been born male. Careful and patient work, which I will describe in detail, made it possible for Jenny to move from being deeply invested in my not knowing about her natal sex to wanting to share with me this information that to her was exorbitantly painful. When that time came, however, rather than say to me, as one might expect, that she had been born male, Jenny confided worriedly: "I don't want you to think I've been lying to you, but there is something I haven't told you: Dad thinks I'm a boy." She paused shortly, scanning my face for a reaction to her revelation, then added sadly, "sometimes I wear boy clothes so his heart doesn't keep breaking."

Jenny's statement captures something crucial about the experience of patients like her: for her it is of course the father who is mistaken in his gender attribution. This brings into sharp focus a key controversy in our field regarding transsexual[1] experience: is the patient gender-confused, failing at adequate reality testing, or is the environment unable to mirror an internal experience that doesn't meet expectable forms of gender?

In its juxtaposition of external reality with internal experience this dichotomous conceptualization of transsexual phenomena pits psychic and social forces against each other instead of attending to their interpenetration. As such, the conceptualization is facile: Jenny, for example, was unquestionably a liar, if only a Winnicottian one. Much like other trans children her age (Ehrensaft 2011a,b, 2013a), she was hard at work developing a false, male-presenting self (Winnicott 1955) to protect her father from his distress about her femaleness.[2] Well aware that body morphology largely dictates how one's gender is understood by others, Jenny's

[1]In this paper I use the term *transsexual* to refer to individuals whose experience of gender contradicts their natal sex and whose gender identification follows a binary, male/female classification (e.g., individuals born with male anatomy who experiences themselves as female). I use the term *transgender* to describe individuals with a wider spectrum of gender experience, gender expressions, and sexual anatomy. For reasons I will explain in detail, I understood Jenny as most likely being a transsexual girl (trans girl). Consequently, the dynamics and interventions I discuss should not be thought of as applicable to all transgender patients; they are relevant mostly to work with transsexual children and adults.

[2]In children, defenses deployed against experiencing themselves as a disappointment to their primary objects can often be perplexing to those in their environment, who understand them as evidence of a child's "confusion" regarding gender identification (Lev 2004). Notably, adult trans female analysands often describe having adopted stereotypically masculine clothing and mannerisms in childhood to conceal their effeminacy.

negation ("I don't want you to think I've been lying") concealed her concern that if I knew, I too would think of her as a boy. Still, the problem Jenny faced did not arise exclusively from without—that is, from a world that treats gender as fixed by biology. Jenny's was also a problem of inner life: insofar as her gender experience clashed in painful and perplexing ways with what she encountered in her body, Jenny was tormented, *herself* confused about how it was possible to feel that she was a girl when her body spelled "boy."

Tackling therapeutically any one of these issues would in itself be a difficult task. To deal with all of them, as well as with the unconscious fantasies and defensive strategies that undergird them, is an extraordinarily challenging clinical endeavor (di Ceglie 2009). Psychoanalysis is ideally equipped to address such nuanced and tangled therapeutic needs precisely because it can help illuminate how inner and outer synergistically complicate and amplify each other.[3]

I will take up these clinical issues from an analytic angle, paying careful attention to the developmental challenges and psychic perils faced by transsexual patients. In the course of this exploration I deliberately eschew the much-debated quest for etiological factors. I will do so for several reasons: first, both research studies and clinical experience have failed to produce data that support robustly any of the explanatory hypotheses advanced to account for transsexualism (de Vries and Cohen-Kettenis 2013; Gomez-Gil, Vidal-Hagemeijer, and Salamero 2008; Smith et al. 2005). Second, the search for etiological underpinnings treats transsexual experience as a unitary phenomenon rather than as the end point of heterogeneous developmental pathways and complex compromise formations (Marcus and McNamara 2013). Gender aggregates polyvalently, not lending itself to being theorized generically. As such, speculative generalizations around the origin of gendered feelings that don't match the natal body often breed inflexible clinical attitudes. Last, while both normative and nonnormative iterations of gender are idiosyncratically and complexly assembled (Corbett 2011a; Goldner 2011; Harris 2005a), questions around etiology arise only when gender experience does not

[3]Contrary to Chiland (2009), I have not found it true that transsexual patients rarely enter analytic treatment. Nor do I agree with Argentieri's statement (2009) that such patients come to analysis only after "the damage [by which she is disparagingly referring to hormono-surgical interventions] has been done" (p. 4).

align with the body's material surfaces. The implication is that patients' normative gender is accepted at face value, whereas nonnormative gender must account for itself and argue for its legitimacy. This conviction lies at the epicenter of our field's problematic theorizing of trans experience as being the unquestioning product of unconscious fantasy. I will depart here from this established belief to explore what we might better understand about transsexual patients if we treat their gender not as symptom but as a *viable subjective reality*. My particular focus will be to try to comprehend how unconscious fantasy may be mobilized to manage the painful experience of gender/body mismatch *once it has been formed*. One possible dynamic deployed to deal with distress arising from the discontinuities between body and gender experience is, I will propose, the unconscious fantasy that one has been born into the wrong body. As developmental considerations are crucial to tracking these unconscious operations, I take up at length a child treatment, supplementing it with material from an adult analysis.

PSYCHOANALYSIS MEETS TRANSGENDER EXPERIENCE

Psychoanalysis has historically engaged problems of gender and gendered embodiment by reflexively treating them as indices of underlying narcissistic disturbance (Chiland 2000; Oppenheimer 1991, 1992; Quinodoz 1998; Stein 1995), perversion (Argentieri 2009; Limentani 1979; Socarides 1970), and difficulties in separating (Coates 1990, 2006; Coates and Moore 1998) or disidentifying from the mother (Stoller 1985). In more recent years a different set of analytic voices is approaching with genuine curiosity transsexualism's bid to delink the sexed body from gendered experience. These authors have been writing about transsexual and transgender phenomena in ways that dislodge variable genders from presumptions of pathology (Corbett 1996, 2009, 2011b; Ehrensaft 2011a, 2013b; Goldner 2011; Hansbury 2013; Harris 2005a; Lemma 2012, 2013; Saketopoulou 2011a,b). Borg (2011), Hansbury (2011), and Suchet (2011), for example, offer excellent case reports from lengthy analytic treatments that move to the foreground of our attention the importance of deepening our insights into the phenomenology, developmental progression, and psychically structuralizing impact of variable gender identities. Considerable ego-fortifying effects accrue from treatments that approach these patients from

within their genders rather than seeking to "cure" them. The prophylactic impact of such treatments, especially with child patients, is critical for this population, which is extremely vulnerable to severe mental health problems: poor self-esteem, difficulties with peer relations (Balleur–van Rijn et al. 2013), acting-out behavior (Bockting et al. 2013), and suicidality (Roberts et al. 2012; Spack et al. 2012).[4]

Psychoanalysis is becoming an increasingly hospitable place in which to theorize nonnormative gender, in part by examining gender's porosity vis-à-vis other strands of experience (Corbett 2008, 2009; Dimen and Goldner 2005; Saketopoulou 2011a). This expansive framework makes it possible to start identifying the theoretical prejudices and institutional biases that have kept transgender experience outside empathic analytic inquiry (Corbett 2011b; Gelé et al. 2012; Pula 2011, 2013).

These significant advances notwithstanding, working with trans phenomena as they are encountered in childhood is an infinitely more complicated matter. This is not only because what Corbett (2009) calls *regulatory anxiety* becomes especially heated when it comes to children. It is also because childhood variant gender is largely fluid and subject to various developmental outcomes (Edwards-Leeper and Spack 2013; Meyer 2012; Steensma et al. 2010; Zucker et al. 2013). For most such children, gender will not coalesce into a full-fledged cross-sex identification, as most of them are likely to develop into gay adults (Davenport 1986; Green 1987; Wallien and Cohen-Kettenis 2008). There does exist, however, a small fraction who will become transsexual adults (Steensma and Cohen-Kettenis 2011; Spack et al. 2012). The question of how to distinguish those whose gender conflicts will persist over time is a question to which we do not yet—and may not ever, even over time—have a definitive answer (Drescher and Byne 2013).

An emerging body of literature seeking to address this distinction categorizes these kids into two groups: persisters and desisters. For desisters, gender continues to be polymorphous throughout life, not coagulating into a crisp male/female split and not accompanied by a pressing need for bodily modification or hormonal treatments. Persisters, by contrast,

[4]It is interesting that gender-atypical behaviors more often attract attention when manifested in natal boys rather than in natal girls (Cohen-Kettenis et al. 2006; Zucker et al. 2009); in the latter, masculine behaviors are more often interpreted as signs of precocious development (Halberstam 2005); see also Abell and Dauphin [2009] for an in-depth discussion of this phenomenon).

grow up to be transsexual adults and evidence a need for hormono-surgical interventions. Studies place the percentage of persisters at 12–27 percent of the gender-variant child population (de Vries and Cohen-Kettenis 2013; Steensma et al. 2010; Drummond 2008 [this last for a natal female sample only]).

This line of research is still in its embryonic stages. Very little is understood as to what factors might help differentiate the two groups. The most consistent finding identifies young persisters as expressing struggles with their bodies (e.g., "I don't want to have a penis"), whereas desisters present with more anxiety about being constricted in the range of their gender expression (e.g., "Why can't I wear a dress?"). When puberty hits and the body becomes gradually masculinized in natal boys, and with the development of breasts and the onset of menarche in natal girls, the differences between the two groups become more dramatic. Persisters' levels of distress rise precipitously. Levels of depression, as well as anxiety symptoms, escalate, and there can be serious acting-out behavior against others and self, including psychotic decompensation. This kind of symptomatic exacerbation is viewed as a diagnostic indicator that the young adolescent should be considered for medical treatment[5] (Spack et al. 2012). For desisters, puberty does not usher in this kind of intensification of psychic pain. While the earlier variant gender expression often persists, it tends to settle into a gendered presentation of self (e.g., an effeminate gay boy) that is not characterized by the extreme discomfort with the body or the need

[5]Hormone blockers are used at this developmental juncture with increasing frequency to suppress the endogenous secretion of sex hormones in order to halt the emergence of secondary sex characteristics. In their absence, transgender children who go through pubertal bodily changes, and who later in life will request reassignment, must contend with unwanted physical changes that will require major medical interventions. It is important to note that some of these undesired physical changes (e.g., vocal changes) are virtually irreversible (Wren 2000). Hormonal suppression has been employed in the U.S. in the past decade: in 2009 the Endocrine Society issued formal guidelines for the treatment of adolescents that fulfill strict readiness criteria recommending the use of reversible GnRH analogs at Tanner stage 2/3 (Hembree et al. 2009). A discussion of hormone blocking per se is beyond my scope here, but the interested reader can consult Drescher and Byne (2013). To my knowledge, there exist only two studies on puberty suppression: the first spanned twenty-two years and indicates good psychological, intellectual, and social adjustment, no medical complications, and no evidence of regret (Cohen-Kettenis et al. 2011), while the second (de Vries et al. 2014) found that hormonal suppression, followed by administration of cross-sex hormones and surgical interventions, yielded an alleviation of dysphoria-related symtoms and steadily improved psychological functioning.

for bodily modification evidenced in persisters. Although the insistence in cross-gender play, activities, and dress may not dissolve, the relationship with the body is not ego-dystonic.

Zucker et al. (2002) have noted that while the findings of retrospective studies observe a progression from childhood gender dysphoria to adult transsexuality, prospective studies indicate that the majority of gender-variant children will not develop into transsexual adults. Since none of these preliminary findings unequivocally indicate a clinical direction as to the treatment of a child who has not yet reached puberty and whose gender-related pain is throbbing, child analysts who treat such patients are left without a compass they can rely on to guide clinical technique.

MASSIVE GENDER TRAUMA

I use the term *massive gender trauma* to denote a developmental trajectory that captures the struggles of two patients of mine I will discuss here—a child patient, Jenny, and an adult analysand, Hazel—and that may also illustrate the difficulties of other transsexual patients. Massive gender trauma arises at the frequent yet onerous intersection of two critical, often paired, psychic events:

The experience of being misgendered: being misrecognized by one's primary objects as belonging to one's natal sex despite the patient's explicit articulation of a different gender identity. When gender is tenaciously conflated with bodily morphology, such individuals often feel unseen and unknown (Goldner 2011; Lemma 2013).

Gender-inflected body dysphoria: the painful feeling that one's physical body and one's gender are misaligned (e.g., female children who understand themselves as being boys). Such dysphoria may present as early as two or three years of age (Coates 2006; Edwards-Leeper and Spack 2013) and is often accompanied by a powerful wish for coherence between one's experienced gender and bodily anatomy.[6]

[6]Though my focus is on individuals who experience body dysphoria from very early in life, not all transsexual individuals share this characteristic. This point of clarification is important because of the categorical statements made in years past by influential analytic authors (e.g., Person and Ovesey 1978; Stoller 1985) and trans care providers (e.g., Benjamin 1977) who insisted on the diagnostic value of early body dysphoria in identifying "true transsexuals," a taxonomy that held incredible political and discursive power, as it determined access to transgender-related health care.

Massive gender trauma arises from the mix of these two distinct but inter-implicated psychic events. It is a particularly toxic, psychically combustible blend that shares some of the formal features of traumatic experience: dissociation, anxiety, depression. By sharing process material from my treatment of Jenny, I will try to illustrate that in children these difficulties must be negotiated together with, and sometimes through, the synchronous burdens of normative psychic growth, leaving the developing psyche vulnerable to psychiatric illness. The dynamic solutions children may adopt to manage these challenges, the way in which unconscious fantasy can become recruited in dealing with the discontinuities between the body and gender, can then become folded into the very structure of the personality, leading to serious characterological problems, difficulties with emotional regulation, and even impaired reality testing. As they get weaved into the very fabric of how one negotiates the intrapsychic and intersubjective worlds, strategies that originated in the attempt to manage massive gender trauma may become part of the individual's character (Krystal 1978, 1985) and overall psychological functioning. The ensuing emotional difficulties and psychiatric problems, I am proposing, often *result from* the traumatic and unmentalized impact of being trans rather than being its originary cause, as is often assumed. Notably, research has shown a propensity to mood-disordered presentations in children who struggle with their gender (Edwards-Leeper and Spack 2013), the symptomatology of which recedes with social and medical transition.

Current treatments of atypically gendered children are often focused exclusively on an understanding of gender as issuing exclusively from culture. Tending to approach gender-variant children as simply misunderstood by their environment, the interventions proposed center on helping the family metabolize the child's complex gender. Analytically oriented treatments, on the other hand, tend to axiomatically privilege corporeality as the sole determinant of gender. Until recently (Corbett is among the exceptions here), this has resulted in reflexively treating a child's atypical gender as a symptom. Treating massive gender trauma analytically requires twinned therapeutic foci: of course, careful attention must be paid to the traumatic effects of being misgendered,[7] as it is often

[7]Lemma (2012) has discussed at length the disruptions in identity formation that result when a transsexual individual's body has not been met by the receptive mind of a parent who can lend meaning to the child's sensorimotor and proprioceptive experiences. Other consequent disturbances in self- and object relations have been compellingly addressed by clinical writers such as Suchet (2011) and Hansbury (2011).

experienced as a form of psychic violence and assault (Langer 2012). That, however, is not adequate.

The critical and rarely addressed issue—and my focus in this paper—is the anguish felt in response to the body's primary and secondary sexual characteristics. Parents frequently react to children's body dysphoria with anxiety, alarm, and bewilderment. Overwhelmed by their own affect, they often seek help. Treatments that focus solely on supporting the child's gender identification, however, are inadequate. Such approaches are oriented toward disaggregating the body from gender and usually stem from a misreading of contemporary gender theory's emphasis on gender performativity (Butler 1993) as positing that gender is something that people consciously choose to enact rather than something that people *are* (Meadow 2014; Serano 2013). As such, these interventions fail to capture the clinical importance of helping body-dysphoric children mentalize their overwhelming and unbearable somatic feelings. This anguish issues from their inability to resolve the conflict between the reality of their gender experience (e.g., Jenny's "I am a girl") and their heavily defended-against attachment to the notion that the body spells gender's reality. Jenny, as we'll see, was herself unable to digest how she could be a girl when her body told her she was a boy.

To resolve this conundrum, some transsexual patients resort to the unconscious fantasy that one's natal sex is not real and never has been. This permits them to hold on to their own sense of their gender without having to confront the material reality of their sex. On a conscious level this can manifest as the belief that one was born in the wrong body. For example, persons born male who have been unable to process the discrepancy between their corporeality and their gender may come to believe that they were mistakenly born in a male body when in fact they *should* have been born female. How are we to understand such beliefs if not as issuing from the exorbitant pain that masquerades as a sense of a cosmically perpetrated injustice? "Ungrieved grief," Cheng tells us, "becomes grievance" (2001, p. 46). Whatever religious or metaphysical convictions may undergird such beliefs, the unconscious fantasy that one was born in the wrong body—as opposed to having been born into a body one does not recognize as one's own—is, I am suggesting, underwritten by the unmetabolized turbulence of body dysphoria. For such patients, mourning the fact that their natal body does not fluidly map onto their gender is a crucial part of the therapeutic process. I use the

term *mourning* here as discussed by Steiner (1992): the feeling of loss often accompanying the relinquishment of omnipotent control. In the case of the transsexual patient, this omnipotent control has sometimes been installed in the first place as a way of keeping at bay the pain of the body/gender disjunction. The analytic task is to help the patient delink gender and body, to disturb the fixed relationship between the materiality of the flesh and gendered experience in order to allow language and symbolism to enter these knotted psychic spaces.

To work productively with transsexual patients, this kind of suffering needs to be better understood. Yet in the absence of analytic models that tolerate body/psyche discontinuities without insisting that psychic experience meet the soma, such individuals often don't receive the help they need to bear the knowledge of their natal bodies. By "knowledge" here, I am drawing on Bion's notion of +K (1967). which treats knowing not as a cognitive act of intellectual perception but as an emotional event that involves contact with inner life and with the pain that saturates it, the capacity to stay still and observe pain before one moves to act. This kind of knowing requires that cognitive acknowledgment and psychic torment be reconciled rather than evaded and denied.

Naming and processing the anguish brought to these patients by their bodies, exploring the body's psychic meanings, and eventually accepting the body one was born into are crucial to psychological health. Yet, contrary to the position argued by many analytic writers (Chasseguet-Smirgel 1985; Chiland 2000; Stein 1995),[8] I do not see this kind of acceptance as resolving transsexual individuals' need for hormonal and surgical interventions. Neither do I believe that such medical interventions are sought to act out unconscious fantasy; instead they are sought to align the body's contours with the "felt body" (I will return to the "felt body" later, but see Salamon 2010, especially chap. 6). Thus, coming to terms with the body one has is a gateway to a psychologically healthy medical transition process. This distinction matters greatly because it should guide our clinical technique: the body one has needs to be known to the patient *so that, when necessary, it may eventually be given up*.

[8]A later section of this paper addresses the common analytic concern that medical interventions privilege action over thought, making transgender patients not analyzable.

JENNY

Jenny, a five-year-old child from an upper-middle-class Caucasian family, was referred to me by Dr. A., an experienced and gifted psychoanalyst who had consulted with her family. Uninformed of the extent of her gender conflicts, Dr. A. had approached Jenny in the waiting room and had crouched down to her height to say, "Hi, I'm Dr. A. And you must be Johnny." What followed was an agonizing outburst, part fury, part despair. Jenny cried inconsolably and, amid her tears, admonished her parents for their betrayal: "You told! You told!" Jenny's parents tried to assure her it was okay, that Dr. A. had met other kids like her, but she could not be soothed. Jenny was unable to tolerate the full forty-five minutes, and the session was terminated early. It became apparent that a combination of the unintended misnaming and Jenny's pronounced fragility had destroyed any likelihood that a therapeutic relationship might be established with Dr. A.

When Dr. A. called me to make the referral, we both appreciated how devastating that particular address must have been, an address that Jenny had perhaps interpreted as "You *must,* you *have to be* Johnny." Dr. A. and I were also struck by Jenny's inability to modulate the intensity of her feelings. Once the experience of distress had been elicited, she could not be comforted. I wondered what else, other than the evident pain of misrecognition, might have landed Jenny into this throbbing tantrum.

When I met with her parents they reported to me that Jenny had been saying she was a girl since she was two years old, that she had always expressed anguish about her body, and that she felt resentful about being perceived as a boy. Over the years she had moved from distress, to depression, to violent acting out, to hurting herself, and she had recently become persistently suicidal. Her parents were incredibly concerned. Despite their being able to provide an otherwise detailed developmental history, however, their memory regarding her gender development was rather vague. This suggested to me that though they appeared to be on board with Jenny's gender identification, they might be struggling with it more than they could acknowledge to me or to themselves. The mother was less able to voice her ambivalence than the father, yet contrary to common parental reactions of distress (Brill and Pepper 2008; Hill and Menvielle 2009), both initially appeared to find it crucially important to present

themselves as unconflicted about Jenny's femaleness.[9] Had their failure to inform Dr. A. of the degree to which Jenny was female-identified, I wondered, been an enactment of their ambivalence? Had Dr. A. been unconsciously recruited to enact what they could not bear to think or to mourn?[10]

A year earlier, the parents reported to me, they were informed, in a meeting with Jenny's coach, that their child had been identifying as a girl. The coach was asking the parents how to handle the situation when Jenny stepped in: it was she who should be asked, and her name from now on was to be Jenny. Her parents were deeply shaken. Neither had heard the name before, and they had not realized that Jenny's femaleness had a life that spread outside their home. On the other hand, Jenny's gender was not news to them. And since, as I soon learned, they had both struggled with issues around establishing their own sense of agency in their early lives, they felt strongly about not wanting to repeat the same dynamics with their own child. Both took considerable pride in their daughter's advocating for herself. From then on they followed her lead, and soon Jenny was socially transitioned to living as a girl: she was in dresses, wore barrettes in her hair, and routinely introduced herself as a girl. The parents fully complied with Jenny's instruction that since she had been born "in the wrong body," all evidence of her male past should be instantly erased. Acting as if Jenny had been born female, the parents dutifully obliterated all references to her bodily anatomy (e.g., at bath time) and avoided any discussion of her natal maleness.

With these changes at home and in school, Jenny's suicidality quickly receded. Yet another set of behavioral problems started surfacing. Jenny began getting into vicious arguments with her younger brother when he struggled with pronouns or the name change. Any accidental mention of her maleness by relatives or schoolmates sent Jenny into unending fits of tears that would cascade into prolonged tantrums that were traumatic for the entire family. What had originally looked like open-minded acceptance was beginning to spiral out of control. The parents started becoming

[9]During the course of the family work this shifted, with the father becoming able to get in touch with and express more openly his discomfort with his child's gender. This, as we came to discover, was something Jenny had been sensing long before her father became aware of it himself.

[10]Mourning one's own fantasy of one's child is an important facet of the work that is not taken up in this paper, but see di Ceglie (2012) and Riley et al. (2011a,b).

worried about how Jenny's refusal to acknowledge her past would evolve and what it would mean for her future. What were they going to tell those who had known Jenny as Johnny and who naturally had questions? How should they manage her tearful and occasionally rageful demands that she be introduced to her new school as a natal girl? What was the line between respecting her need for privacy and colluding with a near-magical transformation that could be neither acknowledged nor remembered?

Soon Jenny's problems with emotional regulation started spreading to areas well beyond gender. Her ability to self-soothe began to erode, and she became increasingly unable to be comforted by caregivers. This eventually culminated in her insisting that she did not have, and in fact had never had, a penis.[11] A large-scale process of denial seemed to be taking root. Jenny started responding to casual references about her body either by ignoring them altogether or by appearing genuinely surprised that her natal body might exist in the minds of others—that is, that it might survive despite the deployment of her omnipotent defenses against it. These defensive maneuvers were beginning to exceed the contours of a wish generated in response to gender pain; Jenny, it seemed to me, was moving into the territory of psychotic operations.

Correctly diagnosing these as signs of psychological difficulty, her parents took seriously my opinion that Jenny might suffer from mood dysregulation, a diagnosis with which the child psychiatrist the family had consulted agreed. Were her gender issues a symptom of an early stage bipolar disorder, the psychiatrist wondered? To me the problem seemed to be the inverse: while Jenny had received a lot of support and mirroring by her environment in regard to her identified gender, the horror aroused in her by her male body had gone fully unaddressed. I believed that her nascent psychotic solution and the accompanying mood dysregulation were indexical of Jenny's inability to process and digest the complicated discrepancies between her body and her gender experience (Figure 1 captures Jenny's gender conflicts, as well as her psychic disorganization from that period). There must be something profoundly disturbing and deeply disorienting in feeling that one is a girl, only to look down at one's

[11]In children, gender conflicts often become localized in the genitals, since secondary sexual characteristics, the other conventional body markers for gender, are not yet developed. This is in contrast to adult transgender patients, for whom an exclusive focus on the genitals can be considered reductionistic and minimizing of the complexity and nuance of feelings surrounding the patient's gender conflicts.

Figure 1.

body to encounter a penis. This discrepancy makes significant demands on one's capacity to think coherently: against the powerful and unremitting feeling of being a girl, Jenny's body answered back with a vociferous "no." How is a body-dysphoric child to process this mind-numbing dissonance?

Let me shift for a moment to my transfemale adult patient Hazel, who came to treatment at war with the world, bathed in feelings of grievance about having been born "in the wrong body." When we began working together, Hazel was deeply depressed, moved through her life in a mostly dissociated state, and was largely disconnected from other people. Only in the third year of her analysis was she able to acknowledge that it was not just others, but she too, who could not fathom the incoherence between her body and her gender. "On the one hand I know, I *know* I am and always was a girl, that *this,*" she said, motioning disparagingly to her body, "is all wrong. But then my chest is flat and there is this *thing* between my legs. I don't know how to resolve that. Is it really enough for me to say I am a woman when I have no breasts? When my penis is there mocking me? If I said I were a kangaroo would that make me one? Wouldn't I just be crazy? Don't tell me." She rushes to clarify that the question is rhetorical, that what is at stake here at this moment is not what *I* think: "It doesn't matter: what matters is that *it makes me feel crazy*."

Some analysts might mistake Hazel's agony as her hubris catching up with her, a moment that reveals that her experience of her gender is, ultimately, untenable. She is, after all, denying the anatomically bound difference between the sexes (Chasseguet-Smirgel 1985; Kubie 1974), psychoanalysis' canonical organizing gender principle. That sort of interpretation, though, misses the plea that patients like Hazel make, a plea for help in contemplating gender experience and embodiment in a way that allows them to make sense of the confusing fact of their natal anatomy. Failing to identify this crucial clinical need in our transsexual patients forecloses the important therapeutic task of facilitating the necessary process of mourning. It was only as Hazel moved away from the tenacious control over her body as something that was "in the wrong," which in turn foreclosed her ability to become pained over the fact of its existence, that she was able to experience the depth of loss that it meant to recognize that her gender experience had to take precedence over her body.

Like Hazel, Jenny felt tremendous discomfort with her penis, but Jenny dealt with that discomfort by rapidly moving into shaky

psychological ground. In substituting her feelings of distress about her penis and her wish that she had been born female with the construction of a reality in which her penis did not exist *and never had* lay the prodromal stages of an unfolding psychotic process (see Figures 2 and 3). For Jenny, perceptual reality was becoming increasingly subordinated to the unconscious fantasy that her body had in fact never been male: a realistic perception of her bodily materiality was losing to the edict of gender coherence. I felt that Jenny urgently needed help to tolerate knowing the material reality of her body's contours, to tolerate the fact that these were agonizingly incongruent with her sense of self. For Jenny, sanity would have to involve an undoing of the notion that her body delivered gender's verdict.

In the play therapy I let Jenny take the lead. I never asked her about her name or inquired about her gender. I offered opportunities for her to introduce these herself by indicating my openness to narratives around identity changes in how I entered her play scenarios (e.g., she played often with a stuffed cocoon which, turned inside out, would become a butterfly). For the most part, though, Jenny ignored me. I understood this to signal her need to bring her body into our work on her own terms. Outside the sessions, however, Jenny was still unraveling whenever forced to deal with her penis. Looking for a bathing suit to take swimming lessons, for example, had been disastrous. Jenny insisted on a girl's suit, but when she tried it on her penis and scrotum impenitently announced themselves as they bulged through the fabric: the experience left her disorganized for days.

Within our sessions Jenny was enjoying in the presence of an other the fantasy that she had always been a girl. Giving her the space within our relationship to experience her gender as a reality that was not delimited by history felt crucial to me for several reasons. First, her clearly articulated and very profound distress around her body—which, preliminary data suggest, likely marks persisters rather than desisters—indicated to me that Jenny might be a transgender girl rather than a proto-gay boy. Further, the incident with Dr. A. had cautioned me that to relate to her gender in any way other than how she was presenting herself to me would seriously jeopardize the therapeutic relationship. Most important, however, I found it essential to resist any pressure to become recruited into policing what she did or did not tell me about herself and her body. To do

Figure 2.

Figure 3.

so, I thought, would be tantamount to allowing her anxieties about her body—and those of her parental environment—to be extruded into me.

The room this afforded Jenny permitted her to come into contact with her own anxiety about her magical resolution. Jenny's struggle began to materialize in our sessions through enactment: in the third month of our work, a pattern emerged whereby a few minutes into every session Jenny would have a pressing need to use the bathroom. I would walk with her to the ladies' room and from inside the stall[12] she would issue her instructions: "Don't come in; I don't want you to see my private parts." Sometimes while urinating she would anxiously yell out, "You can't see anything, right?" These scenes were painful and comical at once. Our "bathroom play" came complete with a ritualized series of interactions around locking the door, testing the strength of the lock, checking the range of visibility in the crack between the bathroom wall and the door hinged on it, and even a whistling code to warn her of further risks to privacy when others entered the shared space.

The frequency of these bathroom trips and her active enlisting of me in the securing of her privacy served a double purpose: they both controlled my access to her body and unconsciously invited me to hold it in mind. Back in the consulting room, though, Jenny ignored any reference I made to our bathroom visits. I soon came to realize that what was happening in the bathroom was to remain unspoken in my office, not in some dissociative pact but as something that needed to be protectively sequestered in a separate space.

Public restrooms are notoriously complex sites for transgender individuals: as firmly gender-marked spaces they raise questions about gender identification and gender rights. From my work with Jenny I have also come to see them as paradigmatic encapsulations of where the bodily and the social meet. Insofar as they require of someone like Jenny that in choosing the ladies' room she interact privately with her male anatomy, while publicly claiming her gender as female, they are meaning-saturated spaces. The restroom, thus, was the ideal location for Jenny to encounter her body/gender split, a liminal space that served the transitional function of trying to work out her omnipotent grip over reality (Winnicott 1953). This paradoxical space marked a register where her body could be both

[12]In the building where I practice, a shared bathroom serves the entire office floor. Several stalls are separated by divides that ensure privacy, while the bathroom sinks are located in the common space.

known and not known, where it could belong to our intersubjective experience and to her intrapsychic life alone, where it could be contemplated and then unceremoniously abandoned.

While I refrained from referencing the content of our bathroom excursions, I did nevertheless focus on her affect. I might, for instance, comment on how anxious she seemed that her privacy was protected or ask if the whistling code we employed felt reassuring. We could then imagine together who would walk in, what they would do, how we would deal with the intrusion. Once these feeling states were imported into the consulting room, the rigidity of Jenny's bathroom play began to soften. My patient started to occasionally "forget" to close the door to the stall. She would then emerge frantically, asking me if I had seen anything. We were getting closer, I felt, to her "revealing" to me—and to "discovering" herself—the fact of her body.

GENDER EMBODIMENT AND THE NATURE OF REALITY

Analytic authors have traditionally approached the body as bedrock. In his seminal paper "The Drive to Become Both Sexes," for example, Kubie (1974) unequivocally located gender as a factual truth residing in anatomical difference. Starting from the premise that the body spells gender's reality, many have argued that for trans patients a good analytic outcome is contingent on their acceptance of their natal sex. This amounted to relinquishment of the transsexual patient's wish for bodily modification (Chasseguet-Smirgel 1985; Chiland 2000, 2009; Coates 2006; Limentani 1979; Stein 1995).

The last decades, however, have ushered in new ways of thinking about the body that are reconfiguring our understanding of corporeal reality. Drawing on the work of the phenomenological philosopher Merleau-Ponty and the psychiatrist Paul Schilder, Gayle Salamon (2010) emphasizes that the body's material surfaces can at times be disjunctive to a somatic "felt" sense. For all genders, she argues, the experience of the body is mediated through fantasy, but it is only in trans bodies that the work of fantasy is observable, as it doesn't fluidly map itself onto the flesh. Medical advances have also greatly impacted what is corporeally possible for transsexual patients. Today it is feasible for the natal body to become largely aligned with identified gender (Ettner, Monstrey, and Eyler 2013; Ousterhout 2009) in ways that can be deeply gender-affirming.

Further, it is important to note that careful study of the gender-reparative outcomes reported in the psychoanalytic literature reveals them to have been less successful than claimed. For example, in a rare paper that gives a detailed account of the analysis of a male-to-female transsexual patient, Stein (1995) closely tracks unconscious fantasy and internal object relations. Through this careful work, her analysand comes to "accept the differences between the sexes" and shows greatly improved functioning. According to her, the "transsexual wish" is eliminated. Buried in the closing paragraph of her paper, though, where Stein offhandedly emphasizes the patient's continued problems with trust and secrecy, she states by way of illustration that the patient continues to keep her "sex-change fantasies a deep secret" (pp. 287–288). This surprising sentence, which reveals her patient to be enduringly body-dysphoric, does not lead Stein to question her assertion that the patient's gender was changed by the analysis.[13] How do we understand this striking omission? Might it speak to the tenacity with which analysts have regarded the body as having singular and definitional power over gender?

A major obstacle to unlinking good analytic outcomes and abdication of the transsexual patient's need for surgical interventions is that the latter has been often misconstrued as at odds with the psychoanalytic emphasis on insight over action. Changing one's body to match gender experience is for Chiland (2009) "a mad idea" (p. 43). For Argentieri (2009) it epitomizes "the concreteness of . . . 'acting out'" (p. 4), while for Kubie (1974) it's nothing short of an absurd "experiment in gender transmutation" (p. 366). In such statements we encounter the disparaging misdiagnosis of transsexual patients' foundational need to act on the body as a disinterest in insight and self-reflection. This not only contradicts clinical data; it also clashes with recent findings on the nature of trans individuals' relationships with their bodies. For some transgender patients a kind of nostalgia seems to be experienced on the level of the body for something that is not anatomically real and yet is somatically felt. Ramachandran and McGeoch's research (2008) shows that trans men experience rates of penile phantom limb phenomena comparable to that of natal men who have been subjected to medically necessitated penilectomies. Moreover, trans mens' rates of breast phantom limb phenomena post-mastectomy

[13]For an excellent and in-depth critique of Stein's approach to her patient's gender, see Chodorow 1995.

are significantly lower compared to those of gender-normative natal females whose breast cancer diagnoses have required mastectomy. Trans women similarly appear to experience considerably depressed levels of phantom penis phenomena following their vaginoplasties compared to gender-normative controls.

Today we also have robust indications that parenting techniques do not shift childhood gender identification (Brill and Pepper 2008; Deutsch 2011) and have research data that suggest that neither psychoeducation nor therapeutic intervention can intentionally shift gender experience to match the body (Menvielle 2013; de Vries and Cohen-Kettenis 2013). Clinical reports in the analytic literature from treatments of transsexual patients indicate that even as layer after layer of psychic trauma, early experience, and unconscious conflict are peeled away, gender remains unwavering (Suchet 2011). Today, after many failed attempts to "treat" gender variance (Pfäfflin 2006; Stoller 1997), we have to accept that when it comes to trans experience it's often the body—and our old theories—that have to cave. With adults this "caving of the body" means surgico-hormonal interventions. Eventually a new bodily materiality *can* be created that conforms better to the contours of psychological experience.

Even after the most sophisticated and successful hormonal and surgical interventions, however, the difference is one of degree. The body does not come to fully align with gender experience; it only aligns much better than it had before. Multiple markers of the natal body and biology (chromosomes, internal sexual organs, breadth of shoulders, size of hands and feet, voice) remain firmly in place.[14] Psychologically healthy transitioning, thus, hinges on a foundation of solid analytic work around mourning the pain brought by the natal body. The body, Langer (2012) writes, "must ultimately be accepted as an imperfect project' (p. 12). This acceptance hinges on being able to acknowledge, own, and integrate the biological past into the newly formed identity. Quinodoz's work (2002) with a trans patient treated subsequent to the patient's vaginoplasty suggests that even after medical interventions have been completed, it is the mourning of the unconscious fantasy that the past can be excised that best facilitates

[14]Hormone suppression at the onset of puberty combined with subsequent administration of cross-sex hormones (strictly administered after age sixteen per the Endocrine Society's guidelines) promise to erase more, yet still do not eradicate all natal sex markers.

adaptation in one's identified gender. When a female-to-male patient, for instance, is able to grieve the fact that he was not born male, it can open up for him the room to develop a male identity that is not plagued by the intractable fear that he'll be "found out" or about "who can tell." The rigid internal and external control such concerns demand of transsexual persons who have transitioned can interfere with the establishment of intimate relationships.

For all these reasons I felt it would be crucial for Jenny's penis to become thinkable (Bion 1967) for her before she could shed her reliance on fantasy-based, omnipotent solutions. She would then, perhaps, be able to interact better with others around the fact of her natal sex. With school friends who remembered that Jenny used to be Johnny starting to whisper in the school corridors, the need for her to acknowledge her past became even more pressing.

As I continued interpreting Jenny's affect around our bathroom trips, our play shifted, revolving now around animals and animal transformations. Could one animal really turn into another? Jenny began drawing in our sessions, and as she drew one such transfiguration after another she started becoming doubtful. Could a cow actually become a bird? If an ostrich put its head in the sand, did the world around her *really* disappear? In beginning to question whether such untraceable transformations were possible, Jenny was, I sensed, trying to push back against the intrapsychic erasure she had enacted. We played through these themes for a while. In one session Jenny drew several renditions of a donkey: as the animal raced through the page its form changed to a horse, and by the finish line it had convincingly transformed into an ostrich (Figures 4 and 5). We talked about the animal's successive bodily changes, and as we reached the final one Jenny turned to me questioningly. I told her I thought she felt confused as to whether this kind of change could actually happen, and that I could tell how much that horse wanted everyone to know it was really an ostrich.

Jenny nodded, giggled loudly, and then, unexpectedly, lifted her skirt over her head in a grand gesture of exhibitionism. The contours of her genitals protruded through her underwear. And that was it: Jenny was coming out to me. She peeked down from over her lifted skirt, stared at her genitals, and then lowered her skirt looking at me expectantly. How was I to treat this communication? Was it an invitation to name what she could not bear to put into words? Was the naming going to disorganize

Figure 4.

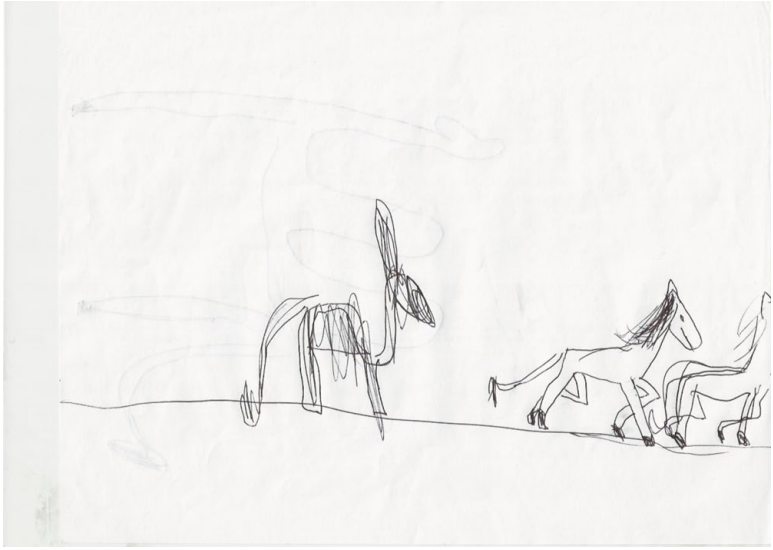
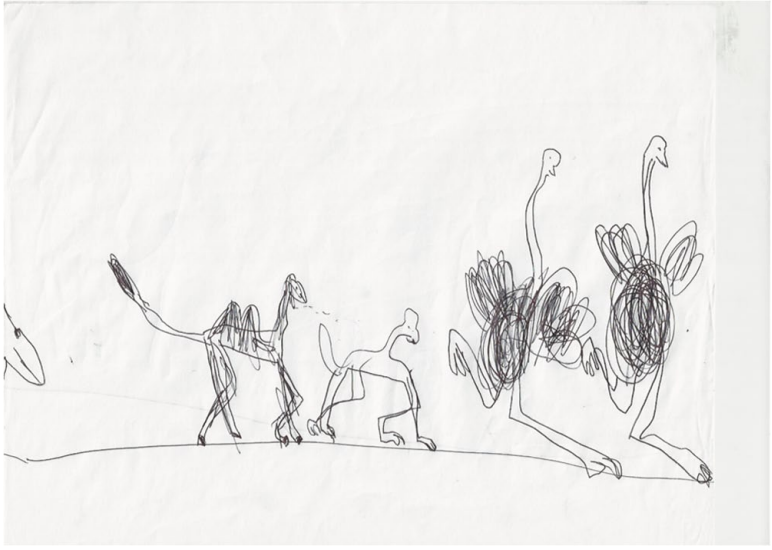


Figure 5.



her? Would it shame her? Injure our relationship? Time presses on us at such unexpected clinical moments: it both dilates and contracts. It seemed to take me a very long time to decide how to respond. Soon the silence would have been too long and perhaps Jenny would think that her penis was unthinkable to me too. I told her: "What I just said about what the horse wanted, it made you feel a lot of things. I think you want to tell me about them but can't find the words." It sounded awkward. She asked if it was time to go. It was.

Jenny started out our next session in an unusual way: rather than making her usual beeline for the toy closet, she sat on my couch announcing she had something she needed to tell me: "Dad thinks I'm a boy. Sometimes I wear boy clothes so his heart doesn't keep breaking." Jenny's statement opened up the floodgates for us. She and I spent much time over the following months trying to understand together what it meant to her to be a girl and what it meant that her daddy thought she was a boy. Those discussions paved the way for us to talk about her body and, eventually, to her admission that it was not just Dad, but that she too was confused about how she could be a girl when she had a penis. Jenny was able to enact in her play her panicked sense of being a "fake," her fear that she had "deceived" everyone, and the unremitting anxiety that she would be "discovered" by classmates, her parents' friends, even strangers.

As her anatomied maleness was becoming digestible to us in the room, we were also able to start talking concretely about her penis and about how much she disliked it. She explained to me with considerable delight that she had discovered how to tuck[15] and wondered if her penis did in fact disappear when she could not see it. Would I take a look and tell her if she took her clothes off? As we continued with these discussions, our excursions to the bathroom began to subside; eventually they stopped. Some of her play began to revolve around gender per se, while some migrated into scenarios exploring whether she was black or white, Chinese or Mexican, whether she was of the earth or an alien, an animal or human (Figure 6). All revolved around questions of categorical identification and legitimacy: did she possess the right attributes that would firmly and indisputably locate her within one class? As these issues made it into words, her anger began to subside, and while she still disliked

[15]The practice of concealing the penis to achieve a flat appearance in the crotch area.

Figure 6.

talking about her penis, her reliance on magical solutions began to wane. The tension around her gender and her conflicts with her parents did not disappear, but they did significantly mellow. Jenny began recovering her capacity for affect regulation when she found herself being misgendered by her brother or her classmates.

It was thus that Jenny started dreaming, a sign of her emerging ability to form representations of her affect states. In one of her dreams an ostrich put its head in the sand: there had been others like it where the ostrich would reemerge headless, a hoped-for, if gruesome, castration. In this particular dream, though, Jenny felt anxious that the sand would get in the ostrich's eyes: "This won't work!" she thought in the dream in a panic. When the bird lifted its head, however, Jenny found that its neck had shrunk. It now looked more like a chicken, "but not like a regular chicken, because you can kind of tell it used to be an ostrich." Jenny paused to search for language and in a Eureka! moment exclaimed with excitement: "It was not an ostrich or a chicken: it was an ostricken!" This dream, which is laced with relief, condenses the ostrich's omnipotent control over reality (the head in the sand), her emerging insight into how problematic the unconscious fantasy had become (the sand that gets in the animal's eyes), and the coveted absent penis (the shrunken neck). Having been able to move away from her omnipotently conconcted fantasies, Jenny dreamt up an *ostricken,* a reassuring and generative neologism that inscribed memory, temporality, and history.

CONCLUDING THOUGHTS

I share this clinical story of having watched Jenny waver on the precipice of psychotic dysregulation because I want to underscore that when we fail to see that pathology follows from mismanagement of body dysphoria, we can iatrogenically fence trans patients *into* the psychotic mechanisms that some of them may resort to in order to manage unbearable affect. Having worked for many years with severely mentally ill young children, I have had many occasions to observe how a mechanism that originates in the attempt to cope with one particular area of trauma can acquire a life of its own, how it can become autonomous from its origins to install itself as the dominant strategy of dealing with all emotional difficulty (Krystal 1978, 1985). By the time this solution coalesces into a pattern of interacting with the world, character runs the risk of becoming colonized by the pathological strategy, as if surrounded by a thicket of poison ivy.

We are in a strange place in history. We know much more about trans issues than we did a mere ten years ago. Our analytic discourse on gender is becoming more nuanced and textured. Side by side with the many questions that remain unanswered regarding clinical work with transsexual patients, there are, quite likely, numerous others we have not yet even imagined asking. And alongside nuanced conceptualization and patient analytic work, a careful tending to countertransferential anxiety is also critical. Take, for instance, Chiland's ironically intended statement in discussing the "problem" of transsexuality: "so goodbye to the difference between the sexes and between the generations, the 'sexual compass' of psychoanalysis" (2009, p. 52). How are we to understand such statements if not by registering the anxious affect that proliferates when what we have long considered to be our magnetic north becomes unmoored?

REFERENCES

Abell, S., & Dauphin, B. (2009). The perpetuation of patriarchy: The hidden factor of gender bias in the diagnosis and treatment of children. *Clinical Child Psychology & Psychiatry* 14:117–133.

Argentieri, S. (2009). Transvestism, transsexualism, transgender: Identification and imitation. In *Transvestism, Transsexualism in the Psychoanalytic Dimension,* ed. G. Ambrosio. London: Karnac Books, pp. 1–40.

Balleur–van Rijn, A., Steensma, T.D., Kreukels, B.P., & Cohen-Kettenis, P.T. (2013). Self-perception in a clinical sample of gender variant children. *Clinical Child Psychology & Psychiatry* 18:464–474.

Benjamin, H. (1977). *The Transsexual Phenomenon*. New York: Warner Books.

Bion, W.R. (1967). *Second Thoughts: Selected Papers on Psychoanalysis*. London: Karnac Books, 1984.

Bockting, W.O., Miner, M.H., Swinburne Romine, R.E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health* 103:943–951.

Borg, M.B. (2011). Heist-ing the analyst's penis (at gunpoint): Community enactment in the treatment of an FtM transgendered analysand. *International Journal of Transgenderism* 13:77–90.

Brill, S., & Pepper, S. (2008). *The Transgender Child: A Handbook for Families and Professionals*. San Francisco: Cleis Press.

Butler, J. (1993). *Bodies That Matter: On the Discursive Limits of "Sex."* New York: Routledge.

Chasseguet-Smirgel, J. (1985). *Creativity and Perversion*. New York: Free Association Books, 1996.

Cheng, A.A. (2001). *The Melancholy of Race: Psychoanalysis, Assimilation, and Hidden Grief*. Oxford: Oxford University Press.

Chiland, C. (2000). The psychoanalyst and the transsexual patient. *International Journal of Psychoanalysis* 81:21–35.

Chiland, C. (2009). Some thoughts on transsexualism, transvestism, transgender and identification. In *Transvestism, Transsexualism in the Psychoanalytic Dimension,* ed. G. Ambrosio. London: Karnac Books, pp. 41–54.

Chodorow, N.J. (1995). Multiplicities and uncertainties of gender: Commentary on Ruth Stein's "Analysis of a case of transsexualism." *Psychoanalytic Dialogues* 5:291–299.

Coates, S. (1990). Ontogenesis of boyhood gender identity disorder. *Journal of the American Academy of Psychoanalysis & Dynamic Psychiatry* 18:414–438.

Coates, S. (2006). Developmental research on childhood gender identity disorder. In *Identity, Gender, and Sexuality: 150 Years after Freud,* ed. P. Fonagy, R. Krause, & M. Leuzinger-Bohleber. London: Karnac Books, 2009, pp. 103–131.

Coates, S., & Moore, M.S. (1998). The complexity of early trauma: Representation and transformation. In *A Stranger in My Own Body: Atypical Gender Identity Development and Mental Health,* ed. D. di Ceglie. London: Karnac Books, pp. 39–62.

Cohen-Kettenis, P.T., Owen, A., Kaijser, V.G., Bradley, S.J., & Zucker, K.J. (2006). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology* 31:41–53.

Cohen-Kettenis, P.T., Schagen, S.E., Steensma, T.D., de Vries, A.L.C., & Delemarre–van de Waal, H.A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior* 40:843–847.

Corbett, K. (1996). Homosexual boyhood: Notes on girlyboys. *Gender & Psychoanalysis* 1:429–461.

Corbett, K. (2008). Gender now. *Psychoanalytic Dialogues* 18:838–856.

Corbett, K. (2009). Boyhood femininity, gender identity disorder, masculine presuppositions, and the anxiety of regulation. *Psychoanalytic Dialogues* 19:353–370.

Corbett, K. (2011a). *Boyhoods: Rethinking Masculinities*. New Haven: Yale University Press.

Corbett, K. (2011b). Gender regulation. *Psychoanalytic Quarterly* 80:441–459.

Davenport, C.W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior* 15:511–517.

Deutsch, M.B. (2011). Use of the informed consent mode in the provision of cross-sex hormone therapy: A survey of the practices of selected clinics. *International Journal of Transgenderism* 13:140–146.

de Vries, A.L.C., & Cohen-Kettenis, P.T. (2013). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. In *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion,* ed. J. Drescher & W. Byne. New York: Routledge, pp. 7–26.

de Vries, A.L.C., McGuire, J.K., Steensma, T.D., Wagenaar, E.C.F., Doreleijers, T.A.H., & Cohen-Kettenis, P.T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, online September 13.

di Ceglie, D. (2009). Between Scylla and Charybdis: Exploring atypical gender identity development in children and adolescents. In *Transvestism, Transsexualism in the Psychoanalytic Dimension,* ed. G. Ambrosio. London: Karnac Books, pp. 55–73.

di Ceglie, D. (2012). Response to Alessandra Lemma, "Research off the couch: Re-visiting the transsexual conundrum." *Psychoanalytic Psychotherapy* 26:290–293.

Dimen, M., & Goldner, V. (2005). Gender and sexuality. In *The American Psychiatric Association Publishing Textbook of Psychoanalysis,* ed. G.O. Gabbard, A.M. Cooper, & E.S. Person. Washington, DC: American Psychiatric Publishing, pp. 93–114.

Drescher, J., & Byne, W. (2013). Introduction: The treatment of gender dysphoric / gender variant children and adolescents. In *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion,* ed. J. Drescher & W. Byne. New York: Routledge. pp. 1–6.

Drummond, K.D., Bradley, S.J., Peterson-Badali, M., & Zucker, K.J. (2008). A follow-up study with gender identity disorder. *Developmental Psychology* 44:34–45.

Edwards-Lepper, L., & Spack, N. (2013). Psychological evaluation and medical treatment of transgender youth in an interdisciplinary 'Gender Management Service' (GeMS) in a major pediatric center. In *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion,* ed. J. Drescher & W. Byne. New York: Routledge, pp. 27–42.

Ehrensaft, D. (2009). One pill makes you boy, one pill makes you girl. *International Journal of Applied Psychoanalytic Studies* 6:12–24.

Ehrensaft, D. (2011a). Boys will be girls, girls will be boys: Children affect parents as parents affect children in gender nonconformity. *Psychoanalytic Psychology* 28:528–548.

Ehrensaft, D. (2011b). *Gender Born, Gender Made*. New York: The Experiment.

Ehrensaft, D. (2012). When talking about children's gender, words matter. Retrieved March 1, 2012, from: http://www.huffingtonpost.com/diane-Ehrensaft-phd/gender-nonconforming-kids_b_1311204.html?view=print&comm_ref=false

Ehrensaft, D. (2013a). From gender identity disorder to gender identity creativity: True gender self child therapy. In *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion,* ed. J. Drescher & W. Byne. New York: Routledge, pp. 43–62.

Ehrensaft, D. (2013b). "Look, Mom, I'm a boy—don't tell anyone I was a girl." *Journal of LGBT Youth* 10:9–28.

Ettner, R., Monstrey, S., & Eyler, A.E., eds. (2013). *Principles of Transgender Medicine and Surgery*. Binghampton, NY: Haworth Press.

Gelé, K., McNamara, S., Phillips, S.H., Shelley, R.D., Grossman, G., Vaughan, S.C., & Roughton, R. (2012). Emerging views on gender and sexuality: Celebrating twenty years of new perspectives on lesbian, gay, bisexual, and transgender people. *Journal of the American Psychoanalytic Asssociation* 60:949–967.

Goldner, V. (2011). Gender in free fall. *Psychoanalytic Dialogues* 21:153–158.

Gomez-Gil, E., Vidal-Hagemeijer, A., & Salamero, M. (2008). MMPI-2 characteristics of transsexuals requesting sex reassignment: Comparison of patients in prehormonal and presurgical phases. *Journal of Personality Assessment* 90:368–374.

Green, R. (1987). *The "Sissy Boy Syndrome" and the Development of Homosexuality*. New Haven: Yale University Press.

Guralnik, O., & Simeon, D. (2010). Depersonalization: Standing in the spaces between recognition and interpellation. *Psychoanalytic Dialogues* 20:400–416.

Halberstam, J. (2005). *In a Queer Time and Place: Transgender Bodies, Subcultural Lives*. New York: NYU Press.

Hansbury, G. (2005). Mourning the loss of the idealized self: A transsexual passage. *Psychoanalytic Social Work* 12:19–36.

Hansbury, G. (2011). King Kong and Goldilocks: Imagining transmasculinities through the trans-trans dyad. *Psychoanalytic Dialogues* 21:210–220.

Hansbury, G. (2013). The masculine vaginal: Working with queer men's embodiment on the transgender edge. Paper presented at annual colloquium, Manhattan Institute for Psychoanalysis, New York, October 25.

Harris, A. (2005a). *Gender as Soft Assembly*. New York: Routledge, 2009.

Harris, A. (2005b). Gender in linear and nonlinear history. *Journal of the American Psychoanalytic Association* 53:1079–1095.

Hembree, W.C., Cohen-Kettenis, P.T., Delemarre–van de Waal, H.A, Gooren, L.J., Meyer, W.J., Spack, N.P., Tangpricha, V., & Montori, V.M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism* 94:3132–3154.

Hill, D.B., & Menvielle, E. (2009). "You have to give them a place where they feel protected and safe and loved": The views of parents who have gender-variant children and adolescents. *Journal of LGBT Youth* 6:243–271.

Krystal, H. (1978). Trauma and affect. *Psychoanalytic Study of the Child* 33:81–116.

Krystal, H. (1985). Trauma and the stimulus barrier. *Psychoanalytic Inquiry* 5:131–161.

Kubie, L.S. (1974). The drive to become both sexes. *Psychoanalytic Quarterly* 43:349–426.

Langer, S.J. (2012). Our body project: From mourning to making the transgender body. Paper presented at the Third Annual Trans Symposium, Institute for Contemporary Psychoanalysis, New York, February 26.

Lemma, A. (2012). Research off the couch: Re-visiting the transsexual conundrum. *Psychoanalytic Psychotherapy* 26:263–281.

Lemma, A. (2013). The body one has and the body one is: Understanding the transsexual's need to be seen. *International Journal of Psychoanalysis* 94:277–292.

Lev, A.I. (2004). *Transgender Emergence: Therapeutic Guidelines for Working with Gender-Variant People and Their Families*. Binghampton, NY: Haworth Press.

Limentani, A. (1979). The significance of transsexualism in relation to some basic psychoanalytic concepts. *International Review of Psychoanalysis* 6:139–153.

Marcus, B.F., & McNamara, S. (2013). "Strange and otherwise unaccountable actions": Category, conundrum, and trans identities. *Journal of the American Psychoanalytic Association* 61:45–66.

Meadow, T. (2014). Being a gender: A new conceptual framework. Lecture given at Princeton University, April 2.

Menvielle, E. (2013). A comprehensive program for children with gender variant behaviors and gender identity disorders. In *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion,* ed. J. Drescher & W. Byne. New York: Routledge, pp. 63–74.

Meyer, W.J. (2012). Gender identity disorder: An emerging problem for pediatricians. *Pediatrics* 129:571–573.

Oppenheimer, A. (1991). The wish for a sex change: A challenge to psychoanalysis? *International Journal of Psychoanalysis* 72:221–231.

Oppenheimer, A. (1992). The wish for a sex change. *International Journal of Psychoanalysis* 73:582.

Ousterhout, D.K. (2009). *Facial Feminization Surgery: A Guide for the Transgendered Woman*. Omaha: Addicus Books.

Person, E., & Ovesey, L. (1978). Trasvestism: New perspectives. *Journal of the American Academy of Psychoanalysis* 6:301–323.

Pfäfflin, F. (2006). Research, research politics, and clinical experience with transsexual patients. In *Identity, Gender, and Sexuality: 150 Years after Freud,* ed. P. Fonagy, R. Krause, & M. Leuzinger-Bohleber. London: Karnac Books, 2009, pp.139–156.

Pula, J. (2011). When a candidate or analysand identifies as transgender: Impacts for the individual and the institution. Paper presented to the American Psychoanalytic Association, New York, January 15.

Pula, J. (2013). Polymorphously perverse candidates, how we fit and conflict with modern psychoanalytic training: Early personal reflections of a transgender doctor. Paper presented at the William Alanson White Institute, May 1.

Quinodoz, D. (1998). A fe/male transsexual patient in psychoanalysis. *International Journal of Psychoanalysis* 79:95–111.

Quinodoz, D. (2002). Termination of a fe/male transsexual patient's analysis: An example of general validity. *International Journal of Psychoanalysis* 83:783–798.

Ramachandran, V.S., & McGeoch, P.D. (2008). Phantom penises In transsexuals: Evidence of an innate gender-specific body image in the brain. *Journal of Consciousness Studies* 15:5–16.

Riley, E.A., Sitharthan, G., Clemson, L., & Diamond, M. (2011a). The needs of gender-variant children and their parents according to mental health professionals. *International Journal of Transgenderism* 13:54–63.

Riley, E.A., Sitharthan, G., Clemson, L., & Diamond, M. (2011b). The needs of gender-variant children and their parents: A parent survey. *International Journal of Sexual Health* 23:181–195.

Roberts, L.A., Rosario, M., Corliss, H.L., Koenen, K.C., & Austin, B. (2012). Childhood gender nonconformity: A risk for childhood abuse and posttraumatic stress in youth. *Pediatrics* 129:410–418.

Saketopoulou, A. (2011a). Minding the gap: Intersections between gender, race, and class in clinical work with gender variant children. *Psychoanalytic Dialogues* 21:192–209.

Saketopoulou, A. (2011b). Queer children, new objects: The place of futurity in Loewald's thinking. *DIVISION/Review*, January.

Salamon, G. (2010). *Assuming a Body: Transgender and Rhetorics of Materiality*. New York: Columbia University Press.

Serano, J. (2007). *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*. Emeryville, CA: Seal Press.

Serano, J. (2013). *Excluded: Making Feminist and Queer Movements Inclusive*. Emeryville, CA: Seal Press.

Smith, Y.L., van Goozen, S.H., Kuiper, A.J., & Cohen-Kettenis, P.T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine* 35:85–99.

Socarides, C.W. (1970). A psychoanalytic study of the desire for sexual transformation ('transsexualism'): The plaster-of-paris man. *International Journal of Psychoanalysis* 51:341–349.

Spack, N.P., Edwards-Leeper, L., Feldman, H.A., Leibowitz, S., Mandel, F., Diamond, D.A., & Vance, S.R. (2012). Children and adolescents with gender identity disorder referred to a pediatric medical center. *Pediatrics* 129:418–425.

Steensma, T.D., & Cohen-Kettenis, P.T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior* 40:649–650.

Steensma, T.D., Biemond, R., de Boer, F., & Cohen-Kettenis, P.T. (2010). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology & Psychiatry* 16:499–516.

Stein, R. (1995). Analysis of a case of transsexualism. *Psychoanalytic Dialogues* 5:257–289.

Steiner, J. (1992). The equilibrium between the paranoid-schizoid and the depressive positions. In *Clinical Lectures on Klein and Bion,* ed. R. Anderson. London: Routledge, pp. 46–58.

Stoller, R.J. (1985). *Presentations of Gender*. New Haven: Yale University Press.

Stoller, R.J. (1997). *Splitting: A Case of Female Masculinity*. New Haven: Yale University Press.

Suchet, M. (2011). Crossing over. *Psychoanalytic Dialogues* 21:172–191.

Wallien, M.S., & Cohen-Kettenis, P.T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry* 47:1413–1423.

Winnicott, D.W. (1953). Transitional objects and transitional phenomena: A study of the first not-me possession. *International Journal of Psychoanalysis* 34:89–97.

Winnicott, D.W. (1955). Metapsychological and clinical aspects of regression within the psycho-analytical set-up. *International Journal of Psychoanalysis* 36:16–26.

Wren, B. (2000). Early physical intervention for young people with atypical gender identity development. *Clinical Child Psychology & Psychiatry* 5:220–231.

Zucker, K.J., Drummond, K.D., Bradley, S.J., & Peterson-Badali, M. (2009). Troubled meditations on psychosexual differentiation: Reply to Hegarty. *Developmental Psychology* 45:904–908.

Zucker, K.J., Owen, A., Bradley, S.J., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology & Psychiatry* 7:398–411.

Zucker, K.J., Wood, H., Singh, D., & Bradley, S.J. (2013). A developmental, biopsychosocial model for the treatment of children with gender identity disorder. In *Treating Transgender Children and Adolescents: An Interdisciplinary Discussion,* ed. J. Drescher & W. Byne. New York: Routledge, pp. 75–101.

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