*Remarks delivered at the 2018 Stacia I. Super Ethics Conference hosted by the Washington Baltimore Center for Psychoanalysis.*

## Introduction

We live in different times then that of Freud (1924) who famously declared that, "Anatomy is destiny." Feminist thinkers are right to challenge the chauvinism underlying such phallocentric ideas, and theorists such as Karen Horney and others have brought much needed attention to those cultural factors, many rooted in paternalism, that continue to influence the way we understand gender. However, despite such recognition and acceptance of such factors, anxieties and symptomatic difficulties in relation to sexuality and gender have not dissipated and continue to cause suffering in our patients. For the psychoanalyst practicing today, a commitment to continuing to engage with social and cultural developments is a necessity if one is to understand the ever evolving, gender-fluid world in which we practice.

We shouldn't hesitate to interrogate other schools of thought, not only to clarify our own position in relation to our theoretical assumptions, but to investigate whether our field of knowledge can hold up to outside scrutiny. What we ought to be avoiding is the death-grip of Freudian doctrine out of fear that if the epistemological assumptions on which psychoanalysis was founded are brought into question and found to be invalid, then the whole enterprise could collapse like a house of cards. A commitment to inter- and cross-disciplinary research is one method of keeping our field alive as both a theory of the mind and a clinical practice anchored in curiosity and open exploration. It is in this spirit that I welcome SJ Langer's neuro-psychoanalytic theory of gender and his invitation to all of us to look critically at psychoanalysis' history of transphobia, which persists even today as we struggle with the anxiety and discomfort of working with patients who challenge many of the assumptions embedded in our theories of gender.

## The Psychoanalyst's Internalized Transphobia

Why does psychoanalysis continue to pathologize transgender people? The historical relationship between psychoanalysis and the trans community is one that is exceedingly fraught and it for good reason that trans people are skeptical of our intentions towards them. How could this be? Neither a strictly biological nor social deterministic theory, psychoanalysis strives to understand all humans as psychic entities driven by unconscious fantasies outside of our awareness. We as analysts often assume a neutral and curious stance in relationship to our patients, as we try to better understand them. However, in the case of trans and gender non-conforming patients, we have often been anything but neutral. As Patricia Gherovici (2011), a Lacanian psychoanalyst, writes, "In both subtle and brutal ways, psychoanalysis has a history of coercive heteronormalization and pathologization of non-normative sexualities and genders." Indeed, as she points out, until more recently, many analysts were either threatened or puzzled by trans and were often unsuccessful in concealing their disdain. Such transphobia is based on a selective reinterpretation of Freud's writing and what Gherovici calls a "reductive distortion" born of a homophobic and transphobic history. The remnants of such phobia continue to pervade not only psychoanalysis but also modern psychiatry, which only recently eliminated the term "gender identity disorder" from the DSM and replaced it with the less offensive, but still problematic, "gender dysphoria."

Those of us who work with trans patients know that anyone seeking to medically transition—be it hormonally or surgically—needs a diagnosis of "gender dysphoria" in order to qualify for such medical interventions. As a clinician, I have found myself on more than one occasion playing the role of "gender gatekeeper," with the power to decide who does and does not meet criteria. Arlene Lev's book, *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families* (2004), describes the DSM as an impediment to working with trans patients, as the nosology on which the manual is organized only serves to reinforce a gender binary that leaves little room for variation in many trans patient's lived experiences and their expressions. She writes, "As long as psychology continues to condemn people for sexual and gender differences, they will continue to manifest mental health problems related not to their differences but to being labeled pathological."

Historically, psychoanalysts have been some of the worst offenders of such pathological language, labeling trans and gender non-conforming patients as narcissistic, obsessive, perverse, borderline and psychotic. Betty Steiner, who served for many years as the head of the Gender Identity Clinic at the Clarke Institute in Toronto, once wrote that therapists should "be prepared to see individuals who may present physically looking somewhat bizarre, either flamboyantly or inappropriately dressed, or looking like a man in 'drag'" (1990). Similarly, Colette Chiland (2000) in a paper appearing in 2000 in the *International Journal of Psychoanalysis,* described trans patients in this way: "Enclosed as they are within their narcissistic shells they do not care about their analyst's inner reactions to what they say." Assuming such comments are representative of the field, is it any wonder why our patients would be dismissive of what we have to say?

As analysts we are in a privileged position and often seen to be authority figures, whether we like to acknowledge this fact or not. Such privilege is even more apparent when treating the trans patient who seeks our assistance in facilitating their medical transition. In such cases, we have the power—not in fantasy but in reality—to either grant or deny such medical treatment. In this role we often find ourselves in the uncomfortable position of *having to pathologize* the very people who seek to be understood. It is a position I encountered not too long ago, when I was contacted by a trans-**xxx**, who asked to be evaluated and provided with documentation that attested to **xxx** mental competency to undergo **xxx** surgery. **X** arrived at our first appointment well-versed in the DSM—certainly more that me—and proceeded systematically to list, almost verbatim, each of the criteria for "gender dysphoria." It was as though **xxx** needed to prove to me that **xxx** was "sicker" than **xxx** actually was by highlighting the "marked incongruence between **xxx** experienced gender and that assigned at birth." If **xxx** could convince me of **xxx** illness, **xxx** would be allowed the surgery **xxx** needed to feel more comfortable in **xxx** gendered skin. Such an inherent power dynamic between therapist and patient will inevitably elicit strong transference and countertransference reactions in both parties.

The more patients I see, who identify as trans, the less convinced I am that their psychological symptoms are internally generated but rather a byproduct of a society that shames and stigmatizes those who do not neatly conform to socially constructed norms around gender. We know that trauma can take many forms and is often compounded by the intersection of gender, class, and race. As clinicians we are ethically bound to consider these factors when assessing and treating our trans patients. Some clinicians—myself included—would prefer "gender dysphoria" and all other gender specific diagnoses be stricken from the DSM. Unfortunately, at this moment, without such categories, trans patients seeking medical

treatment would be denied access. It is a Catch-22 that has led trans-advocates to argue that the field needs clearer guidelines to help it discern those trans patients presenting with symptoms of mental disorders independent of their gender identity development, and those who present with symptoms more clearly in response to living in a transphobic society.

## Towards a More Ethical Treatment of Trans-Patients

More recently contemporary psychoanalytic thinkers, informed by other disciplines such as queer studies, have begun to conceptualize gender less in terms of an embodied experience and more from a relational perspective. Several current psychoanalytic theorists (Dean 2000, Gherovivi 2017, Gozlan 2011) have turned to the work of Jacques Lacan (1998) and his theory of sexuation to investigate sexuality, subjectivity, and desire in relation to trans and gender non-conforming patients. These theorists support Lacan's understanding of sexuality as rooted in the polymorphous perversity of infantile sexuality and furthermore do not see sexual drives as gender specific. Similarly, these theoreticians view sexual positions of masculinity and femininity as based in unconscious fantasy and not anatomy. Whereas Freud placed reproductive genitals at the center of his model of human sexuality, Lacan and his followers reject such a notion and instead argue that sexuality comes to attach itself to relations of love and gender identity that are socially constructed. Asserting a complex relationship between the body and the psyche, such Lacanians emphasize the instability and uncertainty of sexual identity, arguing that social constructions around gender must be understood as something other than sexual differences.

Being far more versed in the British Object Relations School, the work of Winnicott has been especially helpful to me in conceptualizing and working with trans patients. As we all know, Winnicott frequently wrote about the "good enough mother," a concept that served as a short hand for the importance of adequate mirroring between child and caregiver. Without it, to quote Winnicott (1971), the child's "own creative capacity begins to atrophy." The trans child seeks the good enough mother but often does not find her because his or her sense of who he or she is, is not reflected back. As Langer notes, it is this misattunement that leads trans children to have more difficulty understanding their own proprioceptive and interoceptive sensations, some of which are related to their gender identity.

Langer cites the work of Alessandra Lemma (2013), a Kleinian psychoanalyst at the Tavistock Clinic, who worked for 5 years in weekly psychoanalytic therapy with Ms. A, a 20-something MtF trans patient seeking gender affirming surgery. He accuses Lemma of misattributing Winnicott's theory of maternal mirroring in order to pathologize her patient's trans experience. He points to Lemma's repeated failure to recognize her trans patient's authentic self, as well as her conclusion that her patient's search for the "right body" (through gender affirming surgery) was driven not only by a desire to align her physical body with her experienced gender but also a defense against her lack of psychic self-cohesion. Personally, I didn't read Lemma's use of the "alien self," i.e., that self-state created by the child in response to the parental misattunement, as transphobic. I suspect part of my insensitivity to Lemma's writing has to do with my own internalized transphobia, informed by my analytic training, which is steeped in the Kleinian tradition. Kleinians, such as Lemma, often interpret projective-identification as a form of counter-transference that is invaluable in helping the analyst understand the internal world of the analysand. Such projective material is almost by definition primitive and pathological in its conception, however, to the untrained ear it can sound terribly

judgmental and infantilizing. But, I assume that is part of what Langer is inviting us to consider as cisgender analysts. Though we may consciously strive to be open and affirming of our gender non-conforming patients, our unconscious phantasies, informed by our theoretical training, can at best make us insensitive to and at worst stigmatizing of our trans patients. I appreciate Langer's attempts to put into words, as imprecise as they may be, the embodied experience of the trans patient who cannot "be seen" and taken into the mind of the analyst. Such empathic failures serve as a reenactment of our trans patient's early experiences with caregivers and their failure to sufficiently mirror and mentalize the felt embodied incongruence of the trans child.

As cisgender clinicians working with such patients we must continue to be vigilant in examining those blindspots informing our transphobia. As with all patients, we should be resolute in our efforts to be curious and receptive to our patients' experiences and leave our theoretical dogmas in the waiting room so that we can be truly receptive to our trans patients' lived experiences. Our therapeutic goal should not be the resolution of gender ambiguity but deeper exploration and support of our trans patients' authentic and emerging cohesive gendered selves. Such a stance will inevitably require us to work on conflicts around our own internalized transphobia before we turn our gaze to our patients. Because many trans patients come to us having been robbed of a cohesive gender narrative, we should refrain from rushing to provide one for them; instead, we should be prepared to follow our trans patients' stories wherever they lead and allow ourselves to be challenged and surprised by what we discover. While there may be a strong pull to assume the role of "gender gatekeepers," instead, I would encourage us all to aspire to join our patients as "gatecrashers," challenging those gender norms and stereotypes that serve to limit us all. Such a therapeutic stance might challenge our more neutral inclinations as analysts but as Arlene Lev writes, our trans patients need to "hear themselves into existence" and we need to listen and strive to accurately and supportively mirror our patients' gendered experiences and the different and often creative ways they express these internal worlds to us.

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