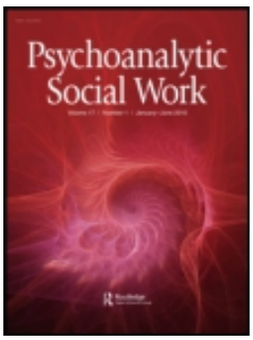

Psychoanalytic Social Work

ISSN: 1522-8878 (Print) 1522-9033 (Online) Journal homepage: http://www.tandfonline.com/loi/wpsw20

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To cite this article: Wendy Winograd (2014) The Wish to Be a Boy: Gender Dysphoria and Identity Confusion in a Self-Identified Transgender Adolescent, Psychoanalytic Social Work, 21:1-2, 55-74, DOI: 10.1080/15228878.2013.840245

To link to this article: http://dx.doi.org/10.1080/15228878.2013.840245

Psychoanalytic Social Work, 21:55–74, 2014

ISSN: 1522-8878 print / 1522-9033 online
DOI: 10.1080/15228878.2013.840245

Routledge
Taylor & Francis Group

The Wish to Be a Boy: Gender Dysphoria and Identity Confusion in a Self-Identified Transgender Adolescent

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Drawing on recent theory of the origin and development of gender orientation, this article explores the dynamics in the treatment of a 16-year-old female to male transgender adolescent. The debate over whether surgery, to change the body, or psychotherapy, to change the mind, is the appropriate treatment became a central conflict for the therapist in understanding the dynamics of her transgender patient whose goal was to be "cleared for surgery."

KEYWORDS transgender, transsexual, transference, countertransference, adoption, trauma

INTRODUCTION

Drawing on recent theory of the origin and development of gender orientation, this article explores the dynamics in the treatment of a 15-year-old female to male transgender adolescent. Traditional psychoanalytic theory understood the development of gender dysphoria to be a matter of arrested development related to problems in managing drive, the relinquishment of fantasies of bisexuality, and disrupted object relations in early life (Stoller, 1968). Not unlike early treatments for homosexuality, the treatment for gender dysphoria focused on working through such conflicts to reach a point where an individual's sense of gendered self matched his or her biological self, which was thought to be immutable (Socarides, 1970; Meyer, 1982; Oppenheimer, 1991; Parfitt, 2007. With the emergence of sexual reassignment surgery (SRS), medical interventions made it possible to change the physical body so that it matched the sense of gendered self. A debate

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ensued in which those promoting psychological intervention argued that sexual reassignment surgery was a misguided option that bypassed the problem, causing an individual to suffer mutilation only to reach a less than satisfactory compromise. Meanwhile, proponents of SRS argued that such surgery allowed an individual to achieve significant relief from the anguish of living in a body that did not match his or her sense of gendered self (Schwartzapeel, 2013). This debate over appropriate treatment became a central conflict for me in understanding the dynamics of my transgender patient and in navigating my way through a treatment in which the adolescent's goal was to be "cleared for surgery."

I found myself preoccupied with the question of theory—gender theory, queer theory, feminist theory, psychoanalytic theory. What could these theories tell me about how and why someone develops this condition in which she feels trapped in a body which does not feel like hers, in which her gendered self is not matched to her own biology? Could biological science explain this as a fluke of genetics that could only be altered with a change in biology? Would that help me get rid of the queasy feeling I had about the potentially profound effects of sexual reassignment surgery? Could psychoanalytic theory provide a convincing understanding of gender dysphoria as a consequence of development, a result of some trauma in the social environment that could be ameliorated with psychotherapy by processing the trauma, resolving any conflicts, and thereby reconfiguring the patient's sense of gendered self? If feminist and gender theory offer us a more fluid understanding of sex and gender (Dahl, 1988; Corbett, 1998; Young-Bruehl, 2001; Saketopoulou, 2011; Suchet, 2011; Chodorow, 2012; Chiland, 2003), why is it that my patient feels limited to the traditional male and female categories for gender identity, gender role, and gender expression? In other words, why can't she have a female body and a male sensibility?

My own confusion and quest for clarity from theory seemed to parallel my patient's confusion about her own identity, which was complicated by the fact of her adoption at 14 months (with little information about her first year of life) and a disturbed and conflictual relationship with her adoptive mother. Understanding the impact of these realities on her developing identity would take time, yet the urgency of her suffering left me feeling that time was short. I wondered if her experience of gender dysphoria was the map on which was written an unknown traumatic history and terror about who she actually was. If so, how would we come to understand that, and if we could, would that alleviate her suffering? Would knowledge of the history of trauma change how I should approach the work with her? If surgery would offer relief, did it, in the end, matter what the cause? I struggled with these questions, and as I attempted to buy time so we could begin to sort them out, I was haunted by the thought that taking time would simply prolong her suffering.

LITERATURE REVIEW

In the popular media, interest in the brain has reached a fevered pitch, and biochemical answers to all sorts of questions previously thought to be matters of the psyche are now accepted as matters of brain chemistry. The era of "the brain" is a heyday for biological scientists who study sexual differentiation. Science is teaching us how female and male brains develop differently during the intrauterine period of life. Pointing out that sexual differentiation of the brain and that of the genitals develop on a different timeline and therefore can develop independently, Bao and Swaab (2011) argue that "sex differences in cognition, gender identity… [and] sexual orientation… are programmed into our brain during early development" and that "there is no evidence that one's postnatal social environment plays a crucial role in gender identity and sexual orientation" (p. 214). Arnold and colleagues (2004) argue that sexual differentiation is more complicated and multi-determined than was previously understood. Again, their research focuses on the influences and interdependent operations of sex chromosomes and gonadal hormones on the development of sex differentiation in male and female brains and assumes little if any effect of the social environment on sexual differentiation. They are mute on the question of a sexual or gendered sense of self.

On the other hand, while Gooren (2006) addresses the question of the "biological underpinnings of gender identity and sexual orientation," focusing on prenatal androgen exposure, he concludes that evidence is still lacking for a "comprehensive understanding of hormonal imprinting on gender identity formation" (p. 589). Indeed, he argues that chromosomes and gonads alone do not determine gender identity or gender roles. A clinical endocrinologist, his research is based on biological understanding, and he acknowledges that although human nature is "rooted" in biology, "we are far away from understanding how gender identity and sexual orientation come about in the human species" (p. 599). He draws on anthropological and sociological studies to paint a more nuanced picture of the complicated nature of the development of gender identity. He points to expressions of sexual behavior rooted in sociocultural forces that are irreconcilable with biology, suggesting that biology is not, after all, sexual destiny. For Gooren, at least, it seems that even in the age of the brain, the jury on biology of gender identity is still deliberating.

Following Bao and Swaab (2011) but interpreting Gooren (2006) as more certain than even he claims to be, Panksepp and Biven (2012) contend that because the gender of the body and the gender of the brain proceed on different developmental lines, beginning in utero, there *is* biological evidence for transgender phenomena. "In short, the sex hormones that determine the sex-specific organization of the brain during prenatal development are different from those that help specify the appearance of the genital

apparatus of males and females. If those fetal brain chemistries unfold atypically, a developing organism's brain-gender identify can be shifted at the primary-process level" (p. 269). Without supporting evidence, they posit that maternal stress during pregnancy, certain medical treatments, or possibly environmental toxins may explain how "an infant can quite literally be born with a male-typical brain in a female-type body or a female-typical brain in a male body, as well as abundant gradations between the 'extremes"' (p. 269). While they maintain that embryonic chemical variation does in fact result in some transgender presentations, they acknowledge that it "probably does not account for all homosexual or even transgender tendencies" (p. 272). Moreover, they stress that there is to date little understanding of "the neuroscientific causes and correlates that underlie these [many] variations of mammalian sexuality in human brains" (p. 276), leaving significant uncertainty about the transgender phenomena. In short, despite their claim of biological determination of gender identity, it is not altogether clear there is always a primary-process, biological substrate to explain a particular individual's feeling that his or her gender and body do not match.

Although traditional psychoanalytic theory understood gender dysphoria to be a psychological phenomenon that was a consequence of early trauma (Socarides, 1970; Meyer, 1982; Oppenheimer, 1991; Parfitt, 2007), some contemporary analysts (Harris, 1996; Elliot, 2001; Saketopoulou, 2011; Suchet, 2011; Chodorow, 2012) approach the problem of gender dysphoria with open minds to the reality of the fluid nature of gender, to the possibility of biological influence, and with a less reductive view of the nature of gender itself. Psychoanalytic theory of gender is beginning to question the binary categories of masculinity and femininity and to formulate a more flexible understanding of the development of sexual feelings, sexual orientation, and embodiment of a gendered self. In these more progressive formulations, psychoanalysis and surgery are not necessarily mutually exclusive.

Early psychoanalytic theories of gender dysphoria lack an understanding of genetics and fetal and infant brain development that suggest that gender as well as sexual orientation are determined by both biological and environmental forces. Without such an understanding, the theories of these early analysts focus on early environmental influences and view deviations from the norm as evidence of problematic and pathological object relations. Moreover, their adherence to binary categories of gender and sexual orientation prevent them from seeing the possibility that gender and sexual orientation may be fluid rather than fixed and may, in fact, exist along a continuum.

Following Freud (1905), Stoller (1982) assumes bisexuality at birth and argues for a significant biological contribution to the formation and consolidation of gender. However, he sees gender dysphoria not as biologically determined but as originating in the early social environment. Specifically, he argues that transsexual dynamics develop in response to a maternal/infant relationship in which the mother, herself, exhibits a certain bisexuality and

needs to keep her baby physically close and held until he begins to think of himself as a girl. The father of such boys is typically absent.

Similarly, Socarides (1970) locates the experience of transsexualism in "deep unconscious conflict originating in the earliest years of life" (p. 347) and thinks it is related to a pre-oedipal wish for merger with the mother. Treatment can succeed when the fixation to that phase is analyzed and resolved, allowing development to progress along "normal" lines.

In that same tradition, Meyer (1982) defines gender dysphoria and the quest for sexual reassignment surgery as a "symptomatic compromise formation serving defensive and expressive functions" (p. 413) resulting from arrested development at the separation/individuation subphase. Mothers of such individuals suffer from "significant character pathology" (p. 409) and themselves exhibit "unresolved bisexual conflicts" (p. 408).

Oppenheimer (1991) and Parfitt (2007) see gender dysphoria as a compromise formation with roots in perverse infantile fantasies and deficits in self-structure. Oppenheimer (1991) defines transsexualism as a delusional symptom resulting from narcissistic pathology. Using a Kohutian approach in treatment, she notes that observing the failures in empathy help us "not to regard this syndrome as an entity determined once and for all in childhood but instead to view it as a development and to understand what it is a 'solution' to, as the result of both narcissistic and instinctual processes. . ." (p. 223). She argues that the "depression is linked to a depreciation of masculinity, an intolerable feeling of castration and an unbearable narcissistic wound" (p. 226). Parfitt (2007) identifies some transgendered individuals as exhibiting a fetish related to fantasies of castration. These patients, he explains, struggle with their ideas of phallic and castrated states and entertain transgender fantasies as a means of retreating from the development of sexual relationships and consolidated gender identity.

Gilmore (1995) offers a case study of gender identity disorder in a girl, in which she reports that a seven-year analysis during latency and early adolescence resulted in a "better adaptation to her gender" in which "her masculine strivings gradually became incorporated into an essentially feminine orientation" (p. 39). She argues that the circumstances of the patient's adoption, the disruption of her relationship with her mother, separation anxiety, her adoptive mother's struggles with infertility, and her parents' conflicts over their own gendered selves were primary factors in her earliest feelings about her self and her body and her eventual disappointment in her female body. Gilmore did not entertain the possibility that her patient's wish to be a boy was in fact "real." She treated it as a symptom or a phase, and the focus of treatment was to get her patient back on track so that she could appropriately adopt the "right" gender to match her biological self and to have "better adaptation to her gender." Like the aforementioned theorists, Gilmore assumes that the "real" or "right" gender is the one determined by biology. Her patient's gender dysphoria is understood to be a problem of

the psyche and not the body. That said, she grapples with questions about how parent/child dynamics, parental projections, and adoption contribute to the identity confusion of a child. In this case, sorting through such dynamics and allowing for development to proceed resulted in the patient's coming to terms with her biological gender.

Departing from traditional psychoanalytic theory, Dahl (1988), Harris (1996), Elliot (2001), Chiland (2003), Saketopoulou (2011), and Suchet (2011) move away from a consideration of gender as fixed in a particular developmental phase and even from binary categories of gender and toward an understanding of gender as evolving and fluid. In their work with patients, they attempt to maintain a precarious balance between an exploration of trauma and unconscious conflict and an openness to the possibility that transgender suffering may ultimately be best relieved through surgery.

Dahl (1988) challenges the notion that gender identity is fixed at some identifiable, developmental point and rejects as an oversimplification the view that gender dysphoria is the result of a failure of separation in the mother/infant dyad. She argues that while pre-oedipal object relations, narcissism, and aggression contribute to an awareness of gender in the developing infant, "complex fantasies about gender... may help us understand something of the vicissitudes of gender and the ways in which an individual may develop such constructions in the service of resolving conflict in the inner world" (p. 353). Indeed, since gender emerges from bisexuality, it "contains within it the capacity to resonate with fantasies of mutability" (p. 363). The appearance of the immutability of gender "obscures the fact that gender organization is not a dichotomous variable, male/female... but a complex psychological construction centering on the body, interactions with the bodies of others, and the drives" (p. 364).

Harris's (1996) work is an attempt to generate theory to account for variations in feelings about gender and to understand the psychosocial underpinnings of gender dysphoria. She proposes that gender dysphoria is more accurately understood as "gender dysphorias in the parents and family, often expressed in the unconscious wishes and needs of the adults in the family system, played out in the meanings they assign and perceive in the child's gender" (p. 366). She develops an understanding of the complex creation of gender identity, which encompasses residue from the separation process as well as the parents' conscious and unconscious experiences of and fantasies about the child's body and psyche. In order to maintain attachment and ward off separation anxiety, a child may become something or not become something that the parent needs: "A parent-child interactive matrix may come to evolve a genderedness in the child which is not an identity by default but a genderedness drawn from the longing to embody the object of parental desire and thus secure attachment" (p. 370).

Based on years of work with transsexuals, Chiland (2003) addresses the complexity of the transsexual phenomenon, which she sees as "a product of

our technology-based, individualistic culture, a token of its contradictions, and a disease of our culture" (p. 2). She brings a deep understanding of transsexual-like phenomenon in cultures around the world and throughout human history to provide context for understanding transsexualism in the late twentieth century. She identifies the complexity and conflict as well as the frequent history of trauma that characterize those who present to her clinic for transsexual surgery. She confronts the paradox of transsexualism in a world in which gender distinctions are less and less rigid while acknowledging the transsexuals' "frantic will to get themselves recognized as members of the other sex" (p. 18). Her subtle and nuanced understanding of gender, of parental projections, and of identification inform her depiction of the development of identity and the development of a gender dysphoric or transsexual identity. She is attuned to the suffering of her patients but well aware that those who complete a transsexual transition are very often disappointed in the results, suggesting that the belief that changing genders will make everything "all right" is based on a kind of magical thinking that oversimplifies more complicated problems of identity. Consequently, she argues for taking time in making any decision about transsexual surgery so that all issues can be explored and understood. In France, where she practices, individuals must live as the gender they wish to be for at least two years before they will be accepted for hormone treatment and/or surgery.

Elliot (2001), Saketopoulou (2011), and Suchet (2011) depart from approaches that would either normalize or pathologize complex psychosexual processes of any kind. Assuming that we have, historically, offered overly simplified and reductive understandings of sexed embodiment, Elliot (2001) sets out to offer a less rigid understanding and to pave the way to look beyond the idea that psychoanalysis and surgery must be mutually exclusive. Aware of transactions of power played out in legal and medical arenas and perpetrated by professionals and transsexuals alike, she warns us of our blind spots and challenges us to continue to "know" more, despite the perceived risks of doing so. She promotes psychoanalytic inquiry as a means to disable the dichotomies between biological and social and between normal and pathological. Challenging the assumption of binary gender categories, Saketopoulou (2011) introduces the interplay among forces of gender, race, and class as key components in the creation of identity as she attempts to "navigate the space between pathology and difference" (p. 192). Suchet (2011) describes her work with a female-to-male transsexual in which she expands her psychoanalytic perspective to include the possibility of new kinds of narratives of sexed embodiment. She questions her understanding of "correct" psychoanalytic thinking and discusses the challenges she had balancing her psychoanalytic understanding of the underpinnings of her patient's desire to be a boy with a growing acceptance that transsexual transition could be an appropriate solution.

CASE DISCUSSION

B entered treatment nearly two years ago, toward the end of eighth grade. In the initial phone call from her mother, Rhonda, I learned that she was a single mother who had adopted three children from Eastern Europe, twins (a boy and a girl) and B. B, the younger, had a history of troubles in school, carried a diagnosis of attention deficit hyperactivity disorder (ADHD), and had recently come out as transgender. Although she questioned the "reality" of B's feeling that she was a boy, Rhonda had done some research on treatments. To be evaluated at a well-respected clinic for transgender transformation recommended by B's doctor, B would need at least six months of psychotherapy. Toward the end of our call, Rhonda said, "I adopted three children. The twins and B are not related biologically. They are not even from the same country. My son is gay. Now B says she is transgender. How likely is that?"

B arrived for her first appointment with her mother. Dressed in baggy boy clothing, with short, cropped, bushy blonde hair, she stood about five feet, four inches tall. She was slight. Her boyish mannerisms seemed forced. Was that because I knew her to be biologically a girl? Was it her mother's skepticism? Or was there something defiant in her insistence, both in words and in actions, that she is a boy? And, if so, why did she need to be defiant? She had smooth, clear skin and beautiful deep blue eyes that revealed her suspicion of therapy. She immediately told me that she had been in therapy before and it was useless. She only agreed to see me because she needed me to sign off on her surgery. Chiland (2003) notes that transsexual patients do not see themselves in need of therapy as they "stage everything in the theater of the body and nothing in that of the psyche" (p. 16), and that, at least initially, seemed the case with B. As she talked, it was clear that she had done her research on transsexual surgery. Her explorations on the Internet had yielded not only medical information on hormone treatments and surgical interventions but had put her in touch with a community of transgender teens and young adults, some who had transitioned, others who had not, and many who espoused the benefits of the surgeries they had had. It seemed to me, however, that she had not done a parallel exploration of her own feelings. While she persistently and insistently said that she was a boy, that she had known this for sure since fourth grade, I had the persistent, nagging feeling that she didn't really know everything about herself, who she was, or what she wanted. I couldn't shake the doubt that this was "real." I kept wondering, where did this wish to be a boy come from?

History

B was adopted when she was 14 months old. Little is known about her first year of life, though her mother was told that she achieved developmental

milestones on a normal schedule, without incident. Apparently, her biological parents could not afford to keep her, and she was delivered at two months old to the orphanage from which she was adopted. Photographs from the orphanage provided to the mother showed B to be a happy baby. Her mother reported that she cried all the way home from the airport, when they picked her up, and that she suffered from separation anxiety throughout her early childhood. However, she also recalled her to be a delightful child, a girly girl whose childhood fantasy was to be a princess. Until recently, she and her older brother, four years her senior, were very close, and her mother reported that she suffered significant distress when he went to college.

B performed well in school until fourth grade, and testing by the child study team showed her to be of average intelligence. Beginning in fourth grade, however, she developed difficulty concentrating and completing her schoolwork, and was subsequently diagnosed with ADHD. She began to experience social problems in school, and to adopt a more boyish appearance and behaviors. By her own report, at that time, she and her close friends believed she was gay. However, she now says that it was at that time that she began to realize that she was really a boy. The timing of the onset of her gender-dysphoric feelings at puberty raises the possibility that this fantasy of being a boy served a need to split off the reemergence of pre-oedipal fantasies or memories that were triggered by the intensifying sexual feelings associated with the onset of adolescence. At the same time, it became increasingly difficult for her to regulate her affect, and she suffered from uncontrollable rage as well as disabling anxiety. Meanwhile, she discovered that she could soothe herself by cutting. Perhaps the cutting served similar defensive purposes and was an early manifestation of her need to do damage to a body that was betraying her by developing sexually. Ultimately, the cutting led to a psychiatric evaluation that resulted in a short course of psychotherapy to address the self-destructive behavior and acting out, but that was, by both B and her mother's accounts, unsuccessful. Pharmacological interventions were also unsuccessful, as B could not tolerate any of the medications that were tried.

It seems obvious that B's struggles with separation anxiety are related to the two traumatic separations in her infancy, first at 2 months when her biological mother abandoned her and then at 14 months when she was taken from the orphanage. Moreover, before she arrived in the United States, she had never been exposed to English, which probably complicated her adjustment and forced her, for a time, into a lonely and confusing place. I wondered, though, were her anxiety, cutting, and difficulty with affect regulation sequelae of her early abandonments? Or was there something more? Delivered to her adoptive mother at 14 months, in the midst of Mahler's (1972) early practicing subphase, differentiation and separation progress may well have been delayed. Her mother's own conflicts around separation were most likely instrumental in setting the stage for the development

of an enmeshed mother-daughter bond, creating an environment that may have hindered, rather than facilitated, her progress toward autonomy.

Equally troubling were her increasing number of complaints of a poor memory—that she could not remember things that had happened, and once, she denied any awareness of the existence of her twin siblings—along with my uncomfortable feeling that a piece of the story was missing, both of which suggested dissociative symptomatology. Perhaps there had been abuse or sexual abuse. Had her biological mother been trying to protect her when she took her to the orphanage? What happened at the orphanage? Did the photographs tell the whole story, or were they created for marketing purposes, to ensure that the babies would be adopted? What really happened in her first year? While my impression of her adoptive mother was mostly positive, I wondered what might have transpired here in the United States, after she was adopted. I met with her mother regularly and explored these questions quite openly with her, but nothing emerged to bring the picture of her early childhood into focus. I remained confused and questioning about the origins of her identity, just as she, herself, was confused and questioning about who she really was.

"I Am a Boy"

The first phase of treatment consisted primarily of B's attempts to convince me—and perhaps herself as well—that she was a boy. She asked me repeatedly how long she would have to see me before I would "sign off" on her being a boy so she could begin the hormone treatments in preparation for surgery. When I would respond that I wanted to get to know her and better understand her wish to be a boy, she would withdraw angrily into silence and remind me that the only reason she came at all was for that.

Over time, though, as she grew to trust that I was truly interested in what she wanted and what she felt, she began to talk with me about things that were on her mind. She regaled me with stories of experiences she had had in school or after school in the park. She was a captivating and animated storyteller, and it did not take her long to draw me into her world. In most of her stories, she was being threatened in some way but overcame the threat with her quick verbal retorts. I found myself impressed with her ability to deflect those who threatened her, and to deflect my questions as well, but also worried about the way she thrust herself into danger, in an apparently counterphobic attempt to master her fears of potential homophobic attackers. My anxiety about her safety was one of the first signs of the growing connection I felt with her. I shared my concerns: "Why do you suppose you hang around the skate park, where you are likely to encounter dangerous people?" I would ask. "I don't know," she would answer. And then she would tell me about how they taunted her and how she taunted them

back. Defiance and fear mingled together in her tone, but when I inquired about the fear, she denied it. I found myself feeling quite angry with her mother, who was apparently unable to protect her from such threats. She had little to no control over B, and often reported to me that B had left the house, and she didn't know where she was. Why was this woman so ineffective in containing her daughter? What was going on in that house? How did she become so out of control? I wondered if B, too, was angry at her mother, and perhaps other women as well, for failing to protect her, while stating vociferously that she wanted nothing from her, in fact that she didn't even consider her a mother. She had no mother. At times, I wrestled with a countertransference wish that I could be the mother she never had. Perhaps I could protect her from the dangers that she sought out. Perhaps I could protect her from being weak, like a woman. Our attachment to each other was growing.

As we explored her wish to be a boy, two themes emerged: her desire to be strong and her hatred of everything womanly. One time when I asked her what she associated with being a man and what it meant to her to be masculine, she said the following: "It's like this. When women go to the gym, they go to get toned. They don't really want to build muscle. When men go, they go to get buff and strong." This was a very strange statement coming from a skinny adolescent who did not participate in sports and never went to the gym. It seemed childlike to me, more like something I would expect to hear from an eight-year-old. However, I understood her simple and childlike formulation of the difference between masculine and feminine as a clear demonstration of how her wish to be a boy was entwined with, indeed perhaps predicated upon, her need to be strong. And, it seemed, her need to be strong was at least in part determined by her need to protect her mother, whom she saw as weak. For instance, at Halloween, she reported that she would not be trick-or-treating. She would instead stay home and hand out the candy. "You wouldn't believe who comes around to our neighborhood. They are not all nice kids. I can't let Rhonda greet them at the door. She shouldn't have to deal with that." "Why not?" I responded. "I need to protect her. She may not seem like it, but she is weak." B's own femininity, a weakness, was something to be feared, hated, and quite literally cut out of her body.

Initially, B talked many times of her hatred of everything about women's bodies. She would say she hates to shower because it forces her to be in contact with her own female body. In particular, she hates her breasts. She hates all the rest of it as well, but it is too disgusting even to talk about. She doesn't like being hugged, particularly by women, as she cannot stand feeling their breasts. She is a boy, she says, and a gay one. She wants to be a man, and she wants to be with men. She cannot stand women. Later, however, she stopped characterizing herself as a gay man, stating instead that

she didn't know about her sexual orientation. Perhaps she is gay, perhaps she is straight, perhaps she is bi. Why should it matter?, she would ask. Why is it anyone's business? She was a boy, simple as that.

I have asked her repeatedly what it is like for her to be in therapy with me, a woman. She is taken aback by the question and is usually quiet. After a few moments, she says, "This is different." Without either of us stating it, we are both aware that we don't touch. She has talked quite extensively about her repulsion of touching, hugging, and even shaking hands. She has described the terror she felt when changing classes in school, as the hallways are crowded and it is likely that someone will brush by her. These feelings give me pause. While I understand that it is common for transgender teens to dislike their own bodies, to feel that they are not home in their bodies, and even to ward off any sexual feelings, as they feel alien in their bodies, B's hatred of all women's bodies and her terror of being touched is not typical of most transgendered people. Chiland (2003) suggests that "irrespective of phenotypic factors ... or any as yet unknown biological factors, such boys—or for that matter girls—will have experienced a recurring traumatizing situation whose origin they attributed to their sex and which they tried to overcome by dreaming that they could belong to the other sex" (p. 75). Indeed, B's feelings suggest a darker, more complicated, traumatic history. When she talks of these feelings, I grow very sad and somewhat anxious as I wonder what that could be. Does she hate her own body because it betrayed her by being weak? Was she not strong enough to prevent a sexual attack on her body? Does she hate women because they failed to protect her from a sexual attack? Or were women, themselves, the sexual predators? I find myself wondering about the nature of her memories of her first year. Is it possible that there is some traumatic memory that she could access? Or is the memory encoded in her body, the body she so hates and so wishes she could change?

Screen Memory

A screen memory of a childhood friend being "taken away" seems to express a repressed memory of B's abandonment first by her biological parents and then by the caregivers at the orphanage. This screen memory was first introduced four months into treatment, as B's trust in me grew and she began to reveal her more vulnerable, "weak" feelings. Slowly and carefully she started to admit that when she was taunted by students at school, even though she put on a tough face and taunted them back, inside, she was scared.

Then, one day, when she was particularly sad, she told me the story of her best friend ever, Monica. She knew Monica for less than a year, but the memory of this friendship crystallized into something with powerful significance for B. They met in a roller-skating class, and, according to B, they

became fast friends. Both of Romanian descent, both adopted by single mothers, sometimes mistaken for sisters, they became inseparable. Indeed, B occasionally referred to Monica as her twin. During the one school year that they were together, they offered protection to each other from the bullies. But they were both in a downward spiral, with deteriorating academic performance, fighting, and cutting. Toward the end of their fifth-grade year, B remembers Monica being taken away by a man in a car. She never saw her again. Though they both had cell phones and access to e-mail, she never heard from her. When I asked her what she thought had happened, she shook her head and said, "I don't know." For the first and only time, she was weeping. When I asked if she thought Monica had been stolen or kidnapped, she shrugged. Later, Rhonda told me that the family had moved away, probably in response to the daughter's increasingly troubling behavior, and that she suspected that her mother wanted to cut off all ties to her old friends, whom she saw as a bad influence. Haunted by the image of a man taking away her friend, B could not accept these explanations.

She has spoken of Monica many times and alluded to her other times. Sometimes, she said she couldn't talk about it. Other times, she spent an entire session remembering the good times or the bad times with Monica. Once, as she was expressing her inability to comprehend how or why Monica had not called or e-mailed, her pain palpable in the room, she looked straight into my eyes and said, "How can you just do that to someone, just leave them like they are a piece of paper?" I nodded sadly and said, "I don't know."

The memory of Monica's disappearance is a touchstone of feeling in B's personal narrative. She experiences that day as a turning point in her own emotional life, after which she became hardened, closed off, and protective of herself. While she has friends, by her own reporting, she does not let them in. She plays the role of a therapist, she says, with many of her friends, but she will never share her problems, as she did with Monica. No one can replace her.

Although there is a specific traumatic memory of her friend being taken away, this memory also represents many other experiences of being taken or disappearing. I understand the memory of Monica's disappearance to be a screen memory for B's own disappearance, first from her biological mother, and then from the caregivers at the orphanage. She repeats such disappearances on a smaller scale with her mother, when she doesn't come home and won't answer her phone or texts, and with me, in missed sessions. She talks, not infrequently, of running away or going into New York to live with some distant relatives, whom she really doesn't even know. The trauma of leaving, of disappearing, of being taken away in a car, is repeated both in her memory of Monica's disappearance and in her own small disappearances, perhaps so she doesn't forget, perhaps as a way to master the intolerably terrifying affect that accompanies feeling as meaningless and unwanted as "a piece of paper."

Breasts and Breast Cancer

In the fifth month of her treatment, B began binding her breasts. In the seventh month, I was diagnosed with breast cancer. B was my first appointment on the day that I heard from my doctor that I would need a mastectomy. Only a few hours after that phone call, Rhonda called to inform me that although they were on the way, something had happened to B at school and she refused to speak. Rhonda did not know what it was, but it seemed that B was very angry and upset. When they arrived, B slouched onto the couch, headphones in, and stared out the window. I sat quietly for a few minutes, waiting for her to speak. She didn't. Finally, I asked, "So what's going on?" She was still and silent. We had parted the previous session on good terms, but I wondered, was it me? "I understand you are upset about something. Are you angry with me?" She shook her head but would not look at me. I sighed, thinking that on this day, I simply did not have the energy to pursue her. I wondered if she wanted me to pursue her. Or did she want to be left alone? I sat in silence, processing my own feelings about the appointment I would be having the next day with a plastic surgeon and trying to wrap my mind around my own diagnosis and the loss of my breasts. We sat in silence for nearly 40 minutes. Toward the end of the hour, I snapped out of my own reverie and looked again at B. I thought of Winnicott (1965). It felt to me that by allowing for the silence, I had allowed her to "go on being," to be alone with someone there. It felt almost as though she were in a cradle and I, sitting quietly by, was there and not there. And uncannily, it felt as though she were doing the same for me. When it was time to stop, I spoke one last time. I could have been speaking to myself. "B," I said, "I know that something has happened, and that you aren't ready to talk about it. I am guessing, though, that it is something you might want to talk about, eventually. So if you are, before next week, you can call me." Without saying a word, she stood up and walked out.

We had two more appointments before my one-month medical leave. I told B and her mother what I told all of my patients, that I would be having surgery and would be out for one month. Since it was December into January, and they would be away for two of those weeks anyway, B acted unphased. However, in the time between that disclosure and our break, B made a small cut on her face. She covered it and refused to allow Rhonda to see it. Rhonda reacted impulsively and took her to the emergency room, where she was admitted for a psychiatric evaluation. Before my own hospitalization, B spent four days in the hospital, herself. Although I spoke with her doctor there, I'm still not exactly sure why they admitted her, as the cut was superficial and she was not suicidal. The hospital psychiatrist complained that she would not talk. She released her to my care, and we had one final appointment before my leave.

What was going on in the transference/countertransference field? I was stricken and saddened by the prospect of losing my breasts, while B was

binding hers, eager for the same surgery that I was dreading. Clearly, my worry, which had been growing for several weeks prior as I endured a series of mammograms, MRIs, and biopsies, was an unspoken, not fully recognized, but felt presence in the intersubjective field. Did my impending hospitalization trigger hers? In her usual style, she took a tough stance toward the prospect of my leave, seemingly indifferent to it. And yet, just as she was beginning to trust me, perhaps to see me as the mother I fantasized I could be for her, I would be abandoning her. Perhaps she was abandoning me as a retaliation or to master the terror that my impending absence may have evoked. My absence, a mini-disappearance from her, may have triggered intolerable anxiety over the possibility of losing yet another mother. The reason for my absence—a mastectomy—also had countertransference significance. How much were my queasy feelings about the prospect of her moving forward with hormone treatment and sexual reassignment surgery influenced by my own experience of being mutilated by the very same surgery? What about Rhonda's role? While B clearly provoked her mother by cutting her face, it is also clear that Rhonda overreacted. Why didn't she call me? Was she threatened by B's increasing closeness to me? Indeed, as much as B's struggles with separation and abandonment may have their origin in her first year of life, the intensity of love and hate in her relationship with her mother is part of an ongoing interpersonal field where such difficulties continue to play out. And now, it seemed, these struggles were being repeated again in the transference.

Mother and Daughter and Me

Like most parents of my adolescent patients, Rhonda presented certain challenges to me. I had to fight my tendency to consider her a partner and remind myself that she, in fact, was a patient as well. I had to find ways to deal with her resistance and not to confuse it with B's. I met with Rhonda about every six weeks, and we spoke quite frequently on the phone. My feelings about her oscillated between compassion and concern to frustration and anger to a strange feeling that she was not quite present just as B's feelings toward her oscillated between love, hate, and a kind of irreverent tolerance, as though she did not quite matter.

Initially, I admired Rhonda for her willingness to accept B's transgender identity and to attempt to address her daughter's suffering. After all, I thought, she had researched transgender treatment programs, and she followed the recommendations of the gender management program in bringing her into treatment with me. Because Rhonda and I have both felt cautious about going ahead with hormone treatment or surgery before B and I had a chance to explore more fully her feelings about being a boy, I felt that we were on the same page, both of us wanting to slow B down and investigate. B, however, felt that Rhonda refused to see her as she was. She reported fights

at the clothing store, when Rhonda wouldn't allow her to buy from the boys' department, and frustration when Rhonda refused to use her male name. Most painful for B was the fact that whenever they spoke of it, Rhonda cried. B could not tolerate the fact that her mother's acceptance would be a process and might take time. She couldn't bear her mother's disappointment. She couldn't hear it when I reminded her that, after all, her mother had taken her for an evaluation at the gender management clinic, had purchased the clothing she was wearing, and was bringing her to me. I was puzzled by what seemed to be inconsistencies between B's and my sense of Rhonda. Then, in a meeting with Rhonda, I got a sense of what was making B feel as she did. As usual, Rhonda wept throughout the session with me. I listened to her describe the latest round of conflicts and fights that she had had with B, to her concerns about B's lying and school refusal, and to how nasty B was to her. Then I carefully mentioned that I thought that B was struggling because Rhonda refused to use her boy name or boy pronouns when referring to her/him. "However things might turn out in the end," I said, using the female pronouns myself, "I think it's important to respect her wishes about this now, to show her support for what she feels about herself." She responded, "Well, if I'm going to do that for her, then she's going to have to do something for me." I was so taken aback that I didn't ask the next question: What would that be? Instead, I simply nodded. She continued to weep and then said, "Whatever happens, she will always be my little girl."

At this point, I began to realize how invested Rhonda was in B's girlness—her identity with Rhonda—and also in forestalling B's separation from her, in keeping her nearby, a little girl. The school refusal, which I previously understood as a response to bullying, came into focus differently now. It seemed also to serve what I now thought was Rhonda's unconscious agenda to prevent B from growing away from her. If B never finished high school, she would never have to grow up, separate, and leave. She could thereby grant her mother's wish and always be her little girl. And not, as she was a boy. Perhaps the wish to be a boy was a defense against merger with Rhonda. Such a formulation is consistent with theory that locates gender dysphoria in the context of separation/individuation difficulties. Was it B's only way to protect her autonomy? At about this time, I learned from Rhonda that she, an only child, had been raised by a single mother, as her parents divorced when she was an infant. She tearfully recounted how close she and her mother had been, how she had been devastated when she died, and how she finalized the adoption of the twins just months after her mother's death. It seemed that an enmeshed mother/daughter dyad was being repeated in Rhonda's relationship with B.

Varga (2006) argues that psychopathology "arises out of appropriated attachment (attachment contingent upon meeting the parent's narcissistic

needs) in which individuation impulses conflict with attachment needs, stirring up abandonment anxiety, which sets in motion defensive processes, expressed in the form of enactments, understood as anxiety-driven clinging to appropriated attachment" (p. 413). Seen through this lens, B's difficulty individuating may stem from an internally experienced conflict between her own healthy strivings for autonomy and her mother's need to keep her close, indeed at one with her.

I began to think differently about the triangle that B, her mother, and I formed. Were the missed sessions that Rhonda blamed on B's wanderings in town in fact serving Rhonda's unconscious wish that B stay connected to her? Was I Rhonda's rival for B's allegiance? In this mother/daughter dyad, with no father, perhaps I was somehow drawn in to play the role of the father, to help B move away from fusion with mother and get out into the world. Indeed, according to Varga (2006), one role the therapist can play in transforming the dysfunctional enactments that reflect an appropriated attachment is to offer an experience in which greater individuation is tolerated without the threat of abandonment. Perhaps our relationship was just such an opportunity for B and simultaneously a threat to a defensively protected mother/daughter dyad. Being a boy was also a way to do just that—to risk individuating and separating from Rhonda without really leaving.

Perhaps it was also possible that B's gender confusion resulted from unconscious, projected maternal wishes. Gilmore (1995), Harris (1996), and Laplanche (1997) theorize that sexual messages originating in the parents' unconscious wishes, needs, and conflicts influence the development of the child's sense of a gendered self. To what extent was B's sexuality and sense of gendered self influenced by her mother's unconscious projected wish for a partner, for the husband and father of her children that she never had, but wished for? I began to wonder if Rhonda had also projected such wishes onto her son, whose way out of the bind of becoming an oedipal victor with no oedipal rival was to be gay. Could his homosexuality have been a way to avoid threatening incestuous longings? Did B become the man that her gay brother could not become? And yet she identified as a gay man, perhaps also to ward off incestuous longings. I wondered if her stated sexual orientation were an identification with her brother or if it reflected unconscious, incestuous sibling longings. B also had spoken quite directly of needing to protect Rhonda. Was B the recipient of Rhonda's projections of unconscious fears of weakness or wishes to be protected? Perhaps all of these factors were determinants in B's developing personality and gender identifications. Indeed, later, when B began to question her sexual orientation, these theories of mine also came into question. As a result, I began to see B more as a whole person, not "just" transgender, not "just" gay, and the work began to shift as we focused on other aspects of her emerging identity.

A person. With a heartbeat.

All of these formulations and questions, as fascinating as they were to me, did nothing to resolve my confusion and concern over B's urgency over transitioning. During the nineteenth month of treatment, B and Rhonda visited the gender management clinic. After a six-hour evaluation, in which the team met with Rhonda and B, separately and together, they reported at the meeting that while their final results would take a few months to process, they believed B was in fact transgender and ready to consider starting hormone treatment once the evaluation was complete. B was surprisingly unmoved when she got what she claimed she had always wanted—approval to move forward with a transsexual transition. Her ambivalence left her silent and stuck.

At first, I was quite surprised at B's blasé reaction to the meeting. Then, however, aspects of her narrative began to shift. When we spoke of gender and sexual orientation categories, she would become agitated and fight the notion of being labeled at all. She began to state, somewhat defiantly, "I don't know why people need to know if I'm a boy or a girl. When they ask, I just tell them I'm a person. With a heartbeat. That's all they need to know." It seemed that perhaps, after all, her fantasy was to be both. Indeed, on one occasion, she reported that when she was out in town, one of the kids who had bullied her in school approached her. "He said he thought I was both a boy and a girl. Can you believe that? How stupid is that?" "Well," I responded, "that does seem strange. But have you ever read about intersex people in your research on the Internet?" She had not. I explained. "Well, there are some people who are born not really a boy or a girl. They don't really have clear boy or girl genitals. So, because we live in a world where categories are so important, you know, where we line up in kindergarten as boys and girls, where there are separate bathrooms for boys and girls, the doctors and parents can't really imagine a baby being neither a boy nor a girl. So usually, the doctors decide which surgery would be easier, and they do that, making the intersex person a boy or a girl. The problem is that when they become teenagers, sometimes they find out that it was not the right choice. And then they are in the wrong body." B was outraged. She responded, "If that were my child, I would *never* allow them to do that surgery. I would just get them a port-a-potty." I couldn't help but wonder if she was exhorting me not to allow them to do that surgery to her. Having to choose at all was becoming unbearable for B. She was, as she repeatedly told me, not a boy, not a girl, but a person. With a heartbeat.

CONCLUSIONS

As our sociological climate shifts toward more openness to sexual differences and gender fluidity, we may celebrate the fact that individuals will be less

likely to suffer from discrimination and homophobia. At the same time, more children and adolescents will openly question their sexual and gender identities and many will, like B, seek treatment for dysphoric self states and often unbearable internal conflicts. B's case suggests how complex and multifaceted the development of gender identity is and underscores the need for continued clinical research to further understanding of the biological and psychosocial, genetic and epigenic factors that predispose one to gender dysphoria. Moreover, it is imperative to understand such complexity in the development of treatments. It is challenging but perhaps wise for analysts to tolerate long periods of not knowing and endure the painful suffering patients may experience while not knowing as the picture of a child or adolescent's identity slowly emerges.

Earlier in our work, I had struggled with my interest in slowing the push toward transsexual transition. At times, I wondered if delay was prolonging B's suffering. B's shifting narrative suggested that perhaps, after all, the better course was to slow down and keep exploring all of the feelings around all of her gender identities. One of the difficulties of working with adolescents for me is that sense of being rushed, and it is no different with B. Despite the fact that they have their whole lives ahead of them and usually feel immortal, there is often a sense of urgency in solving a problem or deciding something. It must be done now. I was aware that the urgency, at least in part, stemmed from B's intense, almost intolerable ambivalence, yet I longed for a sense of leisure and time to think through all these potential conflicts and to help B look at them as well. In the end, however, if the hormones do begin, we may only be able to do that work as the physical changes are pushing forward. And isn't that the truth for any adolescent, whose biology is careening along, with no regard for the slow and patient process of psychoanalysis?

NOTE

1. This article was presented in an earlier form at the 2013 ICAPP Clinical Conference, Reykjavik, Iceland.

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