

Holding futurity in mind

Therapeutic action in the relational treatment of a transgender girl¹

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My six-year-old patient, Jenny, and I worked together in analytic play therapy for a year and a half before she was able to share with me something I had only known from her parents: Jenny had been born male. Careful and patient work, which I'll describe in detail, made it possible for Jenny to move from being deeply invested in my not knowing about her natal body to wanting to share with me this fact that was painful to her. When she did, rather than saying to me, as one might expect, that she had been born male, Jenny framed the disclosure as follows: "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 am a boy." Jenny paused, scanning my face for a reaction, 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 trans children like her: for her, it is of course the father who makes a mistaken gender attribution. This brings into sharp focus a key controversy: is the child confused about their gender or is the environment failing to understand that which does not meet expectable forms of gender?

These kinds of questions juxtapose external reality with internal experience, pitting psychic and social forces against each other instead of attending to their interpenetration. This makes them unnecessarily facile. Jenny, for instance, was unquestionably a liar, if only a Winnicottian one. Much like other trans children her age (Ehrensaft, 2011; 2013), she was hard at work developing a false, male-presenting self (Winnicott, 1954) to protect her father from his distress about her femaleness.² Aware that body morphology determines how one's

gender is perceived, Jenny's negation ("I don't want you to think I am a liar") concealed her concern that if I knew, I, too, would think of her as a boy. Still, Jenny's problem did not exclusively derive from without; that is, from living in a world that treats gender as fixed by biology. Jenny's was also a problem of inner life. Since her gender experience painfully and perplexingly clashed with her bodily morphology, Jenny was *herself* confused about how it was possible to be a girl when her body spelled "boy".

Tackling therapeutically any single one of these issues would be in itself a difficult task. To deal with all of these, as well as with the unconscious fantasies and defensive strategies that undergird them, is an extraordinarily challenging clinical endeavor (DiCeglie, 2009). Psychoanalysis is well equipped to address such nuanced therapeutic needs precisely because it can help illuminate how inner and outer synergistically complicate and amplify each other. Relational psychoanalysis is particularly helpful in that task because it comes with an armamentarium of conceptual and clinical tools that, as I'll show, can be incredibly useful in the treatment of transgender children.

In this chapter, I will eschew the much-debated quest for etiological factors. I will do so because I believe that we can work well with transgender children only if we treat their gender not as a symptom but as a *viable subjective reality*. My particular focus thus will be to try to comprehend how unconscious fantasy may be mobilized to manage the painful experience of gender/body mismatch *once it has already been formed*. One possible such dynamic deployed to deal with the distress that arises from the discontinuities between body and gender experience is, I will propose, the unconscious fantasy that one has been born into the wrong body. The work of mourning, of coming to terms with the body one has, is critical in order for a child to have a healthy social transition.

Massive gender trauma

I use the term *massive gender trauma* to describe a developmental trajectory that captures the struggles of some transgender children (and of some transgender adults, though I'll be focusing on child work in

this chapter). Massive gender trauma arises at the frequent, yet onerous intersection of two critical, often paired, psychic events:

- a. The experience of being misgendered; that is of being misrecognized by one's primary objects as belonging to one's natal sex despite the child's insistent claims to a different gender identity. When gender is tenaciously conflated with bodily morphology, such children often feel unseen and unknown (Ehrensaft, 2013a).
- b. Gender-inflected body dysphoria: the painful feeling that one's physical body and one's gender are misaligned (e.g. a female child who understands themselves as a boy). Such dysphoria can present as early as two or three years of age (Coates, 2006; Edwards-Leeper & Spack, 2013) and is often accompanied by a powerful wish for coherence between one's experienced gender and bodily anatomy.³

Massive gender trauma issues from the melange 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 like dissociation, anxiety, and depression. In my discussion of process material from Jenny's treatment, I will illustrate that the fact that children have to negotiate these difficulties together with, and sometimes through, the synchronous burdens of normative psychic growth leaves the developing psyche porous to psychiatric illness. The dynamic solutions some such children may adopt to manage these challenges and the way in which unconscious fantasy can become recruited in dealing with the discontinuities between the sexed body and gender experience 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. Notably, research has shown a propensity to mood-disordered presentations in children who struggle with their gender (Edwards-Leeper & Spack, 2013).⁴ As these problems get woven into the very fabric of how a child negotiates their intrapsychic and intersubjective worlds, strategies that originated in the attempt to manage massive gender trauma may become a part of their character (Krystal, 1978, 1985) and overall psychological functioning. The ensuing emotional difficulties and psychiatric problems, I am thus proposing, often *result from* the traumatic

and unmentalized impact of being trans, rather than being their original cause, as is often assumed.

Parents frequently react to children's body dysphoria with anxiety, alarm, and bewilderment. Overwhelmed by their own affect, they often seek help. The anguish felt in response to the body's primary and secondary sexual characteristics is a critical feature of these children's experience and, yet, it is a rarely addressed issue in their treatments. The focus rather tends to be on social transitioning, on their frequent misgendering, and on educative efforts to be made with the familial environment, school setting, and so on. However, such interventions that are organized solely around supporting the child's gender identification are inadequate. Oriented toward disaggregating the body from gender, these approaches usually derive from a misreading of gender theory's emphasis on gender performativity (Butler, 1993) as positing that gender is something that people choose to enact rather than something that people are (Serano, 2013; Meadow, 2014). 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 the child's inability to resolve the conflict between the reality of their gender experience and the child's own, heavily defended against attachment to the notion that the body spells gender's reality.

To resolve this conundrum, some of these child patients resort to the unconscious fantasy that one's natal sex is not and, in fact, has never been real. This defensive maneuver permits them to hold onto their own sense of their gender without having to confront the discrepancy with the material reality of their sexed body. On a conscious level, this can manifest as the belief that one was born in the wrong body. It is thus that, for example, a child born male who has been unable to process the incongruity 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). This grievance and its behavioral correlates, I am suggesting, are underwritten by the unmetabolized turbulence of body dysphoria. For such patients, mourning the body about which they've fantasized but do not have

is a crucial part of the therapeutic process. I use mourning here to describe the experience of loss that Steiner (1992) has described often accompanies the relinquishment of omnipotent control. In the case of the transgender child, this control has been installed in the first place as a way of keeping pain at bay and its gradual resolution involves a confrontation with the deep suffering that is aroused in giving up the conflation of wish and reality. The therapeutic task is to help the child de-link gender and body in their own psyche, to help them disturb the fixed relationship between the materiality of the flesh and gendered experience so that language and symbolism can become possible.

Bearing the knowledge of their natal bodies is critical in work with body-dysphoric transgender children. By “knowledge” here I am drawing on Bion’s notion of K that treats knowing not as a cognitive act of intellectual perception but rather as an emotional event that involves contact with inner life and with the pain that saturates it, as well as the capacity to stay still and observe one’s suffering before one moves to act (1962). This kind of knowing requires that cognitive acknowledgment and psychic torment can be reconciled rather than evaded and denied.

Naming and processing the anguish brought to the child by their body, exploring its psychic meanings, and eventually accepting the body one was born into is crucial to psychological health. Yet, contrary to the position argued by many analytic writers (Chasseguet-Smirgel, 1985; Stein, 1995a; Chiland, 2000), I do not see this kind of acceptance as necessarily resolving the question of whether these children will later require hormonal and surgical interventions. Rather, coming to terms with the body one has is a gateway to a psychologically healthy social, emotional, and, should this become necessary over time, 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.*

Jenny

A Caucasian, five-year-old child from an upper-middle-class family, Jenny 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 crouched down to her height to say, “Hi. I am Dr. A. And you must be Johnny.” What followed was an agonizing outburst, part fury and part despair. Jenny cried inconsolably and, amidst her tears, named her parents’ betrayal: “You told, you told!” Jenny’s parents tried to reassure her it was OK, that Dr. A had met other kids like her, but she was impossible to soothe. Jenny was unable to tolerate the full 45 minutes and the session had to be terminated early. It had become apparent that a blend of the unintended misnaming and Jenny’s pronounced fragility had destroyed the likelihood that a therapeutic relationship could be established with Dr. A.

Dr. A called me to make the referral and as we talked, we both appreciated how devastating that particular address must have been. We assumed that Jenny had perhaps heard it as “You *must*, you *have* to be Johnny”. And yet, 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, Jenny 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. And most recently she had become persistently suicidal. Her parents were incredibly concerned. Despite being able to provide an otherwise detailed developmental history, their memory regarding her subsequent gender development was rather vague. This suggested to me that although they appeared to be on board with Jenny’s gender identification, they were, perhaps, 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 & Pepper, 2008; Hill & Menvielle, 2009), both appeared to find it crucially important to present as unconflicted about Jenny’s femaleness.⁵ I wondered: had not having informed Dr. A of the degree to which Jenny was female-identified been an enactment of the parents’ ambivalence? Had Dr. A been unconsciously recruited to enact that which they could not bear to think or to mourn?⁶

A year prior, the parents reported to me, in a meeting with Jenny's coach they were informed that their child had been identifying as a girl. The coach asked the parents how to handle that when Jenny stepped in, announcing 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 experienced their own parents as having mishandled their autonomy as children, they felt strongly about not wanting to repeat the same with their own child. Both took considerable pride in their daughter's advocating for herself. From thereon they followed her lead, and soon Jenny was fully socially transitioned to living as a girl: she was in dresses, wore hair barrettes, and routinely introduced herself as a girl. The parents also 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 all 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 to worry 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 rage-filled demands that she be introduced to her new school as a natal girl? Where was the line between respecting her need for privacy but not 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. Jenny's ability to self-soothe began to

erode and she became increasingly unable to utilize caregivers' efforts to comfort her. This eventually culminated to her insisting that she did not and, in fact, never had had a penis. A large-scale process of denial seemed to be taking root. Jenny started responding to casual references about her body either by altogether ignoring them 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 interpreting these as signs of psychological difficulty, her parents took seriously my opinion that Jenny might suffer from mood dysregulation, something with which the child psychiatrist with whom the family had initially consulted also agreed. Was her gender 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. There must be something profoundly disturbing and deeply disorienting in feeling that one is a girl only to look down at one's body to encounter a penis. This discrepancy makes significant demands on one's capacity to think coherently: against the powerful and unremitting feelings of being a girl, Jenny's body answered back a vociferous "no". How is a body-dysphoric child to process this mind-numbing dissonance?

Jenny felt tremendous discomfort with her penis, but she 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 *and never had* existed lay the prodromal stages of an unfolding psychotic process. For Jenny, perceptive 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 become able 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, when forced to deal with her penis, Jenny was still unraveling. Looking for a bathing suit to take swimming lessons, for example, had been disastrous. Jenny insisted on a girls' 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 another 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 critical to me for several reasons. First, her clearly articulated and very profound distress around her body indicated to me that Jenny might be a transgender girl rather than a proto-gay boy. In that, I was trying to imagine and protect a *possible* future evolution of her gender into an adult trans woman as well as a gay man. Furthermore, the incident with Dr. A had cautioned me that to relate to her gender in any way other than how she presented herself to me would seriously jeopardize, if not preclude, the establishment of a therapeutic relationship. I also found it essential to resist any pressure to become recruited into policing what she did and did not tell me about herself and her body. To do 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 such that 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 stall⁷ 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 to a separate space.

In my work with Jenny, the restroom became the paradigmatic encapsulation of where the bodily and the social meet. A meaning-saturated space, it required of Jenny to interact privately with her male anatomy while publicly claiming her gender as female in choosing the ladies' room. It is because of this complexity that the restroom became the site where Jenny routinely encountered her body/gender split and why it became a liminal space that served the transitional function of trying to work out her omnipotent grip over reality (Winnicott, 1953). In its confines, her body could be both known and not known; it could belong to our intersubjective experience and to her intrapsychic life alone; 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, and 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. She started to occasionally “forget” to close the door to the stall. She would then emerge, frantically asking me whether I had seen anything. We were getting closer, I felt, to her “revealing” to me – and to “discovering” herself – the fact of her body.

For these reasons, I felt that it would be crucial for Jenny’s penis to become thinkable (Bion, 1962) to her before she could shed her reliance on fantasy-based, omnipotent solutions. She would then, perhaps, become able to interact better with others around the fact of her natal sex. With her 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. 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 it *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 such session, Jenny drew several renditions of a donkey: as the animal raced across the page, its form changed to a horse, and by the finish line it had convincingly transformed into an ostrich. 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, then lowered her skirt and looked at me expectantly. How was I to treat this communication? Was it an invitation to name that which she could not bear to put into words? Was the naming going to disorganize 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 be 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 and announced she had something she needed to tell me: "Dad thinks I am 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 dad 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 her 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 by strangers.

As her male anatomy was becoming knowable 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 tuck⁸ 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 and eventually 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, of the earth or an alien, an animal or human. All revolved around questions of categorical identification and of 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 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 affective regulation when she found herself being misgendered by her brother or her classmates.

It was such 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 re-emerge headless, a hoped-for – albeit 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, she exclaimed with excitement: “It was not an ostrich or a chicken: it was an ostricken!” This dream, which was laced with relief, condensed the ostrich’s omnipotent control over reality (the head in the sand) and her emerging insight as to how problematic the unconscious fantasy had become (the sand that will get in the animal’s eyes) with the coveted absent penis (the shrunken neck). Having been able to move away from her omnipotently concocted fantasies, Jenny dreamt up an *ostricken*, a reassuring and generative neologism that inscribed memory, temporality, and history.

Therapeutic action

How can we understand what was ultimately helpful in my work with Jenny? It seems to me that what was of use to my patient was orienting the work around registering, appreciating, and eventually helping her mentalize the fact that the incoherence she experienced between her gender and her body was the very site of a near psychic catastrophe. Focusing the treatment on helping her bear the pain this brought her, but without pressuring her to do so prematurely, was what may have ultimately made it possible for her to come into contact with this anguish in graduated, manageable doses. As the clinical narrative shows, this happened first through the enactment of the bathroom trips and bathroom play, which forced her to interact with her male anatomy even as she was able to claim herself as a girl. This was followed by her increasing efforts to form representations, which were

captured in her drawings becoming less disorganized. The process culminated in her dreaming and the alpha function at work that produced her brilliant condensation of the ostricken.

The question of therapeutic action is, of course, not only a question of technique. From a relational viewpoint, it must also include an accounting of the analyst's internal process and psychic/conceptual work, for it is this process that informs clinical technique in the first place. "Technique" is a not a term used frequently in contemporary relational work because of its association with a level of conscious and precise intentionality that I clearly did not have during the treatment. I use it, however, to help me draw a distinction between what we do in the consulting room, and the psychic states we attend to and cultivate in ourselves so that we may be able to tune into the patient and follow her in ways that respect her pace and rhythm, rather than acting out our own internal pressures as a way of quelling our own countertransferential anxieties; or, in those instances when we work with children, to prevent acting out that aims to relieve our identifications with the parents' anxieties.

The question of therapeutic action, then, can also be reframed to ask: what was the orienting framework that helped me, as Jenny's therapist, prioritize her gender experience even when, in the immediate, one might have read the clinical progression as further compromising her capacity for self-regulation? What was it that afforded her and me the intersubjective space to believe in her gender and to live it out together for a year and a half, which, in turn, helped her confront her body's forceful disagreement and yet still maintain her gender identity? And what about that internal work is uniquely relational?

I worked with Jenny with two sets of relational tools in mind that enabled the treatment to develop as it did. The first issued from relational psychoanalysts' revamping of traditional gender theory to propose and convincingly articulate the socially constructed nature of gender (Benjamin, 1991; Dimen, 1991, 2007; Goldner, 1991, 2003; Harris, 1991; 2005a; Corbett, 1996, 1997). This work, wonderfully summarized in Dimen and Goldner (2005) and in Corbett (2011), draws on feminist and postmodern theory (Butler, 1993, 1990; Halberstam, 2005; Stockton, 2009; Salamon, 2010) to show that the question of whether gender and sexed body do or don't align bears no relation to mental health. Without the help of these tremendously important

theoretical innovations, we would not, as a field, be able to conceptualize patients like Jenny with the confidence of belief.

The second important element in Jenny's treatment was the temporal framework orienting the work. While most schools of psychoanalysis rely primarily on the past (conscious memory and the archival unconscious) to drive the work, relational work also privileges the role of futurity (Seligman, 2016). With transgender children, and Jenny in particular, this was especially important because so much of what made clinical sense in the here and now also hinged on what would be possible for her in the future. In some ways, the analyst working with transgender patients not only is required to work with the historical past, with defenses and relational facts and fantasies, but is also in the position of having to imagine a world that, as far as transgender experience is concerned, does not yet exist.

To explain what I mean in more detail, I turn to Loewald's classical paper on therapeutic action. I rely on Loewald, whom I, along with many others, think of as the first relational thinker, and specifically on a somewhat undertheorized part of his paper on therapeutic action (1960). In this essay, Loewald speaks powerfully to the transformational potential held by new objects whose novelty resides in *the envisioning of the patient's future*. This has especially potent implications when it comes to trans children because their otherness can often make their futures seem especially tenuous. I'll follow the trail of Loewald's thinking on futurity to reflect on trans kids and to flesh out how thinking about futurity has been critical to my treatment of Jenny.

Loewald's essay has been celebrated for its progressiveness in marrying the topographical model with an understanding of the early dynamics between caretaker and infant, and for recognizing the centrality of the patient-analyst relationship (Chodorow, 2008, 2009). The place of futurity in his work, however, remains mostly unexplored. With a few notable exceptions (Cooper, 1997; Jacobs, 2008), his belief in the clinical power inherent in analytic imaginings of a patient's future has not been given its clinical due. Loewald (1960) tells us that, ideally, the parent relates empathically to the:

...child's particular stage in development, yet ahead in his vision of the child's future and mediating this vision to the child in his dealing with him. This vision, informed by the parent's own experience

and knowledge of growth and future, is, ideally, a more articulate and more integrated version of the core of being that the child presents to the parent. This “more” that the parent sees and knows, he mediates to the child so that the child in identification with it can grow. The child, by internalizing aspects of the parent, also internalizes the parent’s image of the child – an image that is mediated to the child in the thousand different ways of being handled, bodily and emotionally ... The bodily handling of and concern with the child, the manner in which the child is fed, touched, cleaned, the way it is looked at, talked to, called by name, recognized and re-recognized – all these and many other ways of communicating with the child, and communicating to him his identity, sameness, unity, and individuality, shape and mould him so that he can begin to identify himself, to feel and recognize himself as one and as separate from others yet with others. *The child begins to experience himself as a centered unit by being centered upon ...* In analysis, if it is to be a process leading to structural changes, interactions of a comparable nature have to take place.

(pp. 229–230, emphasis added)

Loewald writes evocatively of the process of being able to imagine a future for an other. That process, he tells us, is mediated not only through language, but is also transmitted through multiple avenues, including embodiment. Drawing on Laplanche (1999), I would add that such communications oftentimes exceed conscious registration and/or intent. As the ability to empathically envision a future becomes internalized, an experience of the self “as a centered unit” arises, constituting subjectivity.

It’s easy to see how this passage can generate clinical controversy due to: worry about infantilizing patients by imagining for and, therefore, in lieu of them; over-investment in particular outcomes; and narcissistic overvaluing of the analytic role (Friedman, 2008). These critiques notwithstanding, Loewald’s recommendation is especially productive when what is imagined does not reside in anticipated outcomes as sites of stable meanings, but rather lies in the potential for envisioning growth and emergent possibility. Having a future made imaginable through an other can be doubly powerful for children, because the future lies ahead as something adults promise but is not yet known to be possible.

The need for a different orienting temporal framework is especially pronounced in working with transgender children like Jenny because temporality is mapped differently onto their lives than in those of normative others (Stockton, 2009; Bruhm & Hurley, 2004; Harris, 2005b). Oftentimes deemed too young to be seen as able to claim their gender,⁹ trans children's otherness is considered retrospectively. Only when they look back as adults to announce that early kernels of their queerness had been there all along can others take their childhood seriously. Paradoxically, then, queer children's deferred identities are often only recognized as having existed after their expiration date has passed. This nonlinear relationship to time literalizes *nachträglichkeit*, "putting past and present ... side-by-side almost cubistically" (Stockton, 2009, p. 14).

The therapeutic action in work with trans children inheres, then, among other things, in allowing one's imagination to "go queer" when it, most canonically, goes straight (Corbett, 1997). Part of what made it possible for me to be patient and wait for Jenny's disclosure as long as I did – part of what made it feasible for me to "trust" in her gender – was my sensing that despite the complicated nexus of wish and defense, Jenny had to be treated *as a girl in real time*, with no qualifications as to her gender and with no need to make any anxious proclamations about her body. This permitted a kind of imagining *for* Jenny of how her life might be lived should she be able to settle into her knowledge of her body despite its discrepancies from her sense of self. It is through this extended period of my accepting her gender of experience rather than her gender of assignation – that is, of working from within a framework of futurity – that Jenny was able to take me in enough to tolerate confronting her body. She did so by introducing me to it and, I think on some level, by encountering it anew as the body of a trans girl – rather than as a body that was burdened with the "untenability" of her gender.

Conclusion

I have shared a clinical story of having watched my child patient waver on the precipice of psychotic dysregulation because I want to underscore that when we fail to see that pathology follows from the mismanagement of body dysphoria and when we are unable to imagine

a future for our transgender child patients, we can, without intending to, 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 and 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 poison ivy.

We are in a strange place in history. We know 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 multiple questions that remain unanswered regarding clinical work with transgender children, there are, quite likely, also numerous others we have not yet even imagined asking.

Notes

- 1 This chapter first published as Saketopolou, A. (2014). Mourning the body as bedrock: Developmental considerations in treating transsexual patients analytically. *Journal of the American Psychoanalytic Association*, 62:773–806. Copyright © 2014 by American Psychoanalytic Association. Reprinted by permission of SAGE Publications, Inc.
- 2 Defenses deployed against experiencing oneself as a disappointment to one's primary objects can often become confusing to their environment, which can misinterpret them as evidence of the child's "confusion" regarding gender identification (Lev, 2004).
- 3 My focus here is on children who experience body dysphoria from very early in life. Obviously, not all transgender children share this characteristic.
- 4 This symptomatology tends to recede with social and medical transition.
- 5 During the course of the family work this shifted, with the father becoming able to get in touch with and to express more openly his discomfort with his child's gender. This, as we came to discover, was something that Jenny had already been sensing long before her father became aware of it himself.
- 6 Parents' mourning of their fantasy of their child's gender is an important facet of the family work necessary in these treatments. Discussing it

- is beyond the scope of this chapter, but the interested reader can consult DiCeglie (2012) and Riley, Sitharthan, Clemson, and Diamond (2011).
- 7 In the building where I practice, a shared bathroom space serves the entire office floor. Several stalls are separated by divides that ensure privacy, while the washing basins are located in the common space.
 - 8 This is the practice of concealing the penis to achieve a flat appearance in the crotch area.
 - 9 Normative inflections of gender are, of course, exceptions. Natal girls who play with Barbie dolls and natal boys who play at being Superman are considered perfectly capable of enacting and claiming their gender.

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