ACHIEVING OPTIMAL GENDER IDENTITY INTEGRATION FOR TRANSGENDER FEMALE-TO-MALE ADULT PATIENTS: AN UNCONVENTIONAL PSYCHOANALYTIC GUIDE FOR TREATMENT

A dissertation submitted to the Wright Institute Graduate School of Psychology, in partial fulfillment of the requirement for the degree of Doctor of Psychology

by
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The journey of self-discovery for transgender female-to-male (FTM) individuals is arduous. The desire to identify or transition one’s body from one’s birth sex to the opposite gender is difficult for people to comprehend as the vicissitude of gender is typically an initial identifying marker for organizing one’s experiences. Transgendered individuals seeking psychotherapy may experience a number of conditions, including adjustment, depression and anxiety disorders, trauma, substance dependency, and characterological pathology. Clinicians are not currently trained to identify clinical themes prevalent for transgender FTM individuals and often misunderstand their mental health needs. Traditional psychoanalytic literature fails to address gender and sexuality development for FTM persons from a nonpathological perspective, and negative countertransference from providers and institutions is common. These feelings and attitudes toward the patient include anxiety, fear, disgust, anger, confusion, morbid curiosity, and rejection that can severely compromise the therapeutic relationship.

The primary goal of this manual is to provide educational, medically informed, and socioculturally sensitive information for clinicians who work with transgender FTM individuals. Additionally, it aims to provide a bridge for understanding these patients’ cultural experiences within a contemporary psychoanalytic theoretical framework. In
order to effectively treat transgender individuals from an unconventional contemporary psychoanalytic approach, this manual introduces the practitioner to transgender culture, reflections on psychoanalytic theory of transgender development, as well as diagnostic conditions and clinical implications, which includes a commentary on the role of the clinician, a discussion on the transference-countertransference relationship, as well as offering an empathic approach to treatment that considers gender-variant expressions and behaviors as healthy.

Research for the manual includes literature reviews on (1) language, concepts, and gender/sexual identifications from a queer theoretical perspective; and (2) gender/transsexual development from traditional, contemporary, and psychoanalytic perspectives. Also presented is (3) an historical overview of transgender studies; (4) an analysis of Gender Identity Disorder according to the DSM and Psychodynamic Diagnostic Manual, and a commentary from a transgender perspective; (5) clinical implications and interventions; (6) a discussion on transitioning and coming-out; and finally, (7) commentary on societal issues that affect FTM’s lives. The appendixes provide a questionnaire, a sample letter, and a resource guide.
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Introduction

Transgender identity, an individual’s gender identity and behavioral expressions that tend to deviate from their anatomical sex according to conventional societal expectations, is fraught with deep prejudice that has been present for a long time. “In many parts of the world, having a trans identity still puts one at risk of discrimination, violence, and even death” (Stryker & Whittle, 2006, p. xi). Transphobia, discrimination and prejudice enacted toward transsexual and transgendered people because of their gender identity expression, whether explicit or covert, is often marked by an intense anxious response on the part of the perpetrator. This response stems from the perpetrator’s irrational fear and subjective interpretation of another’s birth sex and presentation that is seemingly in conflict with his/her own ascribed gender identity “ideals” and social scripts. The motivation behind such oppressive acts is infused further by the threat of an individual’s perceived sexual orientation. Thus, transphobia and homophobia often become confused and manifest in forms of harassment, or in more extreme cases, assault and murder. More subtle forms of discrimination exist—many occurring within mental health and legal systems, government and nonprofit support services. They include overpathologizing, misdiagnosing, maltreatment in the form of refusal of services, and demonizing, and they are carried out by providers who fail to respect, protect, provide appropriate treatment (or any at all), or provide impartial (or equal) treatment. As if this is not enough, transgendered persons may be further marginalized by their ethnic and racial identity, economic status, physical abilities, and age.
A number of situations may arise in which a clinician becomes involved with a patient who has a transgender identity. One such important situation is when the clinician is asked to assess and substantiate a patient’s preparedness for various interventions by assessing the Real-Life test. (This test assesses an individual who has been living in an aspired transitioning gender for some time, and determines whether he/she is an appropriate candidate for aesthetic surgeries, hormone intervention, and Genital Reassignment Surgery.) It should not be left solely in the hands of the patients to educate their clinicians about very complex—and at times, convoluted—psychological and social complications in which they must rely on a their clinician’s empathy and ethics.

As the presence and experience of transgender people has entered both public consciousness and mental health facilities, clinicians are now beginning to think about transgender issues. However, no informative guide is available that informs and reviews transsexual and transgender history from a queer theory perspective, integrating that perspective with traditional psychoanalytic and contemporary psychoanalytic theory. Such a manual could provide a clinician with the knowledge necessary to execute a Real-Life assessment, as well as provide an empathic corrective emotional experience wherein an individual is likely to be better able to develop an integrated gender identity. A therapeutic relationship that tenders a way for patients to integrate their sense of self in relationship to the other can perhaps be emulated in the outside world and their relationships. A strong sense of self is likely to build confidence and self-esteem that will foster healthier relationships and, consequently, decrease uncertainty and fear, possibly decreasing violence toward transgendered individuals.
The purpose of this project is to present, in depth, the intricate issues with which transgender female-to-male grapple, as well as to provide an informative manual for the practitioner that will provide a solid foundation of practical knowledge and awareness into the psychological difficulties a transgendered female-to-male might encounter. The manual is the first of its kind and aims to provide the clinician with insight and clarification while bridging the gap between queer theory and psychoanalytic theory, as well as medical information that will offer a template for clinical treatment. Presented are the theories of Judith Halberstam, Sigmund Freud, Karen Horney, Robert Stoller, Judith Butler, Muriel Dimen, Ken Corbett, and Adrienne Harris in an attempt to think about gender phenomenon from various disciplines. Abreast of such knowledge, the informed practitioner will be better prepared to provide empathic therapeutic treatment by means of an accepting relationship. The manual utilizes these theories as a framework in treatment for the practitioner helping a patient to discover an authentic gender identity and bodily presentation albeit variant from societal expectation. It attempts to challenge past views of gender deviations as pathological and, instead, argues for the perspective that the multiple vicissitudes of gender variance are adaptive.

The manual is organized to provide thoughtful and clinically astute ideas that will facilitate a higher standard of therapeutic care. This dissertation will consist of an overview of the subject matter, an introduction to traditional psychoanalytic thought, and an exploration of contemporary gender and transgender development theories. Terms and the sequence of those terms’ development will be discussed. An analysis of the complexity of transgender language, concepts, identities/identifications and their conflicts will be presented. A history of transgender studies, a literary review of psychoanalytic
theory of gender development, as well as the development of female transsexualism are imperative in understanding transgender individuals’ legacy within the dominant culture and the mental health community. A review of Gender Identity Disorder diagnosis, gender dysphoria and clinical implications and intervention of coexisting mental health concerns, body modifications, sexuality, and social milieu engagements will be discussed. The manual will include a list of resources, a semi-structured interview questionnaire, and sample letter to assist the clinician in the development of a culturally sensitive case formulation and guide for psychoanalytic treatment in the appendices.

The goal is to both educate mental health professionals in an effort to aid appropriate intervention from an empathic position and to argue that gender variant expression is healthy.

The specific training modules are organized according to subject matter and will be introduced to the reader by providing a rationale for the specific topic followed by a literature review. The previous introduction orients the reader to the problem, purpose, significance, and intent of the training manual. Training Module 1, which follows this section, is an example of the form this manual will take. The manual is informed by both research and the author’s and others’ past clinical work with transgender and gender-variant identified patients.
Training Module I

Terms and Identities

This section will review sex and gender development, and identify terms and concepts related to the study of the transgender community. The goal is to inform the practitioner of the language that is commonly used among transgender men with the intention of promoting respectful communication that expresses an intricate set of thoughts, ideas, and feelings associated with sex, gender, sexuality and identity. The language used among the transgender community is multifaceted because finding words to articulate a complex group of individuals and their identities is arduous. Knowledge of the language used by the community will enable mental health professionals to understand concepts, organize thoughts, foster discussions, exchange ideas, and support (treat) the community in the least confusing, shameful, and harmful way. Familiarity with the community’s positive expressions of self and identity not only informs the clinician of how an individual views oneself, but also encourages more empathy from mental health providers. Without relying upon the patient to educate the therapist, the patient will more likely feel understood, which will reinforce positive self-concepts that will inevitably improve healing and resiliency.

The following discussion presents a very general overview of how we come to understand the meaning of sex, gender/gender identity, gender roles, and sexuality for the transgendered male. It must be kept in mind that these terms are constantly evolving by those who identify as FTM (female-to-male), gender-variant, or transsexual, as well as by practitioners who intend to help them. It also must be kept in mind that the term FTM encompasses a spectrum or continuum from those who identify as primarily female to
those who identify as primarily male being on the ends of this continuum. Between these
two posts or “extremes” lie most FTM individuals.

Innate biological chromosomal effects that influence a transgender man’s gender
identity development, gender role participation, and behavior will be only briefly
addressed as a more lengthy discussion is out of the scope and objectives of this
dissertation. However, such a brief discussion will serve to clarify and describe the
intersex condition and/or Disorders of Sex Development (DSD) that frequently become
confused, and applied inappropriately to transgender and transsexual groups by
healthcare providers, and scholars. In short, nondynamic factors and innate
predispositions must not be completely ignored, although this dissertation is primarily
concerned with the progress of contemporary psychoanalytic perspective on the
psychological, social, and cultural factors of gender identity development (which will be
discussed theoretically in Training Module 3).

*Sex and Its Circumstances*

*Identifying the Sex of the Fetus Biologically and Early Socialization*

Parents often become aware of their child’s birth sex before delivery. This
information is often a by-product of parental screening tests to assess the viability of
growing fetus, yet often result in an unconscious intent to begin socializing the unborn
child according to societal sex roles:

Almost from inception, the sex of an expected child is a subject of conversation
and speculation by friends, coworkers, and family…. [Shortly thereafter], these
assignments of sex will in most cases last throughout life and will have a
profound effect on the way individuals are treated by their family and society. The
children will be given names, and gendered pronouns will be used accordingly.
Their assigned sex will determine every aspect of their lives, including the
clothing they will wear, their playmates, their speech and behavior patterns, and
even their hopes and dreams. Rigid expectations will be placed on their interests,
their career, and their sexual orientation and behavior. (Denny & Pittman, 2007, p. 205)

As will be discussed in the latter part of this work, and poignantly summarized by Denny and Pittman (2007):

For some people … sex assignment is problematic. … [And] for any of a variety of reasons, their sex assignment does not match their inner views of themselves. The rigid expectations placed on them by society can and do cause external conflict and inner pain. (p. 206)

From a strictly medical perspective, the evaluation of the length of the phallus signifies and ascribes sex status in ambiguous situations.

If the nonerect phallus is 2.5 cm in length or longer, it will typically be labeled a penis, and the baby will be assigned to the male sex. If the phallus is less than .9 cm in length, it will be labeled a clitoris, and the infant will be assigned to the female sex. A phallus between .9 cm and 2.5 cm in length will pose a social and medical quandary. (Denny & Pittman, 2007, p. 205)

Another indicator of birth sex is the urethral meatus; in males this is in the tip of the penis, whereas for females, the phallus or clitoris does not include the urethral tube. Yet another indicator is the tissue that forms the labia for the female child and the scrotum in the male child, which can be partially fused, representing physical uncertainty (Denny & Pittman, 2007).

_Biological process involved in the development of sex and its variations._ During fertilization and upon conception, each parent contributes a chromosome and DNA strands, which then direct the development of their unborn fetus, and approximately, in the 6th week of pregnancy, sexual differentiation begins to occur: “The androgynous embryo possesses both mullerian and wolffian ducts and [thus] has the potential to develop either a male or a female reproductive anatomy” (Rudacille, 2005, p. xvi).
Female-born children possess XX chromosomes, and midway through the 2\textsuperscript{nd} month, “primordial gonads develop into egg-bearing ovaries,” and the woffian ducts deteriorate; meanwhile, the mullerian ducts develop into the “female reproductive system, the fallopian tubes, uterus, cervix and vagina” (Rudacille, 2005, p. xvi).

Male-born children possess XY chromosomes, and during the 2\textsuperscript{nd} month of pregnancy, the Y chromosome stimulates “a gene called SRY [and] directs the primitive gonad to form testicles, rather than ovaries” (Rudacille, 2005, p. xvii). Notably, the XY chromosome is accompanied with hormones such as testosterone, and the XX chromosome contains estrogen hormones (Rothblatt, 1995). Rudacille (2005) offers an articulate description of this process.

One of the chemical messengers, produced by the testicles, mullerian-inhibiting substance (MIS), begins circulation throughout the rapidly dividing cells, barking out orders to arrest the development of a female reproductive anatomy. Testosterone and MIS ensure that the fissure that would otherwise develop into a vagina fuses together to form a scrotum, and the primary instrument of sexual pleasure (glanis penis) develops outside the fleshy mound of the pubis, rather than hidden within it (glans clitoridis). In males, the hormone-driving sexing brain is known to continue into the early weeks immediately following birth, when the testicles pump out a flood of testosterone at levels that will not be matched until puberty. By that time, the male child will have learned what behaviors and attitudes his family and culture expect him to display; these are the based on the presence of male genitals. ….

[Whereas], the process of prenatal sexual differentiation is complex and multifaceted. An embryo needs more than a Y chromosome to become male; it also needs an androgen receptor gene on the X chromosome to enable it to respond to the androgens its testes are producing. If the androgen receptor gene isn’t functioning, the XY fetus will develop female genitalia. Moreover, testosterone (the so-called male hormone) is transformed into estrogen in the brain by an enzyme called aromatase. (p. xvii)

As this delicate chemical process is intertwined with the environment, multiple gender variations seem probable:

Chromosomal mosaicism occurs when cells exhibit a variety of types of sex chromosomes: the individual’s karyotype can include both XX and XY cells or
can include combinations of XY (male); XX (female); XO (Turner); XXY, XXXY, and XXXY (Klinefelter and its variants); XXX; and XXY ("Super-male") sex chromosomes. Some individuals with mosaicism are assigned as females at birth, others as male. (Denny & Pittman, 2007, p. 208)

According to Rothblatt (1995), people are born with “all manner of chromosomal variations, including XXY and X among others” (p. 6). Therefore, both men and women have estrogen and testosterone, though in various amounts (Hines, 2004). The chromosomes direct the gonads to develop as either testes or ovaries. The hormones from the gonads, specifically the androgens from the testes, instruct the biological influences on genital differentiation. When one has a substantial amount of testosterone, it is likely that the testosterone will create more male-like possibilities and vice versa (Hines, 2004).

The hormonal influence on sexual differentiation begins in early gestation, which involves internal and external genitalia, as well as brain and behavior. Different hormonal levels create different bodily organs, physiques, and physical strengths.

As people age, their hormonal levels continually decline, creating a convergence between “male” and “female” hormone states in mature adults. Absent of estrogen replacement therapy (ERT), postmenopausal women often begin to sprout facial hair and acquire deeper voices. Older men and women begin to look more “transgendered,” more like each other than their youth. (Rothblatt, 1995, p. 8)

**Intersex**

According to Rothblatt (1995), then, 4% of all births are to some extent “intersexed” or atypical, meaning that the newborn has both male and female chromosomal chemical compositions, internal reproductive, secondary sex characteristics, as well as external genitalia with multiple variations of both female and male characteristics.

Various intersexed and sexual development conditions, wherein an individual may be born with discrete genetic conditions and bodily abnormalities, have recently
been adopted under the umbrella term Disorders of Sex Development (DSD) by the medical community to provide a general label to multiple intersex and formally termed hermaphrodite conditions. For example, Complete Androgen Insensitivity Syndrome (CAIS) is extremely rare. People born with this condition have male XY chromosomes, though they lack the receptors for androgens, the key masculinizing hormone. Androgens from the male gonads (the testes) have the direct involvement of the external genitalia (Hines, 2004). Therefore, these children are often born and identified as girls, and only during puberty, are they discovered to have such internal conditions due to lack of menstruation. Generally, a genetic analysis will follow, revealing the unanticipated Y chromosome—as well as testes in addition to or instead of ovaries that did not descend (Hines, 2004):

> Girls exposed to elevated androgen prenatally, because of genetic conditions, or because their mothers took androgenic hormones during pregnancy, tend to be born with ambiguous genitalia (in between those of males of females), a situation that is sometimes called an *intersex condition.* (Hines, 2004, p. 12)

Therefore, individuals with CAIS (more recently re-termed Androgen Insensitivity Syndrome [AIS]) will appear female, though they are considered to be intersexed due to their XY chromosomal make-up. AIS persons’ external genitalia can present in female form; in the condition of Partial Insensitivity Syndrome (PAIS), external genitalia can be ambiguous (Androgen Insensitivity Syndrome Support Group, 2007). It is important to note, however, that, though it is possible to study hormonal influence on genitalia, “Hormonal influences on human behavior are harder to establish than are influences on genitalia, partly because behavioral sex differences are subtler than genital sex differences, and because behavior is subject to social (and other) influences after birth” (Hines, 2004, p. 12).
Another important factor is that, although prenatal hormones strongly influence brain development and behavior, individuals who are exposed prenatally to hormones seldom experience gender identity conflicts in relation to their anatomical parts (Hines, 2004). Hines based this assertion on several studies. One study was conducted by Money and Daléry’s in 1976 in which 7 XX individuals with congenital adrenal hyperplasia (CAH) were compared according to their assigned gender, rearing and gender identity. (CAH is a genetic disorder in which girls typically have masculinized genitalia and are often raised as girls who have high levels of prenatal androgen excess.) In Money and Daléry’s study, three of the children had been raised as boys and four as girls “successfully” with surgical and hormonal feminization. These children reportedly adapted successfully to their ascribed gender and lived accordingly. However, many subsequent gender theorists have questioned and disputed Money’s research on the grounds that it is inconclusive. In an alternative study of 53 XX individuals diagnosed with CAH, one individual had been diagnosed with Gender Identity Disorder (GID) and lived as a man despite being reared as a female child (Hines, 2004).

These aforementioned findings concluded that only one individual experienced gender identity conflict as a result of his ascribed female gender at birth. However, in an alternative study presented by Hines, four XX individuals in the New York area with CAH were living as men despite having been raised as girls (Hines, 2004). Based on the statistics, the researchers concluded that 1 in 30,000 to 100,000 women have Gender Identity Disorder (GID), and CAH occurs in approximately 1 in every 14,000 live births (both male and female). Thus, GID and CAH comorbidity occurs in 1 out of every 420,000 (Hines, 2004). Nevertheless, Hines found that though women with CAH
appeared to be somewhat dissatisfied with their female sex assignment, they did not present with GID and may not have wished to change their sex (2004).

In an alternative study, however, in which 2 out of 18 girls with CAH met the diagnostic criteria for GID; 5 of 29 other children met the criteria of GID as well; these children had been reared as girls, but they had also been exposed to high levels of androgen prenatally, causing other intersex conditions (Hines, 2004). One would conclude that the likelihood of many sex and gender identity possibilities is inevitable when the complexities of such hormonal, prenatal, and postnatal biological and social influences are factored in.

In a study conducted by Dessens, Slijper, and Drop (2005), the researchers found that 94.8% of the patients diagnosed with CAH and raised as girls reportedly did not feel gender dysphoric. 5.2% of the patients had various complications with their gender identity, and the authors inferred that these gender dysphoric individuals were among the female-to-male transsexual population; 12.1% (4 out of 33 patients) had been raised as male, showing serious gender identity problems. Despite these disturbances, the authors concluded that in the case of CAH, the assignment of female gender as general policy—even for severely masculinized CAH newborns—should be standard procedure.

These researchers tended to make sweeping recommendations and based their findings upon traditional guidelines set forth by Money and Hampson, gender ambiguous children treated at Harvard University and John Hopkins Hospital, which caution that gender reassignment later in a child’s development is problematic. The authors did, however, admit that the policy regarding late gender reassignment of chromosomal females with CAH is currently under debate by professionals. They supported Diamond
and Sigmundson’s view that “severely masculinized genitals” of newborns “should be assigned the male gender” despite female anatomical coexisting characteristics (p. 390). They contended that these children were likely to have been exposed to high level of androgens, which ultimately lead to higher levels of “brain masculinization.” Therefore, assigning CAH infants with significant masculine traits as “female” can lead to the development of gender identity disorders in females later in their pubescent or adult development.

Androgen Insensitivity Syndrome Support Group (AISSG, an informative support panel on the World Wide Web for the AIS intersex condition), claim that—albeit well-intentioned—transgender and transsexual groups who include intersex persons under the transgender umbrella term do so inappropriately (2007). They contend that intersex individuals are dissimilar to transsexual or transgendered persons who generally include a diverse group of individuals (i.e., persons who identify as androgynous or not fitting into masculine and feminine characteristics and gendered social roles, transgender, drag kings, stone butches, etc.) because they often do not have gender identity issues nor do they intend on transitioning from their reared gender. Intersex persons are also different from transgender people because they are not inclined to have gender identity conflicts, and they tend not to defy gender stereotypes despite their differently sexed bodies (e.g., sex chromosomes, gonads, and genitalia) (Androgen Insensitivity Syndrome Support Group, 2007). People who have intersex conditions have atypical anatomy, and AISSG claims that intersex individuals very seldom transition from their ascribed gender at birth to the opposite; intersexed individuals do, however, often suffer from various
sexual developmental disorders that include a host of physical, developmental, psychological, and emotional difficulties.

AISSG also made reference to how misidentification and labeling has led to the exploitation of intersexed persons in the media and has compromised their health care. They argue that an intersex person’s circumstances usually are entirely unrelated to the circumstances of one who feels their inner state of being male or female is being compromised, as in the transgender/transsexual experience (Androgen Insensitivity Syndrome Support Group, 2007 and Intersex Society of North America, n.d.).

Scholars, feminists, and medical professionals alike have long grappled with the true human condition of multiple genetic conditions. In 1993, Anne Fausto-Sterling first published her proposal to replace our current two-sex system with a five-sex scheme. In a more recent publication by Fausto-Sterling (2000), she revisited her “provocative” stance previously presented in 1993:

In addition to males and females, I argued, we should also accept the categories herms (named after “true” hermaphrodites), merms (named after male “pseudo-hermaphrodites”), and ferms (named after female “pseudo-hermaphrodites”). (Fausto-Sterling, 2000, p. 78)

John Money later commented on Fausto-Sterling’s five categorical system in a new edition of a guide for those who counsel intersexed children and their families; he wrote:

In the 1970’s nurturists…became…”social constructionist[s].” They align themselves against biology and medicine…. They consider all sex differences as artifacts of social construction. In cases of birth defects of the sex organs, they attack all medical and surgical interventions as unjustified meddling designed to force babies into fixed social molds of males and female. (Fausto-Sterling, 2000, p. 78)

(The work of John Money will be presented and discussed further in Training Module 3).
Following Fausto-Sterling’s proposal, many authors and theorists were stirred up, both positively and negatively. They began to address and create elaborate, and perhaps exhaustive, models to categorize different biological-, anatomical-, and gender-represented persons. “The debate over cultural conceptions of gender has escalated and the boundaries separating masculine and feminine seem harder than ever to define” (Fausto-Sterling, 2000, p. 79).

A more conservative perspective supports and utilizes “gene therapy” to ensure that an unborn child will fall into the two-sexed system, male or female (Fausto-Sterling, 2000). However, on the more radical end of the spectrum, “concepts of masculinity and femininity might overlap so completely as to render the very notion of gender difference irrelevant” (p. 101). Fausto-Sterling expressed concern, however, for the situation in which the “new ethic of medical treatment, one that permits ambiguity to thrive, rooted in a culture that has moved beyond gender hierarchies” and surgical interventions, would be implemented even in the face of a condition posed as life threatening, for example, surgical procedures for children who have gonadal tumors or salt imbalances due to adrenal malfunctions (2000, p. 101). She concluded: “Medical intervention aimed at synchronizing body image and gender identity would only rarely occur before the age of reason. Such technological intervention would be a cooperative venture among physician, patient, and gender advisors” (2000, p. 101).

The full breadth of Fausto-Sterling’s work on the intersexed individual is beyond the scope of this project; however, the interested reader is encouraged to refer to her work as well as visit the World Wide Web home page site for Intersex Society of North America (www.isna.org) to gain a better grasp on the multiple dilemmas intersexed
children, adults, and their families may endure. Nonetheless, the intersexed state of
gender forces us to think outside the binary box, or the two-sexed system, which
heretofore has constricted sound clinical thinking and judgment.

*Transgender vs. Intersex*

Fausto-Sterling eventually tied the intersexed patient’s world to transgenderism. She claimed that as a result of the transsexuals’ insistence that the medical community recognize and offer treatment through medical transformations, their struggles led to the “naming of phenomenon … winning the right to surgical and legal sex changes, however exacted [at a] price: the reinforcement of a two-gender system” (Fausto-Sterling, 2000, p. 107). She suggested that requesting surgical intervention to align bodies to the psyche actually endorses the medical profession’s philosophy that an “individual’s body, sex, and gender must conform” (Fausto-Sterling, 2000, p. 107.) She conceded, however, to the fact that transsexuals had very little choice but to view themselves within a narrow frame of gender expression in order to receive medical support (Fausto-Sterling, 2000).

The transsexual organizations more recently have begun to support the concept of transgenderism, which demands an advanced “re-visioning” of sex and gender beyond the binary. Fausto-Sterling argued that traditional transsexuals did not want to depart from gender stereotypical norms, but rather, wished to blend into the two-sexed society and engage in their new sex role. Nonetheless, transgenderism tends to juxtapose the transsexual and intersexed individual by defying the participation within the two-sexed dichotomy of masculinity and femininity. Recently, there has been an increased support from transsexuals to assume and identify with their transsexual identity that is neither male nor female in the traditional sense (Fausto-Sterling, 2000).
Transgender theorist Martine Rothblatt devised a chromatic system of gender, which differentiates among hundreds of personality types. Rothblatt’s arrangement of seven suggested levels of aggression, nurturance, and eroticism, which could lead to 343 ($7 \times 7 \times 7$) shades of gender (Fausto-Sterling, 2000). For Rothblatt, “A person with a mauve gender, for example, would be ‘a low-intensity nurturing person with a fair amount of eroticism but not much aggressiveness’” (as cited in Fausto-Sterling, 2000, p. 108). Though Fausto-Sterling did not necessarily embrace Rothblatt’s nomenclature (the method could seem somewhat “silly” or overly complicated), she argued that such an elaborate system might be a better way of thinking about intersexed children (2000), and, by conjecture, the same is proposed for transgender individuals.

Nonetheless, this perspective purports that “infants enter into the world with predispositions to “masculinity” and “femininity,” and these predispositions appear to result largely from hormones to which they were exposed at birth (Hines, 2004, p.10). Therefore, when discussing the transgender man’s early predisposition, he may be commonly referred to as having a female birth sex, which was established by the medical community in utero or at birth (Israel & Tarver, 1997).

By the mid-1970’s, people acknowledged that gender inferred “roles, appearances, and characteristics that were socially defined and culturally varied” (Kessler & McKenna, 2000, ¶ 4). Kessler and McKenna contended, however, that biological characteristics, which are commonly referred to as sex and secondary sexual traits, are socially constructed as well. They recommended that the term “gender” should be exclusively used, and that the term “sex” should never be used:

If anything is primary, it is not some biological sign, but what we called “gender attribution” —the decision one makes in every concrete case that someone is
either a male or a female. Virtually, all of the time, gender attribution is made with no direct knowledge of the genitals or any other biological “sex marker.” (Kessler and McKenna, 2000, ¶ 4)

**Gender/Gender Identity**

Gender theorists have recently revisited the study of sex, gender, and sexual orientation to investigate the relationship between these discrete entities (Dozier, 2005). Dozier claimed that academic and medical specialists have viewed gender as a phenomenon that is “socially constructed,” presented in diverse cultural settings bearing significance. He argued that, consequently, far too often this construction is built upon the foundation of a person’s birth sex, an “initiating point” (p. 298). In Delphy’s view, gender is dependent on sex, “illustrating the social construction of gender by describing the cross-cultural variations in men’s and women’s behavior and social roles reinforces the notion that gender originates in sex” (as cited in Dozier, 2005, p. 298). On the other hand, Nicholson and Delphy counter-argued by challenging the assumption that gender derives from sex; they asserted, rather, that “Gender is the knowledge that establishes meanings for bodily differences” (as cited in Dozier, 2005, p. 298). Thus, gender “is the concept that creates and defines sex differences” (as cited in Dozier, 2005, p. 298).

Dozier (2005) presented West and Zimmerman’s attempt to discern the social aspects of sex by:

Adding a category to sex, gender, and sexuality framework. They defined ‘sex category’ as socially perceived sex and claimed that ‘recognition of the analytical independence of sex, sex category, and gender is essential for understanding the relationship among these elements and the interactional work involved in ‘being’ a gendered person in society.’ (Dozier, 2005, p. 299)

West and Zimmerman argue the consequence of the social construct of gender, “the performance one is accountable for based on sex categories that limit gender expression
for feminine men and masculine women” (Dozier, 2005, p. 299). Therefore, it is a social construction “rigidly defined by sex categories” and a dialectical expression of gender, which, according to Dozier, is “an inadequate framework for the explanation of atypical gender” (2005, p. 299).

Lorber also attempted to separate masculinity and femininity from sex by suggesting alternative categories (Dozier, 2005). These categories would include (a) gender status (perceived as man or woman), (b) gender identity (sense of self as man or woman), and (c) gender display (being feminine or masculine). Like West and Zimmerman, Lorber “consistently slipped into assumptions of the ‘natural’ link between categories” of masculinity and femininity (Dozier, 2005, p. 299). Lorber claims that transsexuals and transvestites do not challenge the notion of gender variance, i.e., “their goal is to be feminine women and masculine men” (Dozier, 2005, p. 299). In Dozier’s mind, Lorber’s categorical reasoning fails to explain the flexibility of “man/masculinity” and “women/femininity” as expressions of gender that are illuminated in multiple ways. For example, Dozier explained, “Not all men, constructed or biological, are masculine or wish to be” (p. 299). He also argues that Lorber’s stance suggests that “being treated as a man or woman in social interactions creates a masculine or feminine consciousness” (p. 299). Further, this does not explain how individuals tend to have an achieved gender identity that occasionally deviates from their early “socialization” (Dozier, 2005).

Though Lorber’s argument continues to reinforce the fact that sex is considered the core aspect from which gender is derived, Dozier commended Lorber’s claims, specifically that her theory “defin[es] gender as an institution that creates and reinforces inequality” by reinforcing gendered stereotypical behavior (p. 299). However, he argues that
Lorber’s perspective “illustrates how easily sex and gender (masculinity and femininity) become elided when sex is used as the initiating point for gendering individuals” (p. 299).

In a recent attempt to evaluate how people think of gender, Kessler and McKenna polled college students with a questionnaire that queried the meaning of gender. Though the students all reported that they considered themselves either male or female (i.e., one of two genders), the researchers found that there was a more complex understanding of the dichotomy. For example, they explained that gender could be mixed, that is, some “men have vaginas and women have penises”; yet, gender most often is equated with genitals (2000, ¶ 7). Nonetheless, the results of the questionnaire showed that despite the new ways in thinking about gender representations in the body, students remain compelled to “find out what the ‘person’ really is” (2000, ¶ 8). Thus, the authors concluded that despite the fact that there is more “tolerance” for gender ambiguous or conflicted presentation persons, these particular appearances continue to evoke anxiety. Also, that although gender is marginally accepted in mixed and crossed presentations, it continues to be seen as dichotomous and has not led to the “expansion of or transcendence of the gender categories” (2000, ¶ 9).

Israel and Tarver (1997) simplified the notion of gender identity:

Gender identity refers to an individual’s innate sense of maleness (masculinity) or femaleness (femininity), or both, as well as those feelings and needs that are internalized and how they are presented to others. Rather than being fixed opposites, masculinity and femininity may gradate markedly, depending on individual and social interpretation. (p. 6)

Lev (2004) summarized gender identity:

Gender is a social construct that divides people into “natural” categories of men and women that are assumed to derive from their physiological male and female bodies. Most people’s gender identity is congruent with their assigned sex, but many people experience their gender identity to be discordant with their natal sex.
Gender identity is considered a core identity. A person’s self-concept of his or her gender (regardless of their biological sex) is called his or her gender identity. (p. 81)

**Transsexual/Transgender**

The origin of the development of language of cross-gendered and gendered-variant peoples has been ascribed to Hirschfeld with the term “transvestite,” which “derived from ‘trans,’ ‘across’ and ‘vestitus’ ‘clothed’” to include anyone who “cross-dresses for social presentations” (Cromwell, 1999, p. 21). Cromwell, however, claimed that the transgender community has since rejected this term because of the pathological perversion and obsessive implications attached (1999). He concluded by saying that regardless of the negative connotation and personal perspectives; “transvestite” and “cross-dresser” mean:

Someone who wears the clothing and takes on the behaviors, socially constructed as the proper domain, of the other biological sex: males who present themselves as women (male transvestites) and females who present themselves as men (female transvestites). (1999, p. 22)

In 1870, 100 years prior to Kessler and McKenna’s research, a report of transgenderism by a physician named Westphal described a woman who had “contrary feelings” and reported her to be manlike since childhood. It was nearly 80 years later—in Cauldwell’s 1949 article entitled, “Psychopathia Transsexualis”—that this phenomenon referred to as transsexual. In his article, Cauldwell presented a case of a girl who was “obsessive” in becoming a boy (Lyons, 1986). Cromwell and several other scholars and theorists agree that the majority of the U.S. population only recognizes people who fall within a binary gender classification, male and female. Cromwell presented Bolin’s argument that some individuals find that they “identify as transvestites, transsexuals, transgenderists, or ‘something else’ entirely” (1999, p. 22).
In the early 1990’s, “another category emerged: Some individuals label themselves as ‘transgenderists.’ They neither want nor desire sex reassignment surgery, and their gender diversity is not limited to periodic episodes of cross-dressing” (Cromwell, 1999, p. 22).

The term transgender, then, has “established itself as the term of choice,” which infers a:

Wide range of phenomena that call attention to the fact that “gender,” as it is lived, embodied, experienced, performed, and encountered, is more complex and varied than can be accounted for by the currently dominant binary sex/gender ideology of Eurocentric modernity. (Stryker & Whittle, 2006, p. 3)

In 2007, Denny and Pittman wrote, “Transgender is an important term because unlike most other labels in use with gender-variant people, it originated not within the medical community, but from gender-variant people themselves” (Denny & Pittman, 2007, p. 210).

Transgenderists may go back and forth between gender roles, and often medical and mental health providers fail to acknowledge and refuse to allow transgendered persons to self-determine their identity and level of commitment to clinical interventions such as hormones and gender reassignment surgery. Cromwell referred to transgenderists as the “intermediate category” (1999). Transgenderists reject terms such as preoperative transsexual, which tends to refer to individuals who aspire to transition from one’s birth sex and change one’s bodily characteristics to the opposite sex and yet have not had genital surgery, though they anticipate doing so. In sum, transgenderists who have no intentions of having surgery do not view themselves as either transsexuals, preoperative (pre-op) transsexuals or transvestites (Cromwell, 1999).
The term transgender has emerged out of the transvestite and transsexual community by individuals who did not identify with transvestite and transsexual (Cromwell, 1999). In fact, “Transgender is viewed as a viable option between crossdresser [transvestite] and transsexual … [and] transgender is used as an encompassing term for transvestites and transsexuals as well as for those who do not fit neatly into either category” (Cromwell, 1999, p. 23).

Cromwell concluded that the transgender identity is a more self-determined and affirmative term for persons who fall within the range of polarized male and female spectrum, as well as a way to distinguish oneself separate from the biological-based definitions (Cromwell, 1999). “Many within the transgender community have adopted the terms… transsexual, transgender, transgenderists and cross-dresser intentionally to distance themselves from the medico-psychiatry and subsequent stigmatization attached to the terms transsexual, pre-operative transsexual, and transvestite” (Cromwell, 1999, p. 23).

According to Hausman, the meaning of transsexual becomes dependent on medical technologies, wherein the transsexual and practitioners co-dependently produce transsexual definitions:

By demanding technological intervention to “change sex,” transsexuals demonstrate that their relationship to technology is a dependent one. Demanding sex change is therefore part of what constructs the subject as a transsexual: it is the mechanism through which transsexuals come to identify themselves under the sign of transgenderism and construct themselves as objects. Because of this we can read transsexuals’ agency through their doctor’s discourse, as the demand for sex change was instantiated as the primary symptom (and sign) of the transsexual. (Hausman, as cited in Halberstam 1998, p. 161)

Although “Hausman rejects the notion that we can read gender as an ideology without also considering it as a product of technological relations;” Halberstam argues that

Nonetheless, transgender and gender-variant men often have been referred to, or self-identified as, transgenderists; transmen, female-to-males (FTMs or F2Ms), male-to-men (MTM) –deriving from the belief they have always been men despite their inherited biological body. Some individuals may also use terms used in the queer women’s community, such as tomboy, butch, stone butch (influenced by mainstream culture and reclaimed by Leslie Feinberg), bull dagger, he-she, and gender bender (Cromwell, 1999; Israel & Tarver, 1997; Lev, 2004).

It is important to note that a transsexual man who has successfully transitioned from his birth sex (female) to becoming an anatomically congruent male by the means of gender reassignment/gender congruence surgery may no longer identify as a transsexual. He may now identify as a man and wish to be considered as such. However, the medical community may refer to such an individual as a postoperative (post-op) male. Notably, “There is no clearcut pre- and post-op options for FTMs and transmen. Those who have surgery must have more than one operation” (Cromwell, 1999, p. 23). Cromwell pointed out the important fact that female-bodied transgender men own the right to self-determination and “identify in various degrees with masculinity and maleness with a label categorized as ‘men’” (1999, p. 25). Thus, trans is an all-inclusive term despite trans individual’s bodily expression. According to Cromwell, transidentities include:
Transgender (TG), transexual, transsexual: FTM, trans or tranny man, boy, fag, and gay (for MTFs replaced by woman, girl, dyke, and lesbian); masculine or male identified woman, lesbian, man, dyke, daddy, drag king and queen, new woman, new man, soft butch, baby butch, butch dyke, tryke, boy chick, and boy dyke; transfag, gender-bender, gender fuck, gender outlaw, and gender queer; transqueer, queer, cross-dresser, androgynous, transhuman, transfolk, transpeople, man or woman of transgendered or transsexual experience, and finally people. (p. 26)

Clearly, this is an exhaustive attempt to find words that speak to the finer intricacies in which one self-determines their gender identity in concert with societal expectation of gender conformity and compliance. Notably, these terms have interwoven concepts of sexuality, which will be addressed further on.

Kessler and McKenna (2000) argued, “In theory, transgender is a challenge to the social construction of gender.” They claimed that, although they “place themselves outside the conventional female/male dichotomy,” [they] live in a social world that recognizes only females and males” (2000, ¶ 1). According to the authors, “trans” has three different meanings:

1. Change: a transgendered person will change their physical attributes to fit an internal sense of who they are.

2. A transgendered person may choose to “move[s] across genders (or many aspects of the person’s cross-genders).” They suggest that this reference implies that there is no permanent commitment to gender, and therefore, has a “social-constructionist connotation” (2000, ¶ 2). This presentation, however, does not exceed beyond the binary representations of gender (male and female), but rather, the person is complacent: “They are really the other gender [and] they do not need to change their genitals,” hence the term transgender (Kessler-McKenna, 2000, ¶ 2). They claim that this position is
somewhat of a new stance, though it does present a heretofore “unthinkable combination of male and female” (2000, ¶ 2).

3. The third meaning indicates a state that is “beyond or through” as in “one who has gotten through gender, beyond gender.” In this circumstance, “No clear gender attribution can be made. Gender ceases to exist, both for this person and those with whom they interact” (2000, ¶ 2). They argued that this third meaning is the most challenging and the most important for gender theorists because it postulates that erasure of gender.

Hale believed that the transsexual discourse was created by medical and psychological practitioners with the goal to “diagnose, classify, regulate and produce transsexed bodies” and the “supposed truths about their lives and experiences” (as cited in Cromwell, 1999, p. 19). He suggested that the attitude takes the position that transbehaviors are pathological, which ultimately leads to the need to be “cured.” He further argued that practitioners assumptions and beliefs are reflected in the treatment, as well as the language, in referring to transpeople (e.g., “wrong body” and gender dysphoria/ic), thus resulting in stigmatizing treatment.

According to Mageo, the “strategic discourse” is when the trans community began to reclaim derogatory terms created by the medical community and reframed these disparaging words out of their personal experiences (Cromwell, 1999). Cromwell claimed that new terms such as transgender are empowering, self-defined, and nonpathological (1999). In short, the transcommunity alternative discourse is “something more and something other than the creatures our makers [i.e., therapists, endocrinologists, and surgeons] intended us to be” (Stryker, as cited in Cromwell, 1999, p. 20).
Lev (2004) made a poignant comment in noting that the transgender term is broad, and it incorporates multiple meanings and identifications, which, in fact, may not include a transsexual identification. “Many transsexuals,” she wrote, “feel their issues are different from other gender-variant people because of the expressed need to physically alter their bodies surgically and their dependence on the medical profession to assist this process” (p. 6).

The transgender term is an all-encompassing term (Lev, 2004), which is intended to include all gender-variant individuals stemming out of the transgender liberation movement. This transgender term challenges both biological and cultural limitations, capturing the “complexity of gender manifestations and identities” (2004, p. 7; also see Pfäefflin & Coleman, 1997). Thus, transgender is a term that bridges multiple identifications among and between transgender, gender-variant, transsexual men and their gender roles and sexual orientation (i.e., a transgendered man cannot be presumed to be having sexual relations with a biologically-born woman or queer woman—e.g., lesbian, butch, dyke, or bisexual female). While using the term “gender-variant” in the same way as others, Lev also sees it as referring to “those who diverge from what is most common, usual, or expected; It does not assume, however, that what is normative is necessarily healthier, more functional, or in any way more honorable” (Lev, 2004, p. 7).

Israel and Tarver (1997) described the transgender identity as an umbrella term that includes a diverse group of individuals. For example, this identity includes transgenderists, transvestites, androgynous, and intersexed individuals. The authors suggested that any individual may self-identify as having a transgender identity regardless of one’s stereotypical gender representation. Yet, they argue bringing such a
diverse group of individuals under a large umbrella is problematic as many of these individuals have very different inherent senses of gender identity, presentation, feelings, concerns and needs (1997).

Transsexualism

The third edition of the *Diagnostic and Statistical Manual of Mental Health Disorder* (DSM-III, 1980) defines transsexualism as a gender identity disorder in which the individual experiences “a persistent sense of discomfort and inappropriateness about one’s anatomic sex and a persistent wish to be rid of one’s genitals and live as a member of the opposite sex” (as cited in Cromwell, 1999, p. 20). In the fourth edition (DSM-IV, 1994), the term “transsexual” was replaced with “Gender Identity Disorder.” The diagnostic criteria, however, remained the same (Cromwell, 1999, p. 20). Cromwell claimed that although the transsexual term did not originate with Harry Benjamin, Benjamin defined “transsexuals as individuals who believe they belong to, and function as the ‘other’” sex (Cromwell, 1999, p. 20). Furthermore, “‘Transsexual’ is used in two ways: first, to describe someone who is in the process of becoming (transitioning) a man (or woman); and second, to describe someone who has completed sex reassignment surgery” (Benjamin as cited in Cromwell, 1999, p. 20). Many theorists, including Cromwell and Lynn, believe that many postoperative transsexuals no longer consider themselves to be transsexual (1999).

Within this transgender identity, transsexuals are a group of individuals who have suffered acute and often chronic stress related to their assigned gender status, which was determined by external biological genitalia at birth (Israel & Tarver, 1997). As Lev articulated, “Transsexuals feel that their issues are decidedly different from other gender-
variant [and transgendered] people because of their expressed need to physically alter their bodies surgically and their dependence on the medical professionals to assist in this process” (2004, p. 6). Transsexuals generally have a pervasive, overwhelming desire to live in the opposite role of their birth sex. Their beliefs, longing, and self-determined aspirations to change their genitalia, gender roles, and presentation have often been present since childhood and continue throughout their lifespan or until transition. A transsexual man’s goals generally include living full time in the role opposite of his birth sex as a female, exercising behavioral interventions, such as cross-dressing, and gender role reversal of stereotypical social behavior. As stated by Cromwell (1999), “The clinical perspective believes that the transsexual’s goal is to have sex reassignment surgery (SRS) and ultimately live as a heterosexual woman or man” (p. 20). Physical treatment interventions include taking hormones and body sculpting, aesthetic treatments such as mastectomy, dermatological care, and surgical treatments including Genital Reassignment Surgery (GRS). Cromwell expressed these interventions as such:

Rather than “sex reassignment,” some transpeople prefer “gender assignment,” or “sex confirmation,” or “gender” confirmation,” or genital reassignment” surgery. Others, however, like myself, do not believe they are changing or confirming genders, nor that changing or confirming sex is possible. For some transpeople, a more appropriate terminology might be “sex and/or gender [GCS] congruence surgery” (i.e., making gender congruent with sex as much as is possible given current medical technology). (1999, pp. 20-21)

There are several GCS or GRS options for Female-To-Male (FTM) transgenders that include hysterectomy, oophorectomy, salpingectomy phalloplasty, metoidioplasty, and revisions. GCS or GRS alters one’s reproductive capacity and these procedures are not reversible. According to Israel and Tarver, Genital Reassignment Surgery more accurately describes the transitional genital and reproduction change process than the
previous term Sex Reassignment Surgery, which infers that only genital change determines a person’s “sex” (1997).

Gender-Role Expressions

Lev (2004) offers a good summary of gender-role expression:

Gender role is the expression of masculinity and femininity and has often been referred to as “sex role.” Gender roles are thought to be a reflection of one’s gender identity and are socially dictated and reinforced. It is through gender roles that gender is enacted or “performed” (consciously or unconsciously) and may or may not be related to gender identity or natal sex. (p. 84)

Devor (1993) used another interesting phrase, “gender role relational style,” to emphasize a style of relating among the “strongest markers” in what others might refer to as masculinity and femininity (p. 303).

In the context of gender expression as it relates to female gender variance, Halberstam (1998) wrote that masculinity “conjures up notions of power and legitimacy and privilege.” Because of this, female-born bodies that present and participate with masculine personas threaten patriarchy. Halberstam addressed the term “tomboy” explicitly, describing it as a:

“Natural” desire for the greater freedoms and mobilities enjoyed by boys. Very often it is read as a sign of independence and self-motivation, and tomboyism may even be encouraged to the extent that it remains comfortably linked to a stable sense of a girl identity. Tomboyism is punished, however, when it appears to be the sign of extreme male identification. (p. 6)

This identity, she continued, describes an “extended childhood period of female masculinity,” and as long as this is not extended beyond a development stage or by the end of early adolescence, then female gender exploration is more or less accepted—in fact, much more than male gender exploration (pp. 5-6).
Sexuality

Dozier (2005) argued that, like sex and gender, “sexuality can also be socially constructed” (p. 299). He claimed, “Sexual behaviors and the meanings assigned to them vary across time and cultures” (p. 299). In the United States, for example, same-sex sexual behavior is assumed to infer bisexual or gay sexual orientations. However, the AIDS epidemic (Dozier, 2005) and subcultures such as “Brother’s on the Down Low” (King, 2004) would disagree with this assumption that sexual behavior equates identity. One could thus conclude that the concepts of sex, gender, and sexuality are not only concepts merely derived from participation in the larger context of society; they are “socially interpreted.” These concepts are derived from “perceived sex and behaviors and their attribution as masculine or feminine” (Dozier, 2005, p. 300). As such, “seeing sexual behavior and its meaning as highly reliant on social context helps explain the changing attractions and orientation of female-to-male transsexual and transgendered people (FTMs) as they transition” (Dozier, 2005, p. 300).

According to Israel and Tarver (1997), “The term sexual orientation refers to the gender(s) of persons to whom an individual is sexually attracted…. Persons may be the same, or the opposite or both” (p. 7). Notably, transgender persons may be attracted to other transgender or gender-variant persons, “as well as those who are asexual or not attracted to anyone” (Israel & Tarver, 1997, p. 7).

To quote Lev (2004), sexual orientation is “the self-perception of one’s sexual preference and emotional attraction” (as cited in Israel & Tarver, 1997, p. 7). One’s sexual orientation can be directed to virtually anyone, be they the same sex (homosexual), the opposite sex (heterosexual), both sexes (bisexual), or neither
(nonsexual). In short, sexuality is experienced through the person’s gender identity regardless of the person’s biology (Lev, 2004).

In one particular study conducted by Coleman, Bockting, and Gooren (1993), they found that the majority of the female-to-male participants (in a sample size of 9) seemingly were more cognizant of their gender dysphoria concerns prior to grappling with their sexual orientation. Additionally, they found that homosexual transsexuals’ attraction to men might be more common than originally thought. They claimed that despite shifts in their primary sexual choice, at times, some female-to-men even participated in penovaginal sex with their male partners. The authors argued that their sexual interactions might have been more fulfilling due to their male partner’s perception of them as being men rather than being perceived as women. These findings illuminate the complexities of sexuality.

Israel and Tarver (1997) commented that sexual orientation in not simply based on “birth sex” but rather on a person’s self-identification (p. 46). They found that an individual might self-identify as (a) a heterosexual transgender man or woman where there is an opposite-sex attraction; (b) a lesbian transgender woman or gay transgender man where there is a same-sex attraction, and (c) a bisexual transgender man or woman where there is a both-sex attraction.

Individuals who fall under this sexual orientation umbrella are pre- and postoperative transsexuals, transgenderists, and androgynes and are self-identified as a member of the opposite of their ascribed birth sex—they live in a role full or part time. However, some crossdressers, transvestites, and transgenderists, who self-identify as a member of their primary biological sex and their “opposite-gender persona,” may be
inclined to “[mix] social, fantasy, and sexual explorations” (Israel & Tarver 1997, p. 47). The sexual attitudes are driven toward the opposite-sex attraction, and they may identify as heterosexual, crossdresser man or woman. Individuals with sexual attractions to same-sex individuals identify as a gay or lesbian, crossdresser man or woman. Finally, there may be a both-sex attraction by an individual who identifies as bisexual or a crossdresser man or woman (Israel & Tarver, 1997).

Some asexual individuals have no erotic attraction whatsoever for others (Israel & Tarver, 1997). This lack of sexual interest may be longstanding, or it may be temporary while an individual explores his/her self-identification during transition (female-to-male and vice versa). Transgender attractions do not fall within the social context of sexuality in which many are familiar. These individuals commonly find their attractions toward others like themselves, which may be due in part to feelings that they could not maintain sexual relationships with other nontransgender individuals. On the other hand, other transgendered persons may have true sexual attraction and seek out emotional attachments toward transgendered individuals.

Another subgroup, pansexual attractions, includes individuals who find themselves attracted to all individuals and various sex/gender roles. Finally, some individuals may participate in sexual role-play, one who may “find meaningful sexual expression through a wide variety of role-playing activities” that might not otherwise be socially acceptable. Such role-play if conducted within safe boundaries may increase personal growth (Israel and Tarver, 1997, p. 48). Often gender outlaws who participate in such role-play are deemed pathological, unlike their heterosexual counterparts who enact sexual fantasies in a safe environment (Israel & Tarver, 1997). Importantly, transsexual
fetishists should not be confused with the aforementioned groups, as transsexual fetishists crossdress for pure sexual arousal. This group is not a focus of this dissertation as the particulars of sexual role-play are beyond the scope of this work.

Rothblatt (1995) wrote that since sex is “ultimately in the mind and that our minds are infinitely unique,” we need classifications beyond gay, heterosexual, and bisexual for “the new millennia society” (p. 140). She advocates for a universal sexual orientation. She argues that people fall in love, become sexually excited by the person, and become attached to because of their emotional feelings and not their genitalia. While the term bisexual suggests that there are simply two sexes, universal sexual orientation acknowledges the intricate subtleties of our sexual/gender identity, gender roles, and our sexual attractions. Finally, Rothblatt suggested that sex roles should not be based solely on one’s genitalia; rather, sex roles, gender expression, and sexual relations should be more “fluid,” in which case the “apartheid of sex” would end (Rothblatt, 2005, p. 140).

Cromwell (1995) expressed that “As with bodies, sexes, and genders, sexuality has been framed within essentialist and constructionist theories” (p. 36). He argued that an essentialist model views sexuality as “fixed essence” of whom one is. In this view, sexuality is biologically determined, and sexuality can be identified and categorized according to sexual acts, practices, and gendered role participation (e.g., scripts). Gender, then, becomes “conflated” with sex, “sex causes gender … and, gender causes sex” (p. 37). Consequently, the essentialist model assumes that what is true for one culture rings true for another (Cromwell, 1995).

On the other hand, he credited the constructionist view of sexuality as “inventions of societies” that have given sexuality meaning. Therefore, one’s sexuality is based
merely on history and social conventions; heterosexuality is perceived as “privileged” due to biological ideology, thereby becoming dominant in society. In his research, he quoted Vance, with whom he agrees:

A social construction approach to sexuality would examine the range of behavior, ideology, and subjective meaning among and within human groups, and would view the body, its functions, and sensations as potentials (and limits) which are incorporated and mediated by culture. (Vance, as cited in Cromwell, 1999, p. 37)

Cromwell concluded that “regardless of the model or the system of knowledge from which it is derived, sexuality is the result of relations among or between individuals and is created by them” (p. 37). As such, those who find themselves on the periphery of culture (that is to say, gays, lesbians, and transpeople) may feel less constrained by such cultural limitations vis-à-vis their identities, regardless of being marginalized. Groups such as these often invite new ways of thinking and organizing behavior while resisting the “dominant order” (Cromwell, 1995).

Holly Devor’s Study

In her study of 45 self-identified FTM transsexual men, Devor (1993) studied the patterns of sexual attractions, sexual practices, and sexual orientation identities. Her subjects were at different stages of their transition and reportedly having sexual experiences before and after living consistently as men after transitioning as a female-to-male transsexual. She wrote:

It should come as no surprise that people who suffer through a profound search for identity, especially when that identity is entirely entangled in the contours of their sexual body parts, would feel intensely motivated to explore whatever sexual options they perceive open to them. (p. 308)

In this study, all but one participant had reported that he been attracted to women before his transition, and overall female-to-male transsexual sexual attractions reinforced their
identities as men by means of disidentifying with their previous lesbian identity. In addition, these attractions it substantiated their role as heterosexual men. Notably, 10 of the Devor’s subjects had failed to engage sexually posttransition as men with women due to the fact they had been consumed with their transitioning process and were likely fearful of rejection. Devor additionally found that sexual partner relationships seemed to improve the psychological adjustment for transsexual men, especially when their partners were knowingly involved in the earlier part of their relationship and transitioning process.

In general, Devor found three different attitudes about sexual relationships: The first group included individuals who began their transition with their partners; the second group encompassed individuals who were hesitant to engage in sexual relationships due to fear, and the third group expressed the wish to wait until they completed their transition. Of note, then, the first group received the emotional support from the partnership, whereas the second group seemed to be preoccupied with “unrealistic expectations,” and the final group viewed their condition as something the medical community could “cure” (p. 309). Yet, participants from all three groups seemed anxious about their sexuality. (From this study, six participants had not begun hormone therapy, 34 individuals had undertaken bilateral mastectomies, 21 persons had some form of hysterectomies, and four individuals had undergone phalplastic surgeries, and another two participants had metoidioplasties.)

Notably, prior to transition, although these men were primarily attracted to women, half of them also reported being attracted to heterosexual men. Devor understood their attractions to be rooted in the wish to gain social acceptance. When asked, participants claimed their homosexual attractions were driven by sexual explorations as
well as by seeking male confidants and male role mentorship. Eight participants who acted on their sexual curiosity with heterosexual men maintained stable relationships with these men. Overall, the majority of FTM transsexual satisfactions with male companionship were attributed to male role model mentorship.

Devor reported that 1 of 4 individuals who found gay men to be attractive before their transition remained sexually attracted to homosexuals after the transition. Surprisingly, there was a 275% increase in the participants’ homosexual attraction to men subsequent to their transition and in those who appeared to be further along in their transition process. Devor described this complex situation of identity as follows:

They spend much of their lives searching for their own identities as men and the remainder of their lives learning to live effectively as men. During the first part of the process they may find men attractive in myriad ways, including sexually, but for FTM transsexuals, the experience of sexual relations with men, while living as women can be profoundly disconfirming of their fledging identities as men. After FTM transsexuals have securely passed over the invisible fuzzy line that divides men from women, they are less vulnerable to being cast as women. (p. 311)

Overtime, however, as individuals became more confident and secure in living their lives as men (which seemingly boosted their confidence that others believed them to be men) could they begin to explore their sexuality, especially their erotic attraction toward men. However, risk factors (fears of contracting AIDS), inadequacy issues (man without a functioning penis), and commitments to female partners may have impacted this attraction, either suppressing or inhibiting some participants’ enactment on their homosexual desires.

According to Devor’s study, only a small number of participants engaged with other transgender FTM individuals. One participant claimed never to have engaged in sexual activity. This finding was similarly duplicated in her accounts of Blanchard’s
findings wherein these asexual individuals tended to have an “aversion to female homosexual practices and inability to perform sexually as men” (as cited in Devor, 1993, p. 312).

Devor noted that the sexual orientation identities of female-to-male transsexuals tended to shift in a process occurring over the course of their lifespan—particularly surrounding the transition (that is, prior to, during the interim, and posttransition). Few participants viewed themselves as straight men, and previously identified lesbians no longer viewed themselves as lesbians despite sexual partnerships with women who were lesbian identified before their partner’s transition. This stance reflects the importance of the physical self as it changes as well as changing self-perceptions in relation with their romantic partnerships. Some participants claimed that their relationships with women were heterosexual despite the limitations to physical change.

One participant eloquently remarked on the different sexual relationships between homosexual/lesbian and heterosexual women:

It also depends on whether you make love with a lesbian or a heterosexual woman. There is a different approach from a woman to her man than the approach from one woman to another woman who are lovers. It’s just that it comes out in power differences. The areas of openness are different ones. …The areas of allegiance are different ones. …A heterosexual relationship can never match a homosexual relationship because there is so much … depth understanding of the psyche and of the heart and of the sexuality. In a heterosexual relationship, you have … unknown factors that kind of demand a stretch, a greater give. (p. 312)

Only one participant changed his identity to a heterosexual male following his transition. Most participants tended to use the “sick role” to explain their sexuality, which is explained thus:

(a) Sick persons are not considered to be responsible for their conditions; (b) while persons are sick they may be exempt from performing the roles that would normally be expected of them; (c) it is agreed that it is undesirable to be
sick; (d) it is assumed that being sick is a temporary condition which sick persons are expected to seek help to eliminate as quickly as possible. (p. 313)

Both FTM transsexuals and their partners made explanations according to Devor’s sick role theory, and they argued that they participated in heterosexual relationships rather than engaging in a homosexual orientation. Conversely, transsexual individuals who became sexually involved with men infrequently identified as women, and those who did were in committed relationships that superseded their transition. For some, they found it difficult to leave their gay and lesbian-feminist communities.

In general, Devor found that participants were resistant to using their physical selves in establishing a sexual identity despite the fact that these attributes were coexisting factors that initiated their sexual fantasies and practices with their partners. She contended that, although gender is socially constructed, individuals become sexually involved when they enter the realm of sex (physical attributes), which is undoubtedly influenced by their partner’s identities, thus influencing their sexual orientation and identity. She concluded that sexual orientation identities are likely to become convoluted because of their pre-, interim and posttransition process, as well as their engagement in sexual and long-term partnerships.

Identities and Their Conflicts

An individual’s identity is presumed to mean one’s self-concept—a subjective sense of self that often includes one’s self-image, role, and participation within a collective community or group. With regard to transsexuality identification, Halberstam (1998) wrote:

Medical descriptions of transsexuality throughout the last forty years have been preoccupied with a discourse of “the wrong body” that describes transsexual
embodiment in terms of an error of nature whereby gender identity and biological sex are not only discontinuous but catastrophically at odds. (p. 143)

She continued by asserting that although the new era of technological advances has alleviated psychological discomfort for some, these also benefit the medical and psychological communities. However, Halberstam also contends that secondary gains for the medical community (i.e., profits and fees for services) help promote the binary gendered system. However, these advancements also increase the visibility of female-to-male and gender-variant individuals, and undoubtedly, threaten “natural” masculine bodies that inherit privilege and yield power. Consequently, the transitioning FTMs and gender-variant men have a social and political impact (Halberstam, 1998). Transsexual men, then, often entertain intense desires for “reemodiement” wherein masculine gender play becomes a form of gender deviance, while butch women tend to become “associated with a playful desire for masculinity and a casual form of gender deviance” (Halberstam, 1998, p. 143).

It is not so easy to understand the differences among butches and transgender men outside of surgical (e.g., physical) contexts (Cromwell, 1999). In fact, many people assume—often falsely—that all FTM’s are lesbians (Jamison Green, a leader in the transgender community, as cited in Cromwell, 1999). Many transgender men have lived as, or “attempted” to live as, lesbians, and, in general, the lesbian community has been more accepting of female masculine gender expression and behaviors more than the heterosexual community (Cromwell, 1999).

Undoubtedly many butch lesbians have more masculine gender identities, though they do not identify as men. Butch women often combine expressions of masculinity and femininity (Cromwell, 1999). So-called “scientific” studies have attempted to compare
lesbians and FTMs/transmen. For example, a number of researchers have generally found that there are both similarities and differences between FTM’s transmen and lesbians. Lesbians and FTMs tend to defy gendered stereotypes (presentations and behaviors), yet lesbians do not identify as men as FTMs typically do (Cromwell, Blanchard, & Freund (1983); Ehrhardt, Grisanti, & McCauley, 1979; Lee, 2001, Lyons, 1986; McCauley & Ehrhardt (1978). Interestingly, lesbians and FTMs often find these similarities “disturbing” (Cromwell, 1999). Yet, both Halberstam (1998) and Hale (1998) have acknowledged the discord between butch lesbians and FTM transmen in what they refer to as “border wars” (Cromwell, 1999, p. 28).

In a study conducted by Ehrhardt, Grisanti, and McCauley (1979), they evaluated tomboys, transsexuals, and lesbians. They found that in American culture, tomboyism is not considered pathological and it generally occurs in girls who do not have conflicts regarding their gender identity. In this particular study, they found that transsexual- and lesbian-identified participants share similar experiences of tomboyism. However, there are clinically significant differences between transsexuals and lesbians. Transsexuals, in contrast to lesbians, have preferences for boy clothes and distressed responses to their development of secondary-sex characteristics. Transsexuals were strongly dissatisfied about being a girl as a child. However, in general transsexuals and lesbians seemingly had conflicts that coincided with internal, developmental, and external factors.

Lee (2001) evaluated the differences found in the personal accounts of lesbians and FTMs with regard to their body, gender, and sexuality. She found that there were more similarities than differences between these two groups. Both groups felt they did not fall within conventional expectations of being a girl during childhood and
adolescence, “girlhood,” and “womanhood” (p. 356). In fact, the participants’ reflections of their identifications as lesbian or FTM, as well as their sexual identities, remained unchanged. Yet, the participants were not cognizant of the similarities and fluidity between them. For example, she remarked that although none of the lesbian participants identified as “butch,” they could have been included under Rubin’s 1992 definition of “Butch” (as cited by Lee, 2001): that is, individuals who incorporate a “range of masculine traits” (Lee, 2001, p. 348). The author suggested that these similar experiences might best be represented in a continuum of sorts that can be categorized by a “queer” view in that the categorical boundaries between “butch lesbians” and “FTMs” are “blurred, permeable, and fluid” (p. 356) despite the fact that participants would not openly declare their identifications and circumstances in this way.

In this view, according to Lee (2001), which complements Devor’s arguments made in 1997, although FTM’s may perceive themselves as “misfits in a lesbian category/context,” nonconforming lesbians also represent a “variety of lifestyles and subcultures, including social circles of lesbian feminists, non-feminist lesbians, drag-kings, and S/M leather dykes” (p. 352).

In conclusion, Lee argued that discrete groups may be viewed as a “product, not of experience, but of narrative construction.” She continued:

Each participant’s account of their life experience and their understanding of their gender and sexual identity formation relied upon the continuous reinscription of categorical boundaries. The juxtaposition of the lesbian and FTM accounts reveals, therefore, not only clear similarity of experience but an indication of these processes involved in this narrative construction of categorical boundaries. (p. 356)

By categorizing personal circumstances and masculine expressions of these experiences within various contexts, both groups of individuals tend to feel marginalized within the
subculture of their gay community, which reflects some of the tensions that lie near “border wars.” Lee found in her accounts that “specificity’ of identity was achieved in relation to an ‘other’ who was seen as unproblematic against their own complex selfhood and identity” (Lee, 2001, p. 356). She quotes Gayatri Chakravorty Spivak (1990): “The person who knows has all the problems of self-hood. The person who is known somehow seems not to have a problematic self…the self of the other is authentic without a problem” (p. 356).

Cromwell contended that these tensions arise out of the misunderstanding of one another’s circumstantial perspectives. He concluded that for “some FTM/transmen’s perspectives, butches are transsexuals in denial; from some butches perspectives, FTM/transmen are misguided lesbians. It is not always possible to make clear distinctions” (1999, p. 28).

Yet, Rubin (as cited in Halberstam, 1998), gave the example of butch women, whom she contended respond differently to their female bodies. So, all the variations in the standard classifications—e.g., class, race, ethnicity, religion, occupation, age, subcultures, and personality—render it impossible to create a system of categorization to these somewhat marginal identifications (p. 172).

In an attempt to reach a layman audience, PFLAG (Parents, Families and Friends of Lesbians and Gays) simplified the definition of gender identity by stating that a person’s gender identity is an internal sense of being masculine or feminine, wherein an individual often demonstrates their identity through appearance and behaviors. Sexual orientation, then, is someone’s sexual attraction, impulses, and behaviors expressed for the same, opposite, or both sex(es). Gender identity and sexual orientation issues often
become blurred because gay, lesbian, and bisexual people exhibit similar forms of gender expression. For example, some lesbian or queer-identified women wear androgynous or men’s clothing and are referred to as “butch.” Though these women may identify with these masculine feelings and traits, they do not feel or believe themselves to be male (Halberstam, 1998). Halberstam (1998) suggested that these subtle differences may be more closely associated with identifications and disidentifications than with notions of masculinity.

The terms FTM and transmen can lead one to grapple with complexities of coherently understanding each position. “‘FTM’ is used in at least two ways: female-to-male and female-toward-male (as in having surgery) or female-toward-man/masculine (as in gender or gender identity)” (Cromwell, 1999, p. 28). In the first group, FTMs obtain medical interventions, which allow them to “disappear into society as men.” By claiming they are participating in a process whereby once surgical interventions have been implemented, “their identities shift from FTM to that of males/men” (p. 28). “Hardcore” FTMs—called “stealth” or “woodworkers” by others—include folks who obtain more surgical and hormonal interventions. “They tend to obtain the information or resources they need and then disappear again into the woodwork” (Bowen, as cited in Cromwell, 1999, p. 28). In the second group, of FTMs continue to identify as such because they “acknowledge their female socialization and history” (Cromwell, 1999, p. 28). They may or may not utilize various hormonal and surgical procedures and do not think of themselves as men; some may identify as female men; others may choose the term “transman” to distance themselves from their female born and transsexual status.
Notably, both groups may live part time or full time as transmen or FTM.

**Transmen/Transpeople**

“Transman” is the term for one who is born female and yet identifies somewhere on the “so-called continuum between male/female and man/woman” (Cromwell, 1999, p. 28). He/she may or may not implement hormonal or other surgical procedures to alter his/her body, and he/she lives either part- or full time as men. Therefore, transmen and FTMs are interchangeable; there is a sense of awareness and acceptance of being born and socialized to some extent as female (Cromwell, 1999).

With regard to sex reassignment surgeries, Cromwell wrote:

> Sex reassignment surgeries (in particular, genital surgeries) are inadequate no matter what techniques are used. Depending upon the technique and the surgeon’s skill there is at least one or more physical reminder of once being female in body: scars, and inability to have spontaneous erections, and (for most) a lack of sensation in the penile shaft, the insertions of a prosthetic device for intercourse, and inability to urinate [or ejaculate] through the penis. (1999, p. 29)

Some FTMs who opt for surgical procedures may deny ever having been born female. (This will be discussed further in Training Module 5: “Clinical Implications and Interventions.”) Also noteworthy is the fact that some FTMs may never identify themselves as transsexuals, and as such, they may never contact a support group, seek psychotherapy, or have sex reassignment surgeries, choosing to live simply as men (Cromwell, 1999).

Cromwell contended that the term “transpeople” is more appropriate (1999) than transsexual because, he maintained, this term distances itself from transsexual, which historically implies a female identity (1999). He recommended that when there is a need to distinguish between female-to-male and male-to-female, the terms “female-bodied”
“male-bodied” be used (p. 29). Female-bodied derives from the transcommunity, which:

Recognizes that the individual was assigned as female or had a female body. Biologically, the individuals’ genitalia, chromosomes, and phenotype (although that varies from person to person) are those of a female. Many have medical interventions that reconstruct their bodies to be more congruent with their identities, yet they never, contrary to what some may believe, have male bodies in the same sense that those born male, phenotypically and genotypically, do. Instead they have transbodies or transexed bodies, which is not to insinuate that they are imprisoned by or limited by phenotype or genotype. (Cromwell, 1999, pp. 29-30)

To be designated a man, then, recognizes that the person is living as a man (Cromwell, 1999). Female-bodied transpeople acknowledge their true biological composition, though they “may not identify as a female transvestite or a female-to-male transsexual” (p. 30). Cromwell recommended that a distinction should not be made between female-bodied transpeople and male-bodied transpeople. In so doing, we are able to “move away from generalizations and toward specificity and the equal marking of females and males” (Cromwell, 1999, p. 30).

Stryker and Whittle wrote in their *Transgender Studies Reader* (2006):

The taxonomy of sex and gender seemingly become disordered; sex and gender themselves no longer appear as stable external categories but rather appear embedded in the individuals who experience them. (xii)

In general, an individual’s identity refers to one’s self-concept and comprehension of sense of self, an image or ideal, including attitudes and behaviors associated with their identity, which is entirely a subjective sense of oneself (Wikipedia, 2008; Cromwell, 1999). Confusion, misunderstanding, and conflict tend to arise out of disagreements between that of the subjective experience and the external, perhaps, projected point of view from the other; though, as Cromwell (1999) implied, gender, gender identity, and
sexuality are not all encompassing of a transgender FTM’s identity (which will be discussed in Training Module 5, “Cultural Considerations”).

Halberstam (1998) argued that as transsexuals and transgendered individuals become more visible in the community, conscious awareness of gender identities expressed through various mediums becomes inevitable. She recommended a discourse between scholars and feminists to explore the variability of queer butch and transgender identities, despite the fact that some lesbians have disdain toward individuals whom they believe are acquiring male privilege. Halberstam described the “transgender butch” as “the transition that the identity requires from female identity to masculine embodiment” (p. 146). She expressed perplexity that while feminists and scholars now believe that gender is a social construct, why transsexuality, then, continues to be a widespread phenomenon (p. 146). Though admitting to having been misunderstood by many, she envisioned creating a “theoretical and cultural space for the transgender butch that did not presume transsexuality as its epistemological frame” and challenged the transgender butch to be capable of emerging into an identity that is “non-operated” yet a “transgendered person” (p. 146). She advocated opening up the possibilities for less “rigid” gender identity and sexuality categories by moving toward “fluidity and flexibility” (p. 147):

Sexual and gender identities involve to some degree movement (not free-flowing but very scripted) between bodies, desires, transgressions, and conformities; we do not necessarily shuttle back and forth between sexual roles and practices at will, but we do tend to adjust, accommodate, change, reverse, slide, and move in general between moods and modes of desire. (Halberstam, 1998, p. 147)

Halberstam attributed the tension between scholars as having greatly different viewpoints when discussing theory. Prosser saw this as queer theory, which focuses on
the performative, a “fixation on the body,” versus transgender theory, which focuses on the narrative, subjective experience, thus discriminating the meaning between female masculinity and transgender and transsexual populations. According to Halberstam, queer theories are constructivists and transgender theories are essentialists; Prosser suggested that transgender theory should be separate from queer theory (Prosser as cited in Halberstam, 1998).

Halberstam uses Leslie Feinberg’s novel, Stone Butch Blues, as an example of both essential and constructed points of view—“both performative and genetic embodiment” (p. 148)—as the main character decides not to transition from female to male. Jess’s character, then, speaks to the “insufficiency of binary gender rather than the solidity of transsexual identification” (p. 148). Halberstam has been criticized by some transgender scholars for narrowing the divide between transgender and female masculinity; however, she chose to use terms such as “transgender butch” to illustrate:

There are a variety of gender-deviant bodies under the sign of nonnormative masculinities and femininities, and the task at hand is not to decide which represents the place of most resistance but to begin to work on documenting their distinctive features. (p. 148)

Jordy Jones, a FTM performance artist, suggested that Halberstam is, in fact, beginning to describe the relation between concepts and bodies. In the FTM Newsletter, he wrote:

Not everyone who experiences gender dysphoria experiences it in the same way, and not everyone deals with it in the same way. Not all transgendered individuals take hormones, and not everyone who takes hormones is transgendered. I have a (genetically female) friend who identifies as male and passes perfectly. He’s never had a shot. I certainly know dykes who are butcher than I could ever be, but who wouldn’t consider identifying as anything other than a woman. (as cited in Halberstam, 1998, p. 149)

In this article, Jones clarified the complexity of self-identifications, which limits the “monolithic model of transsexuality” (Halberstam, 1998, p. 149). He evoked the idea
of a spectrum or continuum in his conclusion that there are various degrees of movement between bodies, desires, transgressions, and these cross-identifications dupe the binary model of gender. Halberstam then presented an alternative interpretative model that diffuses the “fundamental antagonism between lesbian and FTM subjectivities” (p. 149). She argued that distinctions between some “transsexual identities may become quite blurry”; therefore, clearly, there can no longer be “hard and fast distinctions between lesbians and transsexuals” (p. 149). Halberstam suggested that the current tension between lesbians and FTMs is generally mitigated in the following model, which is used to express a masculinity continuum among female bodies:

Not Masculine———————————————————Very Masculine.
(p. 149)

A model such as this, according to Halberstam, has “no interpretative power when thinking about transgender variety” (1998, p. 151).

Halberstam suggested that since this model has no interpretative value, she encouraged readers to keep Jones’ earlier statement in mind: “Not everyone who experiences gender dysphoria deals with it the same way, gender dysphoria [then] can be read all along the continuum” (p. 151). Halberstam concluded by stating, “The greater the gender dysphoria, the likelier a transsexual identification” (p. 151).

At the transgender end of the spectrum, the continuum model miscalculates the relation between bodily alterations and degree of masculinity; at the butch end, the continuum model makes it seem as if butchness is sometimes just an earl stage of transsexual aspiration. (p. 151)

She suggests that a model such as this, “miscalculates the relation between bodily alteration and degree of masculinity” (p. 151). For example, a butch presentation is not simply the preliminary state of the “transsexual aspiration” (p.151) and so on.
Using Stone Butch as an Example

According to Halberstam, the “stone butch occupies a ‘gray area’ between lesbian and FTM” (1998, p. 152). With regard to the Stone Butch’s description (which lies somewhere in the middle of the spectrum suggested above), Halberstam wrote that it is:

A last-ditch effort to maintain masculinity with female embodiment: the expectation, of course, is that such an effort will fail and the stone butch will become fully functional once she takes steps toward transitioning to be at transsexual man. (pp. 151-152)

Halberstam discussed Heather Findlay’s essay, “Stone Butch Now,” where she queried stone butches about their gender and sexual identifications. According to one interviewee, a stone butch tends to find humor in his/her gender discomfort, whereas a FTM “finds his discomfort to be source of great pain” (p. 152). In other words, a stone butch is able to “manage her gender dysphoria” though a FTM is unable to (as cited in Halberstam, 1998, p. 152). Halberstam argued that polar views such as these “come at the expense of a complex butch subjectivity” and tends to categorize in “relation to a set of experiences” (p. 152). Findlay’s essay also contended that “being stone may mean moving in and out of gender comfort and may mean a very unstable sense of identification with lesbianism and femaleness” (as cited in Halberstam, 1998, p. 152). It is important to note, according to Halberstam, that diverging categories of butchness do not equate or precipitate a transgendered or transsexual identity.

Other categories, such as a dyke masculinity (butch identity), do not preclude or necessitate the transsexual and transgender identity; rather, they present, again, a range of masculine identities within a female body. These divisions become even more blurred when individuals choose to implement interventions to alter secondary sex
characteristics, such as testosterone; this does not then mean one identifies as transgendered (Halberstam, 1998).

There are, in fact, significant differences between biologically born females who identify as transsexuals and those who are comfortable with their female masculinity. Though these may not always be obvious, there are many butches or masculine women who pass as men and transsexual men whose gender is ambiguous, and finally, many bodies simply do not meet the linguistic qualifications of transsexual (p. 153).

Crawley (2002) argued that “‘stone butch’ and ‘transgender’ are distinct labels that one could wear, the practitioners of these categories are quite similar in the gender expressions and in their ambivalence towards their female bodies” (p. 12). After partaking in online discussions between the two groups, she concluded:

Stone butch identifications prioritize a lesbian, specifically butch and fem, audience in developing self, whereas transgender identifications prioritize a heterosexual audience, specifically people invested in the dominant paradigm of a rigid gender system (as a critique to that paradigm). (p. 12)

Though Crawley’s viewpoint is similar to West and Zimmerman, unlike most scholars and theorists, they fail to remark on the significance of the dyadic relationship between the self and other.

Halberstam argued that transsexual models:

Assign gender deviance only to transsexual bodies and gender normativity to all other bodies, and on the other hand the hetero-normative models that see transsexuality as the solution to gender deviance and homosexuality as a pathological perversion. (pp. 153-154)

It is not uncommon for tensions to reside between lesbians and FTMs and lesbians and butches (p. 153). Halberstam wrote: “The distinction that butches have made throughout the last twenty years between lesbianism and female masculinity hinges on a
mounting perception of distinct differences between gender and sexual identities” (p. 153).

Lesbianism, according to Halberstam, refers simply to “woman-loving woman”; butch, on the other hand, is a more complex form of “femaleness,” which may be “woman-loving woman” or “butch-loving butch” (1998, p. 153).

*Differences in Semantics: An Orientation toward Clear Communication*

In the sections that follow, the words transgender female-to-male (FTM) and gender-variant men are used, and they define (a) a female born, transgender man (female-to-male, FTM), (b) one who has psychologically internalized a masculine sense of self (psyche/mind), and (c) the wish to be perceived as having more masculine features/presentation (body). And, finally, these terms refer to one who engages in enactments of more stereotypical masculine gender/sex roles (behaviors) despite the limitations placed upon our ubiquitous nature as categorized gendered beings.

The training modules that follow continue to contemplate psychoanalytic thought and practice of assisting the transgendered or gender-variant female-to-male individual by addressing the question, “how can the clinician help a patient find comfort in their gender identity, gender role participation, and sexuality (drive toward primary object choice) so that it merely reflects bodily and psychic comfort, a cohesive self in a world that is blind to the kaleidoscope of possibilities?”
Training Module II

Historical Overview

The following module will be a brief introduction to a historical overview of gender-variant, female bodied, and transgender men and transgender studies. A thorough and well-documented history is beyond the scope of this project, and moreover, such history fails to accurately represent the legacy of the transgender community within this categorical domain and across divergent cultural experiences. To adequately attend to the needs of FTM individuals who may come for treatment, it is important to understand the historical backdrop in which the transgender female-to-male community has both endured and achieved notability in the face of significant prejudices.

In the section that follows, a history of transgender people within the dominant culture, important people and events, and the development of transgender studies will be discussed. Historical accounts of transgendered and gender-variant persons are limited. This limitation has significantly hindered transpersons’ quality of life. With the increased visibility of transgendered individuals, recognition of their history is crucial. In this way, an informed practitioner can assist in enhancing the transgendered person’s quality of life.

Historical Events

The Civil Rights Movement in the 1960s sparked a number of other movements of heretofore inadequately or mis-represented groups. The Feminist Movement and feminist studies in the mid 1970’s brought to our attention women’s lives that were often silenced, considered to be insignificant, or distorted throughout the documentation and
writings of men, be they Western explorers, military men, missionaries, special interest groups, scholars, or mental health professionals. Contemporary scholars and academicians have thus been driven to reevaluate history and provide new historical perspectives. Following the Women’s Movement, lesbian and gay men and women took it upon themselves to rewrite their history as well. Similarly, transgender people have been inspired to capture their subjective experience within the greater culture and offer a new discourse with regard to their unique heritage and history. A new historical narrative can serve the function of helping establish a sense of belonging, and fostering empowerment.

In what can now be coined the transgender phenomenon, homosexual and gender-variant behavior has certainly influenced the study of “sexology, psychiatry, endocrinology, and other medical-scientific fields,” as well as anthropology, sociology, and psychology since the nineteenth century (Stryker & Whittle, 2006, p. 13). These disciplines often have sought to understand “Western constructs of sexuality and gender, in a manner that recapitulates the power structures of colonialism” (p. 14). Historically, research and study, in part, sought to capture pathology and need for treatment in order to prevent a discourse that would threaten patriarchal institutions, such as marriage and family. “Female gender diversity as a phenomenon occurs cross-culturally and historically, yet has been rendered largely invisible in anthropological and historical literature” (Cromwell, 1999, p. 45).

There are a few historical occurrences worth noting here. During the Civil War, while Dr. Mary Walker was serving in the United States Army, she asserted the right to wear trousers by bringing her case before the U.S. Congress. She then continued to
advocate for women’s rights. Reportedly, she continued to wear male uniforms and assume the male role (Bullough, 1975, p. 564). Rudacille (2005) found evidence that many female-born women lived their lives as men. These included “James Barry, British army physician and Inspector-General, 1965; Charles Durkee Pankhurst, California stagecoach driver, died 1879; Murray Hall, Tammany Hall politician, died 1901; Jack Bee Garland, soldier in the Spanish-American War, died 1936; and Billy Tipton, jazz trumpeter, died 1989,” to name just a few (p. 4). Most often—and to the public’s astonishment—the true birth sex status of these men were not discovered until their death, wherein wives and friends adamantly denied knowing the true sex of their partners. Notably, transsexuals, gender-variant and transgender female-to-males have been documented throughout history, though modern-day descriptors were unlikely to be used in historical texts. It is important to note that there are several female-born gender-variant men who have been reported to fall within this historical domain (that is, female born living their lives in the role of a male).

Individuals interested in transgender and transsexual studies tend to understand transgender phenomena by referring to similarities between cross-gendered and gender role participants in Native American, Asian, and African cultures (where they were described in a number of ways: e.g., two-spirits, beardaches, hirjas, and female husbands). However, caution must be taken as it can be detrimental to various cultural groups to perceive and conclude associations through socially constructed lenses from outside specific groups. Therefore, a more thorough study is encouraged to better understand Native American people’s cultural traditions rather than assuming they are
similar to Western social and political constructs, despite the fact that gender-variant participants have presented and defied socially ascribed roles throughout time.

*Current History*

Queer studies arose out of the AIDS crisis in the late 1980’s and early 1990’s, which served as a catalyst for new thinking about the relationship between sexuality and identity within the public domain (Stryker & Whittle, 2006). Queer politics was based on the “oppositions to ‘heteronormative’ social oppression,” rather than keeping individuals marginalized (Stryker & Whittle, 2006, p. 7). “The queer movement allowed transgender people to make compelling claims that they, too, had political grievance against an oppressive heteronormative regime” (p. 7). Stryker and Whittle cautioned, however:

Like recent feminism and feminist scholarship, queer politics and queer studies also remain invested, to a significant extent, in an underlying conceptual framework that is problematized by transgender phenomena. “Sexual object choice,” the very concept used to distinguish “hetero” from “homo” sexuality, loses coherence to the precise extent that the “sex” of the “object” is called into question, particularly in relation to the object’s “gender.” (p. 7)

Poignantly, they have suggested that queer studies hold that same-sex object choice is the only way to differ from heterosexual social norms. Consequently, unknowingly, they promoted heterosexist ideals (Stryker & Whittle, 2006). The authors claimed:

Transgender studies is in many ways more attuned to questions of embodiment and identity than to those of desire and sexuality, and is akin to other efforts to insist upon the salience of cross-cutting issues such as race, class, age, disability, and nationality within identity-based movements and communities. (p. 7)

They proposed that the transgender phenomenon should invoke queer studies to reconsider how “bodies, subjective identities and sexual desires are entwined” (Stryker & Whittle, 2006, p. 8).
Historically, researchers, theorists, and scholars have often presumed what is found to be true for the homosexual male population is the same as for the female homosexual population in terms of research results and exploratory theories. These studies need to be conceptually replicated for the homosexual female populations as well. Similarly, Cromwell claimed that transgender male-to-female studies and literature tend to attribute similar theoretical themes toward female-to-male populations (1999). He suggested that this is because studies tend to merge the concepts of sex and gender by both outside observers and persons who are within the homosexual community (Cromwell, 1999).

Cromwell supported Devor’s point of view that, “by definition, a transsexual is a person whose physical sex is unambiguous, and whose gender identity is unambiguous, but whose sex and gender do not concur” (1999, p. 45). He also argued that gender markers, such as pronouns, often are not articulated; subsequently, content is lost in context: “As researchers once assumed that lesbianism was ‘the mirror-image of male homosexuality,’ … many now assume that female transgenderism is the mirror image of male transgenderism. … It is time to break the mirror” (Blackwood as cited in Cromwell, 1999, p. 45).

The initial feminist perspective, as expressed by Janice Raymond, was that “transsexuality [is] a form of false consciousness” (as cited in Stryker & Whittle, 2006, p. 4). Raymond argued that transsexuals “failed to properly analyze the social sources of gender oppression” and fight for gender equality (as cited in Stryker & Whittle, 2006, p. 4). She believed that transsexuals internalized feminine and masculine stereotypes that harmed their bodies in order to subscribe to a gender that “misrepresented their ‘true
selves’ to others,” which were considered to be pathological disturbances (as cited in Stryker & Whittle, 2006, p. 4).

Sandy Stone’s 1991 publication of “Posttranssexual Manifesto” urged transsexuals to discontinue the practice of passing as nontranssexuals (Stryker & Whittles, 2006). Stone insisted that transsexuals resist “gender oppression” which maintains restricted and narrow views and relies too much on binary realities. She urged transsexuals to “come out” – as lesbian and gay men had done. Her stance was cornerstone to the transgender liberation movement and rebellion against earlier feminists’ claims that transsexuality was a “false consciousness,” a theory promoted by feminist Janice Raymond (as cited in Stryker & Whittle, 2006, p. 4). Shortly thereafter, Leslie Feinberg distributed a pamphlet entitled “Transgender Liberation: A Movement Whose Time has Come,” which seemingly fostered Stone’s literal critiques of feminist theory (Stryker & Whittles, 2006, p. 4).

Halberstam (1998) pointed out that while early feminists, such as Janice Raymond, viewed female-to-male transsexuals as “phallocratic agents who were trying to infiltrate women-only spaces,” some lesbians, in fact, continue to see the trans community as “traitors” (p. 149). Halberstam also claimed that lesbians have misrepresented transgender and transsexual men in history, giving the example of the legendary Billie Tipton, a famous jazz musician who was married to a woman and lived half of his life as a man, yet historically has been portrayed as lesbian rather than transgender (Halberstam, 1998, p. 149).

The transgender community was undoubtedly jolted when, in the early 1990’s, Nancy Burkholder, a postoperative transsexual woman was denied the right to attend the
Michigan Women’s Music Festival: “a women-only event,” which is strongly affiliated with the lesbian feminist community (Stryker & Whittle, 2006). Following the Gulf War, Kate Bornstein, a transgender author and performance artist, brought her personal history and expertise on gender to the queer community, encouraging scholars and advocates to think more profoundly about gender identity, self-expression, and gender role participation. Meanwhile, a number of important publications came out: *Gender Trouble* by Judith Butler, *History of Sexuality, Vol. 1* by Michael Foucault, as well as Sandy Stone’s essay, “Posttranssexual Manifesto,” which was published in another important book entitled *Body Guards: The Cultural Politics of Gender Ambiguity* by Julie Epstein and Kristina Straub. The latter has had a profound impact on feminist circles and academia by leading a progressive discourse on gender and sexuality studies and is presently considered by the transgender community to be the cornerstone of Transgender Studies (Stryker & Whittle, 2006).

As a result, newly-found scholarly groups as well as community-based organizations began advocating for transgender rights. The Transgender Nation, an activist group founded in 1992, began presenting arguments protesting the “inclusion of “gender identity disorder” in the *American Psychiatric Association’s Diagnostic and Statistical Manual* (Stryker & Whittle, p. 5, 2006). During this same time, legal activist Phyllis Frye organized the first professional conference advocating law and employment policies in Texas for transgender individuals. Meanwhile, Lou Sullivan (a transsexual female-to-male, historian and activist) and Jamison Green transformed a local support group for transgender men in San Francisco into the FTM International. (Lou Sullivan’s career efforts ended prematurely due to his unexpected death from AIDS-related
complications, a serious loss for the community). Currently, FTM International newsletter and website provides educational and emotional support for transgender female-to-male men and their families (Stryker & Whittle, 2006; Female-to-MaleInternationalhttp://, n.d.).

One setback occurred in 1993, when academic and community advocates marched in Washington for Gay, Lesbian, and Bisexual Rights and “explicitly” voted to not include “transgender” in the title (Stryker & Whittle, 2006, p. 5). However, a year later in 1994, the University of Iowa fostered the first international Queer Studies Conference, followed in 1995 by the First International Conference on Cross-Dressing, Sex, and Gender at California State University at Northridge. Both of these are academic benchmarks that have impacted transgender studies by including them in their discourse (Stryker & Whittle, 2006).

During the California State University conference, however, Stryker & Whittle noted that “primarily nontransgender academic specialists who studied transgender phenomena were confronted by a significant number of academically trained specialists who also happened to be transgender people themselves” (2006, p. 6). Transgendered participants were angered and revolted against nontransgender scholars who had insisted that they use separate restroom facilities. Additionally, the nontransgender scholars encouraged transgender participants to attend “community track” lectures rather than “professional track” seminars. In time, relations have improved between trained professionals, scholars, and transgender participants, and since the late 1990’s, academic journals covering transgender issues have appeared (Stryker & Whittle, 2006).
Not to be overlooked, the World Wide Web has also had a profound impact on transgender studies. The term “transgender” and concepts surrounding the term are now being discussed among peers and scholars within academic circles. In fact, “even the Harry Benjamin International Gender Dysphoria Association, the old-guard professional organization for medical and psychotherapeutic service-providers to gender-questioning people, capitulated to the new nomenclature by naming its in-house publication the International Journal of Transgenderism” (Stryker & Whittle, 2006, p. 6). More recently, the Harry Benjamin International Gender Association, Inc. (HBIGDA) has changed its name to the World Professional Association for Transgender Health, Inc. (WPATH). WPATH is a professional organization that provides the Standards of Care, which are ethical guidelines for practitioners who treat gender identity disorders. (This organization will be discussed in Training Module 5: Utilization of the Standards of Care.) (WPATH, 2001).

Courses in transgender studies are being taught at universities across Northern America and Europe, and often transgender studies have been included in gender and sexuality studies, as well as being incorporated into various disciplines such as sociology and psychology. According to Stryker and Whittle, graduate students have begun researching and writing dissertations on transgender topics, totaling 300 by the date of their book’s publication (2006, p. 6). Stryker and Whittle also opined that transgender studies may, in fact, be established as a discrete discipline, though currently lacking institutional support (2006). Stryker and Whittle (2006) made an important observation with regard to the current field of transgender studies:

The new field approached gender not as a system for correlating two supposedly natural, stable and incommensurable biological sexes (male and female) with two
normative, fixed and equally incommensurable categories (man and woman). Rather, it called into question that entire epistemological framework, and conceived of gender as yet another global system within which a great many diverse and specific forms of human being were produced, enmeshed, and modified along multiple axes of signification. … Transgender studies grappled with the imperative of counting past two, when enumerating the significant forms of gender personhood. (p. 8)

“Transgender Studies,” a new “postmodern” condition, argued Stryker and Whittle (2006), “for better or for worse,” has evoked that collapse of the binary world of gender and the new historical era stemmed out of the new millennium energies that refused to be coerced into participating in what Rothblatt earlier coined the “apartheid of sex”: that is, our genitals categorize our social identities, which define our access to privilege and power (Stryker & Whittle, 2006, p. 8; Rothblatt, 1995). A continuing threat to the dichotomy of gender, lies in the fact that blurring boundaries and divisions of sex threaten the male-dominated structure (Rothblatt, 1995):

Transgender critical theory is technically postmodern, in one narrow use of that term to the extent that it takes aim at the modernist epistemology that treats gender merely as social, linguistics, or subjective representations of an objectively knowable material sex. Epistemological concerns lie at the heart of transgender critique, and motivate a great deal of the transgender struggle for social justice. (Stryker & Whittle, 2006, pp. 8-9)

The authors have argued that the transgender phenomena initiate a “different understanding of how our bodies mean, how representation works and what counts as legitimate knowledge. These philosophical issues have material consequences for the quality of transgender lives” (Stryker & Whittle, 2006, p. 9). They continued by claiming that:

The materiality of anatomical sex is represented socially by a gender role, and subjectively as a gender identity: a (biological) male is a (social) man who (subjectively) identifies himself as such; a woman is similarly, and circularly, a female who considers herself to be one. The relationship between bodily sex,
gender role, and subjective gender identity are imagined to be strictly, mechanically, mimetic—a real thing and its reflections.” (2006, p. 9)

Therefore, the trans position questions the constancy of birth sex and the relationship in concert with convoluted “linguistics, social and psychic categories of ‘gender’” (Stryker & Whittle, 2006, p. 9). Stryker and Whittle concluded by saying that “‘sex’ is a mash-up, a story about how the body means, which parts matter most, and how they register in our consciousness or field of vision” (2006, p. 9). Further, they stated that:

Transgender people who problematize the assumed correlation of a particular biological sex with a particular social gender are often considered to make false representations of an underlying material truth, through the willful distortion of surface appearance. Their gender presentation is seen as a lie rather than as an expression of a deep, essential truth, they are “bad” by definition. (2006, p. 9)

These “falsehoods” may instill in others transphobic attitudes and practices wherein transgender persons are marginalized within the binary world, discriminated against, and often victims of violent assaults that far too often become deadly. These perpetrators commonly defend their actions by claiming that they were tricked by the “mismatch” of one’s genitals and gender identity (Stryker & Whittle, 2006, p. 10).

Transgender Phenomenon in Academia

Notably, as transgender studies are included in the educational curricula, the presence of transgender students who come to identify and transcend their gender identity before and during college also rises. According to the National Center for Transgender Equality, one percent of US population is transgender (Quart, 2008). In fact, transgender students have advocated in over 147 colleges and university’s to include the freedom of “gender identity” and “gender expression” in the their nondiscrimination policies (Quart, 2008). As more transgender students become a part of the student body in academic institutions, administration, faculty, and student relations become complicated and at
times, strained, particularly in women’s colleges as they struggle to address the needs of their diverse community. Women’s institutions are beginning to grapple in making accommodations and develop policies to include gender non-conforming individuals and transmen. Meanwhile, trans male students continue to fight for acceptance and many transgender students believe that women’s colleges are safe and hope to embrace the liberal educational opportunities they provide. They contend that their emerging identity stems from first, feminist ideals and lesbian identifications (Quart, 2008). Transgender students are continuing the discourse of gender and sexuality in academic circles, as well as in the professional and social arenas.

This module introduced a historical overview of transgender individuals and their legacy, as well as transgender studies with an emphasis on female-to-male population. The purpose was to present a corrective historical account in which the clinician can frame his or her understanding of the historical and social aspects that have influenced their lives. The following training module will include a review of traditional and contemporary psychoanalytic formulations of gender development and theoretical ideas for female transsexual development.
Training Module III

Psychoanalytic Theories in Gender Development

This training module will look at gender identity development from a psychoanalytic perspective. This perspective is important for transgender individuals because, in the past, traditional psychoanalytic theory has interpreted their gender variance and sexual object choice pejoratively, often costing nonconforming individuals their mental health and marginalization from nonheterosexual groups.

One might view Sigmund Freud’s psychosexual development theory as rigid or sexist. However, his contribution to the field and later revisions of his initial theory by feminist and contemporary theorists hold significant value for both the clinician and patients in the development of their gender identity as well as their sexuality (Bell, 2004). In fact, historically, there was little interest in the development of gender; femininity and masculinity were “simply assumed to correspond by nature to the two biological sexes, despite their historical and cross-cultural variability” (Person & Ovesey, 1983, p. 203). Yet, according to Person and Ovesey (1983), “Psychoanalysis was the first comprehensive personality theory that attempted to explain the origins of what we now call gender” (p. 203) despite the shortcomings of traditional formulations, which have failed to articulate the differences between sex and gender.

Organizations such as the National Association for Research and Therapy of Homosexuality (www.narth.com) continue to make claims that homosexuality and gender-variant behavior are perversions (Rosaria, 2006). These views misinterpret incomplete, dated research, as well as traditional psychoanalytic theory. At the same time, they hinder the extent to which psychoanalytic theory and technique can inform
clinicians, and subsequently their patient’s treatment. Notably, many gay civil rights organizations put forth a great deal of energy in persuading our governments and institutions not to discriminate against persons because of their biological and genetic inheritance. The perspective that human behavior is based on biological predispositions (i.e., the etiology of homosexuality is argued to be genetic) is at the forefront in the fight against social prejudice (Rosario, 2006).

Psychoanalytic theory proposes developmental norms, while urging clinicians to discover the idiosyncratic meaning to a patient’s experience. However, Bell (2004) claimed: “In psychoanalytic theory, there is never a one-to-one relationship between objective and observable circumstances in one’s development and subjective experience of it” (pp. 148-149). Is it possible for the psychological community to make use of the unconscious process to discern motivations and fantasies for gender play that does not pathologize one’s intrapsychic structure or interpret gender non-conformity based on poor familial dynamics?

This section will present a summary of the contributions that traditional psychoanalytic theories have made in understanding gender and sexual identity development, followed by a review of contemporary psychoanalytic theoretical formulations of gender development and sexuality. As this dissertation is primarily concerned with the female-to-male transgender individuals, the literature will also include a section on the theoretical perspectives on female and female transsexual (transgender) gender development, identities, and sexual object choice. It is important to note that only recently have theoretical perspectives begun to evaluate the differences between transsexual and transgender phenomena, limiting the vast amount of literature to
female transsexual perspectives. An analysis of traditional psychoanalytic theory and a review of contemporary psychoanalytic thinking in light of gender and sexuality development will provide the clinician with sufficient theoretical guidance conceptually, assist in the develop of a case formulation, and guide treatment with gender-variant and transgender female-to-male patients.

*Traditional Psychoanalytic Theories in Gender Development*

_Sigmund Freud_

Freud derived his theory of femininity and masculinity from what we now refer to as gender role identity—the contrast between the behaviors of the two sexes after one has been ascribed a gender at birth (Person & Ovesey, 1983). Freud suggested that masculinity is the “natural state” and that a girl would eventually discover her femininity subsequent to her awareness that she does not have a penis (Person & Ovesey, 1983).

Bell (2004), a psychoanalytic historian on issues of gender and sexuality, portrayed in her essay, _Psychoanalytic Theories of Gender_, a comprehensive review of psychoanalytic theoretical perspectives on gender. She argued that Freud’s early work, _Studies on Hysteria_ (which was published in 1895), was his first attempt to address gender and the psychological symptoms that result from social and familial pressures. Bell stressed the importance of recognizing that Freud’s work took place during the Victorian Era, and she contended that, although Freud was a man and most of his patients were female, and while he tended to focus on the differences between male and female, scholars at the time viewed male-gendered development to be the norm. Bell asserted, “Freud was perhaps the first gender theorist in his insistence that biological sex is not the same as acquired
gender, that biology is not destiny, and that gender is made and not inborn” (2004, p. 147).

Freud was the first to suggest that “biology is not destiny” (Bell, 2004, p. 147); however, Bell admitted that Freud might not have argued this point of view as strongly as the theorists who followed. She asserted, “But the tools and insights he provided us are invaluable in understanding gender in its universal and particular aspects” (p. 147). In Bell’s opinion, Freud’s work provides us with a blueprint in thinking about gender and its manifestations; that is, our psychology of gender includes aspects of internal conflicts as well as unconscious parts of ourselves that motivate our actions. She further credited Freud’s “talking cure” as a method for discovering the origin of symptoms through careful analysis of a patient’s thoughts and associations (Bell, 2004, p. 147). She wrote, “An unconscious part of the mind reflects desires, wishes, and fantasies that are not conscious to us in our waking lives but inform the ways that we, think, act, and feel” (pp. 147-148).

From this perspective, a clinician could treat his/her patients’ symptoms by analyzing and interpreting the patient’s free associations, which tend to encompass unconscious fantasies that depict one’s deepest desires and wishes (Bell, 2004). In summary, the unconscious part of ourselves may, in part, explain the contradictions that we feel in relation to our internal world, which then stir up internal conflict, and subsequently, lead to symptomatic behavior. Symptomatic difficulties are likely to be lessened by naming repressed thoughts and feelings, as well as interpreting the tensions between the patient’s unconscious wishes and social expectations. Bell suggested that playing with the concept of gender occurs in the unconscious part of ourselves and is the
source of our contradictions (Bell provided an example of a woman with feminist ideals who unconsciously may be wishing for a “sugar daddy,” 2004, p. 148).

Freud was interpreted by early psychoanalytic practitioners as describing “normal” gender development as encompassing a compliance with gender roles accordingly, while engaging in heterosexual sexual relationships. For example, early psychoanalysts attempted to use the “talking cure” to treat homosexuality (Bell, 2004). Bell contrasted this with theorists of today, such as Chodorow, who, basing her interpretation on his “Three Essays on the Theory of Sexuality” and “The Psychogenesis of a Case of Homosexuality in a Woman,” (1920) depicted Freud as a “sex radical who theorized about great variability in both gender and sexuality” (as cited in Bell, 2004, p. 148). Bell asserted:

More contemporary psychoanalytic theory returns to the radicalism of Freud and claims that mature gender involves the capacity for more fluidity, less splitting, and less rigidity, in terms of gender, the body, and sexuality. (p. 148)

Bell concluded that the contemporary perspective invites one to “play with gender categories in relationships with others rather than to be limited and constrained by them” (p. 148).

Bell argued that, although psychoanalysis makes normal developmental claims:

Psychoanalysis is always working to make meaning of patients’ own very particular and individual experiences of development and gender. Psychoanalysis recognizes the tremendous diversity and variability in individual experiences of universal phenomena, for example, breast feeding and early tending by caregivers, attachment to and separation from caregivers, and bodily, social and psychological changes accompanying puberty. In psychoanalytic theory, there is never a one-to-one relationship between objective and observable circumstances in one’s development and subjective experiences of it. (pp. 148-149)

She illustrated this best by describing distinct reactions of a mother’s adoring love and pride. One girl may experience her mother’s attention as intrusive, whereas another girl
may experience it as affirming (Bell, 2004). Bell noted, “These subjective differences in objectively similar relationships produce very different experiences of gender in these two girls” (p. 149). One can utilize the psychoanalytic exploration of a girl’s unconscious as a means for understanding how she internalizes the mothering: “Psychoanalysis provides us with a theory that considers both fantasied meaning and materially observable phenomena to account fully for individuals’ experiences of gender” (Bell, 2004, p. 149).

Bell continued in her discussion of psychoanalysis by asserting that it has been “interested in gender and sexuality from its inception” (2004, p. 149). In this regard, Freud “located sexuality and the body at the center of development in general, and gender development in particular” (p. 149). This is important because the first physical and sensual handling of and caring for the infant marks the initial impact of how the baby comes to know him- or herself in relation to an other. Put another way, it is by “experiencing one’s body in relation to an other” that one’s sense of self and gender begins to form (p. 149).

With regard to Freud’s paper entitled, “Three Essays on the Theory of Sexuality” (published in 1905), Bell interpreted it as follows:

Whereas gender is always related to sexuality, neither fully causes the other. Instead, he argued that men and women are both masculine and feminine, passive and active, and inherently bisexual in orientation, and that one’s gender experiences is not predictive of whom one loves; that is, a man may be male and masculine in his erotic life, but may love men, and a woman may be masculine and also love men. (p. 149)

In this vein, Bell argued that one experiences both masculine and feminine parts of oneself while seeking love objects, and these love objects hold polar-like traits and/or
both masculine and feminine qualities. In Freud’s view, both constitution and subjective experiences may result in different sexual and gender identities (Bell, 2004).

In Freud’s psychosexual stage of development theory, girls and boys are bisexual in early development and have comparable male anatomical structures (penis and clitoris) (Lyons, 1986). The maturation process of the oral and anal stages is also similar for both. However, in Freud’s Oedipus complex, he addressed boys’ development of their masculinity. Freud postulated that boys must detach from their primary attachment, which has been their primary libidinal object since infancy. They must relinquish the wish to have their mother for themselves and sublimate their rivalry toward his fathers (Person & Ovesey, 1983). The task for the male child is to identify and “replace the cathexis of the desired parent” (Morton, 1993, p. 37). For boys, the fear of castration (perpetrated by his own father) evokes unbearable anxieties, and so the boy detaches from his mother and begins to identify with his father (Bell, 2004; Lyons, 1986). According to Person and Ovesey (1983), because of the boy’s “prior experience of loss of the breast and of feces, that his penis might be the price of his libidinal cathexis to his mother” (pp. 206-207). Thus, castration anxiety leads the boy to choose his penis (identification with his father) and abandon his libidinal love for his mother. This identification with his father enhances the boy’s masculinity, which was heretofore innate or “natural gender” (Person & Ovesey, 1983). This phase marks a “natural movement toward unification in the psyche,” and during this time, object choice and gender identifications are shaped (Morton, 1993, p. 37). Positive Oedipal resolution is favorable when a boy’s sexual and libidinal desires are for the opposite sex, while his gender identification remains with the same-sexed parent (Morton, 1993).
According to Lyons’ interpretation of Freud, a girl is unable to differentiate her clitoris from her penis counterpart, which is the primary source for executing libidinal pleasure (1986). Freud was baffled by women’s choices and development:

How does femininity develop, and why do women submit to its limitations? How do heterosexual girls shift their love from their mothers to their fathers, and then to other men? ... How and why do girls change the organ from which they derive pleasure from the clitoris to the vagina? (Bell, 2004, p. 151)

It is between the ages of 4 and 6 that a girl discovers she lacks a penis, thus precluding her experience of the castration complex (Bell, 2004; Lyons, 1986; Person & Ovesey, 1983). It is important to note that succeeding theoretical perspectives argue that a girl recognizes that she does not have a penis at even an earlier age. Freud argued, “They feel seriously wronged, often declare that they want to ‘have something like it too’ and fall victim to ‘envy for the penis’” (as cited in Lyons, 1986, p. 24). The female child then turns away from her primary caregiver, her mother, and seeks to bond with her father, as she believes that her mother has deprived her of having her very own penis and has, in fact, castrated herself (Lyons, 1986). The girl then holds her mother responsible for leaving her ill equipped, and as a result, her anger and contempt shifts her primary love interest toward her father (Bell, 2004; Lyons, 1986), and she aspires to obtain a penis through her new relationship with her father (Person & Ovesey, 1983). However, eventually a girl must come to terms with the fact that she cannot have a penis, thus relinquishing her clitoris as her sexual aim and accepting her vagina (taking in/ holding). With this shift, she now wishes to have her father’s child (Person & Ovesey, 1983).

The Oedipal resolution and mastery, then, is central to the development of a female gender identity; that is, the female-gendered self substitutes her envy for a penis with the wish to have her father’s baby (Lyons, 1986). She remains in the Oedipal
struggle with her mother as they both vie for the father’s attention. Continuing in Freud’s interpretation of a girl’s development, the girl, then, remains “in this phase ‘an indeterminate length of time … resulting in the suffering of super-ego formation’” (as cited by Lyons, 1986, p. 24).

According to Freud, the girl’s superego was derived from the Oedipal resolution (Person & Ovesey, 1983), and he believed that the “total dissolution” was unlikely due to her profound wish to either “possess the father’s penis” or “have the father’s child” (Person & Ovesey, 1983, p. 207). However, because the girl does not fear castration or annihilation by her mother, but rather maintains “contemptuous and angry feelings toward her mother,” she is likely to transition her loving feelings from her father to men later in her development (Bell, 2004, p. 151). Thus, from Freud’s perspective, a girl’s Oedipal resolution is established and confirms a female/femininity gender identity.

Difficulties attaining this phase may lead to neurosis, sexual inhibition, or what was coined by Freud, “the masculinity complex” (Lyons, 1986). For girls, Freud admitted that his developmental theory was “unsatisfactory, incomplete, and vague”; he believed nonetheless that the “masculinity complex” was central in developing a female psyche (Person & Ovesey, 1983, p. 207).

In summary, deeply grounded in Freud’s psychology was the concept of penis envy, or the masculinity complex, which was at the center of the female psyche; castration anxiety was at the center of the male psyche (Person & Ovesey, 1983). Further, sexual development, as well as personality development, were shaped by the female’s reaction to the loss of both the penis and the father. Subsequently, the girl recognizes that she could never become masculine and thus retreats to femininity: “Femininity derived
from the psychological ramifications of a single, momentous, and traumatic perception: the girl’s discovery of her anatomic difference from boys, a difference viewed as inadequate” (Person & Ovesey, 1983, p. 208). Characteristics and personality traits such as “passivity, masochism, and narcissism” are paramount in the girl’s psyche (Person & Ovesey, 1983, p. 206).

Freud attributed dual meanings to the term bisexuality, as either anatomical hermaphroditism or psychical hermaphroditism (Morton, 1993). Psychical hermaphroditism, according to Freud, meant “masculine and feminine instincts, attitudes, or mental characteristics and ‘active and passive aims’” (Morton, p. 37). Additionally, Freud used bisexuality to describe primary object desire, and, at other times, to refer to homosexual desire. Freud, thus, depicted the bisexual term interchangeably, which refers both to object choice and/or psychical and physical character traits for males and females. “Thus in the Freudian model, the development of each is intricately connected to the relationship with the other” (Morton, 1993, p. 38).

Freud’s theory has its limitations, specifically with respect to his focus on the Oedipal and postoedipal phase of gender and sexuality development. In the 1920’s and 1930’s, Karen Horney and Ernest Jones proffered an alternative explanation. In their view, “Both femininity and masculinity predated the phallic phase” and “each derived separately from the innate predispositions” (i.e., origins that were preoedipal; as cited in Person & Ovesey, 1983, p. 204). Freud’s gender and sexual identity theories have also been criticized by various cultural groups, including feminists, lesbian, gay, bisexual, and transsexual and transgender persons, as well as within various academic circles. These
critics have claimed that Freud’s theory is phallocentric and heterosexist and that such
developmental perspectives infers adaptive normality (Bell, 2004).

Karen Horney

Between 1923 and 1935, Horney published nineteen prominent essays that
focused on female psychology, offering a feminist perspective on the differences between
the gender developments of the two sexes, arguing that femininity and masculinity
derived from innate predispositions and relational dynamics preceded the preoedipal
phase of development. Although her arguments seemed to deviate from Freudian thought,
it is important to note that her early work was profoundly influenced by orthodox
psychoanalytic theory (Paris, 2000). Later in Horney’s career, her ideas shifted
significantly as she became more interested in and influenced by the perspectives of
anthropologists, sociologists, and ethnologists, (Paris, 2000). She concluded that “cultural
variations and the role of social forces” undoubtedly influence gender identity
development and the Oedipal complex (as cited in Paris, 2000, p. 14). For example, child
and parent relating might not exist in certain “cultural conditions,” or they may vary

Horney’s collection of essays, entitled “On the Genesis of the Castration Complex
in Woman” (1923) and “The Flight from Womanhood” (1926), focused on the
masculinity complex. These were soon followed by two additional essays, “Inhibited
Femininity” (1926) and “The Masculinity Complex in Women” (1927) (Paris, 2000). In
“On the Genesis of the Castration Complex in Women,” Karen Horney argued that young
girls were aware of their vaginas at an early age, which clearly contradicted Freud’s
theory, and suggested that womb envy may be comparable to penis envy (Bell, 2004;
Horney, 1967; Lyons 1986; Morton, 1993). Horney’s main counterarguments with Freud were in the following three domains: “(1) the cause of the girl’s turn from mother to father; (2) the nature of female genital awareness; and (3) the genesis of penis envy” (Person & Ovesey, 1983, p. 208). However, Horney agreed with Freud by claiming that in the “usual course of development, the girl does, in fact, substitute the father for the mother as the libidinal object” (as cited in Person & Ovesey, 1983, p. 208). Horney “attributed heterosexual object choice to innate femininity, itself grounded in female biology and awareness of the vagina, not from disappointment at lack of a penis” (Person & Ovesey, 1993, pp. 208-209). Jones agreed with Horney by conferring that a girl had an initial erotic attachment toward her father (Person & Ovesey, 1993). Morton argued that Horney and Jones pointedly contradicted Freudian primary masculinity conviction:

They [Horney and Jones] described a primary femininity for females based on body awareness (e.g., females know they have a vagina) that parallels a primary masculinity for males, and Horney identified penis envy, not as a narcissistic envy for the male organ itself, but as an envy of the male’s mode of urination, envy of the apparent permission to masturbate and see and exhibit his genital, and a libidinal desire for the penis. (pp. 38-39)

Jones argued that resolve with the Oedipal conflicts developed out of “innate femininity,” stating:

This view seems to me more in accord with ascertainable facts, and also intrinsically more probable, than one which would regard her femininity to be the result of an eternal experience (viewing the penis). To my mind, on the contrary, her femininity develops progressively from the inner promptings of an instinctual constitution. … The ultimate question is whether a woman is born or made. (as cited in Person & Ovesey, 1983, p. 209)

Both Horney and Jones put forth the idea that the knowledge of the vagina was known by both sexes, even though penis envy was a secondary motivation, they believed a girl desired the penis libidinally, which reflected what Horney interpreted to be an
“innateness of heterosexuality” (as cited in Morton, 1993, p. 39). Therefore, “innate femininity and innate heterosexual object choice was linked to biology and the girl’s awareness of her vagina” (Person & Ovesey, 1983, p. 209). Person and Ovesey submitted that frequent rape fantasies substantiated a girl’s awareness of her vagina, whereas Freud would hold that the girl did not have such fantasies or knowledge of her vagina. Freud claimed that the girl’s “leading organ was her clitoris and explained her renunciation of the clitoris as a consequence of penis envy” (as cited in Person & Ovesey, 1983, p. 209).

In “On the Genesis of the Castration Complex in Women,” Horney concurred somewhat with Freud’s concept of penis envy, writing “penis envy probably most frequently directly manifests itself, namely, in the desire to urinate like a man” (Horney, 1967, p. 39). She proffered that omnipotent fantasies contain the ability to “look at himself” while satisfying “sexual curiosity, at least as far as his own body is concerned, every time he passes urine” (p. 40). As an example of penis envy, Horney referred to a female patient who had expressed the desire to masturbate in a manner that mirrored her wish to urinate and stimulate her organ like her father (Horney, 1967). Horney also suggested that cross-gendered attire suggests one’s disappointment, particularly for a female, and her inability to display her genitals (1967).

According to Horney, a girl is primary concerned with “the space within her body, not the little boy’s penis” (as cited in Person & Ovesey, 1983, p. 209). Surprisingly, Horney’s masculinity complex supported Freud’s formulation of penis envy, although she explained it somewhat differently, asserting that the girl did not turn to her father to take his penis, but rather, to defend against her libidinal and Oedipal longings. From Horney’s perspective, then, a girl’s unconscious fears and anxiety
stemmed from incestuous fantasies, and fears of her father’s penis and sexual aggression, which would likely lead to genital injury (Paris, 2000).

Initially, Horney discounted the social factors attributed to women’s unconscious masculine fantasies. She disputed Alder’s argument that the “masculinity complex, (which he called the ‘masculine protest’) is the result of social situation[s]:” “The driving force is ‘the fear of female sexual experience’ that arises ‘from early emotional relationships’” (Horney, as cited in Paris, 2000, p. 7). Later, Horney’s position on social factors shifted. Paris stated:

Horney saw women as victims of both biology and culture. Their “unconscious motives for the flight of womanhood are reinforced” by their “social subordination.” They are bound to have a masculinity complex because of their need to escape the guilt and anxiety that result from their oedipal situation, and they are bound to be alienated from their essential feminine natures because of the overwhelming power of their male-dominated culture. (2000, p. 6)

Horney believed, however, that if the two sexes were socially equal, there would be no need to retreat to the male role (Paris, 2000). “In essence, she substituted an object-relations analysis for the masculinity complex in women for an explanation grounded in penis envy as an existential fact of female life” (as cited in Person & Ovesey, 1983, pp. 209-210).

In “The Flight from Womanhood” published in 1927, Horney asserted that psychoanalysis failed to accurately represent gender development (Paris, 2000). Although men may be convinced that gender development is focused on genitals, she argued, “women have the capacity for motherhood,” thereby suggesting men could also envy womanhood: “envy of pregnancy, childbirth, and motherhood, as well as of breasts and of the act of suckling” (as cited in Paris, 2000, pp. 4-5). According to Paris’s accounts of Horney, “the desire to be a man has very little to do with early penis envy but is ‘a
secondary formation embodying all that has miscarried in the development toward
womanhood” (Paris, 2000, p. 5). “Girls recoil from the feminine role at the Oedipal
stage when they renounce the father as a sexual object, and the strength of primary penis
envy is then reinforced, ‘by retrogression from the Oedipal complex’” (Paris, 2000, p. 5).
Paris continued:

Because of its association with incestuous desires, “female genital anxiety like the
castration dread of boys,” bears “the impress of feelings of guilt”; but whereas the
boy can inspect his genitals to see whether the dreaded damage has occurred, the
girl remains uncertain on this point. To escape her anxiety the girl “takes refuge in
a fictitious male role.” Fantasies of being a man secure the girl “against libidinal
wishes in connection with the father” and enable her “to escape from the female
role now burdened with guilt.” Women have castration fantasies because when
they adopt a male role their “feminine genital anxiety is … translated into male
terms—the fear of vaginal injury becomes a fantasy of castration.” (Paris, 2000, p.
5)

Subsequently, girls have the need to restore the penis in which they have lost (Paris,
2000).

As Horney saw women as victims of both biology and culture, she continued her
exploration of the origin of the masculinity complex, finding it routing in social standing.
In the “Masculinity Complex in Women” published in 1927, Horney began to discuss
women’s preference for the masculine role in many of her essays (Paris, 2000). She
defined the masculinity complex as “‘the entire complex of feelings and fantasies that
have for their content the woman’s feelings of being discriminated against, her envy for
the male, her wish to be a man and to discard the female role’” (as cited in Paris, 2000, p.
3).

Horney suggested that mothers are likely to inhibit their daughters’ developing
femininity to prevent them from winning their father’s affection or the affection of other
men (Paris, 2000). Those mothers who fled or rejected the conventions of womanhood or
otherwise scorned their female roles will most likely induce masculinity complexes in
their daughters by communicating their disdain of the female role (Paris, 2000).

In the 1930’s, while still holding rather orthodox views (and Paris would argue
dated views), Horney began to explore the masculinity complex in female homosexuality
specifically, working with homosexual female patients. In her first Berlin lecture, entitled
“Manifestations of Repressed Female Homosexuality,” she challenged previous accounts
of female homosexuality by exploring multiple “‘manifestations’ of the phenomenon”
(Paris, 2000, p. 8). She opined homosexual women’s relations with men: “They did not
really love any man but covered up their homosexuality by developing “fantastic
superstructures” by playing a role in the transference toward their analyst (as cited in
Paris, 2000, p. 9). She concluded that the predominant themes were “ambivalence and
identifications with the male role” (as cited in Paris, 2000, p. 9). She noted that not all
homosexual women were aggressive or masculine in their relationships with their female
partners; yet, she argued that a “masculine attitude is present even when their behavior is
submissive and masochistic” (as cited in Paris, 2000, p. 9). She believed that this
ingrained attitude was rooted in conscious or unconscious fears of female (mother or
sister) rivalry, which tended to evoke sadistic tendencies despite the fact that these
sadistic tendencies were also feared by them (Paris, 2000). Horney believed that
aggressive patterns of relating were sublimated and became more passive or masochistic
in nature, and she referred to a clinical example in which a masculine-looking woman
allowed “other women to abuse or ignore her but ‘strangled and maimed’ them in her
dreams” (as cited in Paris, 2000, p. 9).
Horney further addressed homosexuality in her lecture given in Chicago in 1933, entitled “Common Deviations in Instinct Development.” In this lecture, she claimed that all deviations from “normal” female gender development stemmed from a woman relinquishing her subordinate female role and acquiring a masculine role with its attendant power (Paris, 2000). She suggested that this masculine demeanor placed a new importance on the role of the mother, as the daughter would either be terrified of her mother or feel disdain for her (Paris, 2000): “The girl’s fear and hatred of her mother lead her to flee the feminine role. Because she hates the mother, she does not want to be like her; and because she fears her, she shrinks from being her rival” (as cited in Paris, 2000, p.11). Both the mother and the father have an impact on their daughter’s homosexuality or masculinity complex. In one scenario, for example, the daughter might turn away from her father’s rejection during the Oedipal phase and subsequently be unable to become dependent on a man later in her life (Paris, 2000). Horney suggested four possible scenarios or subtypes in a girl’s maturation process. The latter two scenarios, which extended the mother’s role, were developed later in “Personality Changes in Female Adolescents” (1935):

1. The girl becomes “boy-crazy” and is unable to develop successful relationships with men while defending against any homosexual desires she might have.
2. The girl develops a homosexual status.
3. The girl becomes “absorbed in sublimated activities.”
4. The girl becomes “emotionally detached.”
In all four subtypes, the girl is dissatisfied with her feminine role, which she may choose to “exaggerate” or reject altogether (Paris, 2000, pp. 11-12). Paris summarized Horney’s theories on adolescent girl subtypes as follows:

Such girls have an antagonistic attitude toward men but an even more intense hostility toward women, which derives from their life history: Certain approaches against the mother come up: lack of warmth, protection, understanding, preference for a brother, over-strict demands as to sexual purity. (Paris, 2000, p. 12)

Many subsequent theorists debated Freud’s and Horney’s theories with regard to the feminine and female gender development. These differences of opinion were reviewed by Fliegel and Mitchell, and interestingly, the debates between Freud and Horney disappeared from psychoanalytic debate for years and have only recently been revisited by scholars (Person & Ovesey, 1983).

Horney and Jones argued that gendered behaviors become evident at a very early age, prior to awareness of anatomical differences. However, Person and Ovesey (1983) noted that, like Freud, Horney and Jones placed a profound importance on gendered bodies and the perception of their genitals. Jones concurred with Horney that both sexes were aware of the vagina; yet, he based his theoretical point of view of “penis envy on the work of Melanie Klein and the idea of the incorporated penis within the preoedipal mother” (Morton, 1993, p. 39). Jones defined the castration complex for both girls and boys as an “aphanisis … the total and, of course permanent, extinction of the capacity (including opportunity) for sexual enjoyment” (as cited by Morton, 1993, p. 39).

According to Morton (1993), the “Freud-Jones Debate” depicted one school against the other: “‘London’[s] school of psychoanalysis (influenced by Melanie Klein and Object Relations Theory) and the ideas of the ‘Vienna’ school of psychoanalysis
(represented by Sigmund and Anna Freud)” (p. 38). It should be noted that these theoretical explanations of the masculinity complex and gender developmental theory, as developed by Horney and Jones, are somewhat limited in that they tended to conclude that gender identity is almost always dependent upon “perception of genitals and genital sensations” (Person & Ovesey, 1983, p. 211). Over time, Horney changed her position, asserting that the masculinity complex is purely a feminine phenomenon, thus raising the importance of cultural experience. She stressed cultural factors as well as familial dynamics particularly with the mother rather than biological underpinnings to explain gender and sexuality development. She concluded, “What we definitely know at present about sex differences is that we do not know what they are” but that culture ultimately shapes the feminine psyche (as cited in Paris, 2000, pp. 13-14).

Robert Stoller

Stoller was a major contributor to the study of gender development from a psychoanalytic perspective while considering physiological abnormalities such as in the condition of hermaphroditism and Klinefelder’s Syndrome (Fast, 1985). (The latter, Klinefelder’s Syndrome, is an atypical condition in which the brain malfunctions while hindering gender development and behavior [Fast, 1985].) Stoller’s interest shifted predominantly toward the psychological “disturbances” of masculinity and femininity and the developmental process of divergent-gendered behavior. He claimed such disturbances were influenced by intrapsychic conflicts (Fast, 1985).

Stoller’s controversial gender development theory is similar to the theories preferred by Jones and Horney. In Stoller’s theory, both female and male children have a predisposition to primary femininity, although Stoller stated that he did not offer this
theory as a repudiation of Freud’s theory, which holds that a child’s predisposition is primarily masculinity. Stoller argued that, although children have innate gendered predispositions influenced by fetal hormones, environmental circumstances undoubtedly influence gender development (1989). Stoller continued, however, that, “At birth, infants are assigned to the male or female sex on the basis of the appearance of the external genitals,” which are then, confirmed by the “authoritarians,” that is, the medical community (1989, p. 100). Subsequently, children are reared consciously and unconsciously by the mother’s attitudes, both in subtle and covert ways, regardless of the primary caregiver’s feelings toward the sex of the child (Stoller, 1989).

From this point of view, gender derived during the early periods of infancy, which he named protofemininty (primary femininity); this phase was an integral part of gender identity for both genders (Person & Ovesey, 1983 p. 211). Stoller regarded “the early environment of the infant as ‘feminine’ simply because it is bounded by the mother-child symbiosis. In order to account for early intrapsychic femininity,” he concluded that the etiology of gender development is shaped undoubtedly by “imprinting” (Person & Ovesey, 1983, p. 214).

In addition to the biological differences that are apparent at birth, “handling of the sexes by mothers” results in notable differences in typical behaviors for girls and boys (Stoller, 1989, p. 103). Infants are assigned a sex according to the appearance of their genitalia; mothers then encourage specific behaviors in their child according to gender stereotypes (Stoller, 1989). Thus, sex alone does not create one’s gender development; rather, a child’s gender is largely shaped by his or her primary caregivers, who promote socially derived characteristics that are polarized into two distinct groups, masculinity
and femininity (Morton, 1993). Nurturance, then, has a ubiquitous effect on one’s personality developmental (Stoller, 1989).

By the end of the second year, and certainly by the fourth year, a child will hold a solid conviction of his/her gender: either “I am a boy” or “I am a girl,” which Stoller refers to as a child’s “core gender identity” (1989, p. 101). These self-affirmations are confirmed and generally shaped by the mother or primary caregiver and the social community, thereby reaffirming an awareness of the body, referred to by Stoller the “bodily ego” (1989, p. 101). Simultaneously, the bodily self will either be “confirmed” or “threatened” after one possesses a conscious acknowledgement of his/her sense of self as being either male or female (Stoller, 1989). In one study of blind children, Stoller observed:

Boys with congenital absence of the penis, and girls with congenital absence of the vagina have all been observed to differentiate along gender lines corresponding to the biological sex. These observations prove that gender differentiation cannot be primarily derivation from body awareness or perception of the sexual distinction. (as cited in Person & Ovesey, 1983, p. 210)

Stoller, in accordance with Jones and Horney, and later Green on and Chodorow, argued that primary femininity does not mirror primary masculinity (Morton, 1993). “Protofemininity,” as coined by Stoller, is the process whereby a child of both genders initially identifies with his/her mother (Person & Ovesey, 1983).

From this perspective, the boy must disidentify with the mother in order to achieve normal developmental masculine qualities. As an example of this concept, Stoller referred to Greenon’s work with a transsexual boy who seemed to confuse his wish to have his mother with his wish to become his mother (Person & Ovesey, 1983). Stoller also postulated that such families fail to have the Oedipal conundrums that encourage the
boy to identify with his father, and have the mother “serve[s] the purpose of renunciation
by being a model for future love objects. Heterosexual masculinity is the consequence”

Greenson believed that fears of separation lead to absorption of female
identifications by little boys: “He regarded the boy’s interest in his mother’s clothes as
both ‘a failure of individuation and a defense against separation anxiety’” (Greenson, as
cited by Person & Ovesey, 1983, p. 212). However, Greenson based his work on
Greenacre (1958) and Jacobson (1964), in claiming that gender identification was only
one aspect of gender identity:

> In early infancy both girls and boys form a primitive symbiotic identification with
the mother’s person. … This results in the formation of a symbiotic relationship
with the mother. … The next step … is the differentiation of self-representation
from object-relationships. (as cited by Person & Ovesey, 1983, p. 212)

Greenson identified four factors that he considered essential in the formation of
gender identity:

(1) The awareness of anatomical and physiological structures in oneself; (2) sex
of assignment; (3) a so-called “biological force,” inferred also by Stoller (1968),
which only rarely was strong enough to counteract the first two factors; and (4) in
the boy, the necessity for disidentification from the mother and the establishment
of a new identification with the father. (Person & Ovesey, 1983, p. 212)

Therefore, a boy’s prolonged identification with the mother may lead to adverse
gender identity issues. Greenson asserted that parents are responsible for providing
counteridentification, particularly finding “motives” for the boy to identify with the
father, despite impeding failures such as lack of motivation and defense. He cautioned
that envy was a challenging obstacle in this process. He explained that “envy is one of the
main driving forces in man’s wish to be a woman and originates in the early envy all
children feel towards the mother” (Greenson, as cited in Person & Ovesey, 1983, p. 213).
Stoller disagreed with Freud’s phallocentric view of psychosexual development, stating:

First … [Freud] assumed as a biological given that maleness was the firmer, more natural state (which as we have noted present-day research contradicts). The second was that he said the male is off to a healthier start because his relationship with his mother is by definition heterosexual. (Stoller, as cited in Person & Ovesey, 1983, p. 213)

However, Stoller asserted that:

While it is true that the infant boy’s first love object is his mother, there is an earlier phase in which he is merged with her before she exists as separate object; that is, he has not yet distinguished his own body and psyche as different from hers – and she is a female with a feminine gender identity. It is possible, then, that the boy does not start heterosexual as Freud presumed, but rather that he must separate himself from his mother’s female body and femininity and experience a process of individuation into masculinity. (as cited in Person & Ovesey, 1983, p. 213)

Freud ignored the symbiotic relationship between the child and the mother from which the infant gradually separates and individuates (Stoller, 1989). Stoller claimed that a normative gender identity developmental task for a boy is achieved when he absorbs masculine traits and is able to disidentify with his mother and identify with his father (Person & Ovesey, 1983). In contrast, for girls, the developmental task included transitioning her primary love object from her mother to her father. He further claimed that girls benefited from primary femininity:

There is a conflict built into the sense of maleness that females are spared; core gender identity in males is not, as I have mistakenly said, quite so immutable. It always carries with it the urge to regress to an original oneness with mother. (as cited in Person & Ovesey, 1983, p. 214)

Stoller claimed that because of the “bedrock of feminine identifications,” boys are more likely to have difficulties in mastering gender development. He claimed, “A preoccupation with being strong and independent, untender, cruel, polygamous,
misogynous, perverse … may be reactive to the male’s fear of a regressive pull to that early symbiotic merger with the mother” (as cited in Person & Ovesey, 1983, p. 214). Thus, according to Stoller, the early symbiotic union with the mother is an “imprinting” of intrapsychic femininity wherein boys learn to identify with their mothers. A consequence in doing so leads to etiological male transsexualism (Person & Ovesey, 1983). Because the task of detangling from the “protoidentification” from the mother and the coexisting “symbiotic anxiety” (with the mother) are so arduous, many cultures have various customs and rituals to aid in this process of defending against intimacy with women:

One can speculate that the greater part of manifest masculinity in many cultures is constructed from fear of intimacy with—worse, of becoming like—women. This might even be one of the sources of the finding that most of the perversions are rare or not found at all in women. (Stoller, 1989, p. 104)

“A natural experiment”—primary male transsexualism—tests the hypothesis that mother-infant intimacy promotes femininity” (Stoller, 1989, pp. 104-105). Significantly, Stoller asserted that the inability to disentangle from the symbiotic union of the mother is likely to result in a request for medical intervention, that is, a sex change. Stoller concluded:

This condition, which is only one of many that can bring a person to ask for a change of sex, is defined as follows: an anatomically normal male who has been feminine since earliest childhood, who has never shown masculine behavior or lived successfully in a role typical for boys or men in his society, and who at present—whether child, adolescent, or adult—is the most feminine of males. (p. 105)

Thus, this child’s separation-individuation process is hindered, leading to abnormal gender identifications, which Stoller claimed are abnormal manifestations of gender identity (1989).
Stoller, and more recently Tyson, have attempted to clarify gender identity and establish a normal gender identity development trajectory (Lyons, 1986). Tyson distinguishes gender identity by considering three facets:

(1) Core gender identity, (2) gender role identity and (3) sexual partner orientation. Gender role refers to the external behavior one displays in society, the role that is played with others to establish one’s position with them with respect to one’s gender. Sexual partner orientation simply refers to the preferred sex of the love object. (Tyson, as cited by Lyons, 1986, p. 22)

Core gender identity is formed from physiological and biological predispositions, and it is the most “basic sense of belonging to one sex or the other, i.e., calling oneself a girl or a boy” (Lyons, 1986, p. 22).

Tyson and Tyson (1990) stated that the gender-identity role is “a gender-based patterning of conscious and unconscious interactions with other people” (p. 254). The gendered-self derives from parents’ and other primary caregivers’ attitudes toward the child’s biological sex, as well as their beliefs associated with their own ascribed sex. The gendered-self originates from early representations of the self and objects and the child’s internalization of their relational interactions (Tyson & Tyson, 1990):

These “role relationship” representations coalesce with other aspects of gender awareness, so that eventually the self-representation contains elements of one’s gender identity together with the role or habitual mode of interaction used in relation to other people vis-à-vis one’s masculinity or femininity. (p. 255)

This gender-role identity, however, should not be confused with other socially learned roles, as it reflects an intrapsychic, internalized relational representation. At the same time, one cannot overlook the fact that a child’s identifications and interactions are undoubtedly influenced by cultural and social influences (Tyson & Tyson, 1990). Notably, Tyson and Tyson claimed that a child’s cognitive capacities play a large part in developing his/her gender-role identity, which is strongly influenced by a child’s
perception of “physical and behavioral differences and similarities between same- and
different-sex siblings, peers, or parents” (p. 255). Categorizing oneself as male or female
tends to organize “gender experience,” and self-labeling guides the child in seeking
“self-like objects” as role models with whom to identify” (p. 255).

Horney and Jones both claimed that innate heterosexuality stems from gender
development attributed to “primary femininity” as opposed to primary masculinity as
argued by Freud. They argued that there is far too much importance attributed to genitals,
and “they linked gender identity almost exclusively to body ego” (Person & Ovesey,
1983, p. 211). However, Person and Ovesey also suggested that, although Stoller’s
“protofemininity” explains female/feminine gender development, it is limited in providing
a theoretical explanation for male/masculine gender identity development (1983). Later,
Kleeman (1976) argued that the “psychoanalytic theory of primary identification leaves
unanswered why a normal three-year-old boy is clearly a boy even though his contact has
been largely with a female adult” (as cited in Person & Ovesey, 1983, p. 215). Person and
Ovesey, however, contested that no evidence, in fact, exists to support the theory that
primary identification, which confers gender behavior or gender identity, is what occurs
during the symbiotic state that exists prior to self-object identification (1983).

These aforementioned theories were largely concerned with what constitutes
“normal” gender and sexuality development, and they have been used, historically, to
serve as a framework to pathologize homosexual object choice and gender-variant
expressions by both female and male individuals. While clinicians continue to grapple
with Freud’s and Stoller’s theories and perspectives, this manual challenges these
traditional formulations. Several feminist and contemporary theorists,’ Nancy Chodorow,
Jessica Benjamin, Virginia Goldner, and Muriel Dimen to name a few, have raised a number of unanswerable questions based on their suppositions: How do we understand gender and sexual development of children who are not raised in “intact” family constellations? In consideration of female transsexualism (as well as for the female-to-male transgender), why would a girl choose a primary masculine identification and reject her primary attachment and identification with her mother?

The following section presents a brief review of female transsexualism development. Since Stoller’s psychoanalytic theory has served as the primary source for explaining cross-gender disorders, the following section will review female transsexual development from his perspective, as well as the perspectives of John Money, a well-known researcher on sexual identification and the biology of gender. Contemporary perspectives on gender development and sexual object choice will follow.

**Female Transsexual Development**

A number of terms have been used in psychoanalytic literature to discuss sex, gender, gender role, gender identity, core gender identity, and sexual object choice. Many of these terms have been used interchangeably, which undoubtedly has served to collapse the meaning and contribute to the considerable confusion that exists today with regard to the meaning of a number of these concepts and their relationship to one another. Fortunately, the growing presence of gender-variant and sexual minority groups have elicited a need for clear and sophisticated communication with regard to the terminology used to define the concepts of gender presentation and bodily participation.

The following is a brief exploration of female transsexual development theories from a psychoanalytic perspective. Terms will be defined briefly in order to clarify
confusion when relevant. It is important to note that the area of female transsexualism development represents other theories that might be relevant for the transgender female-to-male population. Currently, no literature specifically addresses transgender female-to-male development.

Aside from a few case histories, significant attention to female transsexualism has only occurred within the past 15 years; yet, as a result of the Internet in particular (Lyons, 1986; Stryker & Whittle, 2006), as well as medical advances and social change, female-born patients have begun to request interventions to change their bodied presentation to resolve gender identity conflicts, thereby demanding a shift from neglect and maltreatment in clinical practice.

Contrary to what some may think, dissatisfaction with one’s assigned birth sex and incongruent gender role did not occur as a result of modern scientific advances that now make sex reassignment possible, nor are cross-gendered identities necessarily more prevalent in males than females (Lyons, 1986; Person & Ovesey, 1983). Of note, Lyons wrote, “Amazons are described as women who at the age of eight had their right breasts burned off so that they could fire a bow with greater accuracy (1986, p. 6).

John Money

In 1955, John Money and his colleagues were credited with identifying the differences between sex and gender by means of their work with transsexuals and intersex patients, who had formally been referred to as hermaphrodites (Denny, 2007; Person & Ovesey, 1983). Money and his colleagues were the first of many to support sexual reassignment for transsexual individuals, which led to the opening of the first clinic specializing in gender-related procedures at John Hopkins University (Lev, 2004).
From his research, Money concluded that while sex was biological, gender was psychological (Denny, 2007; Ovesey & Person, 1973). And in fact, Money was among the first to distinguish between “sex” and “gender.” and recognized that terminology describing these differences was lacking in many languages (Rosario, 2006).

Money coined the term “gender-role” in 1955 to discern the differences between sex/genitalia, sexuality, and “non-erotic” sex roles. Money and his colleagues also found that historical and sociocultural factors contribute to one’s gender identity (Rosario, 2006). In fact, gender identity is learned, is usually irreversible by 18 months, and is solidly formed by four and a half years of age (Person & Ovesey, 1983). Money summarized gender role (Person & Ovesey, 1983) as:

All those things that a person says or does to disclose himself or herself as having the status of a boy or man, girl or woman, respectively. It includes, but is not restricted to, sexuality in the sense of eroticism. Gender role is appraised in relation to the following: general mannerisms, deportment and demeanor, spontaneous topics of talk in unprompted conversation and casual comment; content of dreams, daydreams and fantasies; replies to oblique inquiries and projective tests; evidence of erotic practices and, finally the person’s own replies to direct inquiry. (as cited by Person & Ovesey, 1983, p. 205)

Later, Money clarified the broad definition of gender identity and its relationship to gender role because of the confusion and the collapse of meaning that had occurred between the two terms. Gender role, Money clarified, related to observable behavior, while identity was relevant to one’s mind:

The sameness, unity, and persistence of one’s individuality as male or female (or ambivalent), in greater or lesser degree, especially as experienced in self-awareness and behavior. Gender identity is the private experience of gender role, and gender role is the public expression of gender identity. (as cited by Person & Ovesey, 1983, p. 205)

Money and his colleagues argued that “gender differentiation is the self-designation by the child as male or female; this designation arises in agreement with
the sex of the assignment and has unconscious as well as conscious components,” which leads to the sense of self having a core gender identity (Person & Ovesey, 1983, p. 220). Most gender theorists agree that core gender identity is evident by the first year of life and unchangeable by the third year (similar to gender role identity, which is evident at 18 months and set by 4 and a half years); under the best of circumstances, core gender identity derives from nonconflictual learning experiences (Person & Ovesey, 1983).

Though Money worked extensively with intersexed children, he believed that all individuals were subject to “psychosexual neutrality” (Lev, 2004, pp. 356-357). According to this perspective, a child who was reared in a consistent manner, discrepant of their natal sex, would ultimately develop a core gender identity accordingly (Lev, 2004). It is notable that after reviewing 250 cases of intersexed children who had received no surgical interventions (Money’s dissertation, 1951), Money concluded that the children were found to be psychologically adjusted. “Far from manifesting psychological traumas and mental illnesses,” Money claimed, “… [they] not only made an ‘adequate adjustment’ to life, but lived in a way virtually indistinguishable from people without genital differences” (Colapinto, 2000, as cited in Lev, 2004, p. 363). (John Money’s unpublished dissertation is available through Harvard University’s Widener Library.)

“John/Joan” case

Money became a strong advocate for sexual reassignment surgery, even in the aftermath of the controversy surrounding the “John/Joan” case for which he was primarily responsible. In this particular case, a boy named David Reimer had had a botched circumcision; otherwise, he was a remarkably normal child. Money, however,
cajoled David’s parents to undergo a sex reassignment because David was an identical twin. Money had a natural lab to prove his theory. He was determined to prove that parent’s rearing of the child according to an attached gender label that identifies the child as either male or female was more crucial than the child’s gonads or genitals per se. Thus, David Reimer became Brenda Reimer and was raised as a female. Money wrote of his success with the twins in his famous text, *Man & Woman, Boy & Girl* (Colapinto, 2004). However, at 14 years of age, Reimer became self-identified as a male. He reportedly resisted female clothes and toys from an early age. He was teased by his peers for his masculine qualities, and he never felt as if he was a girl. Despite the fact that for several years Money had encouraged the family to rear David as a girl, David’s new identification (as a boy and not a girl) challenged Money’s argument that despite parental upbringing, David had innate underpinnings that revealed his true gender and sexuality.

David agreed to go public with his story when he learned that his case was being used to promote sexual reassignment surgery on intersex children. Because of Reimer’s denunciation of Money’s recommendations and handling of his case, the theoretical claims of “psychosexual neutrality of newborns would finally be reexamined” (Lev, 2004, p. 357). Reimer’s then-treating psychologist, Dr. Milton Diamond, was given permission by the family to document his treatment of Reimer (Colapinto, 2004), which was published in the *Archives of Pediatrics and Adolescent Medicine* in March of 1997. In this article, Diamond attested to the fact that David and his family had suffered from psychological problems, including guilt, shame, and secrecy. A series of misfortunate events would adversely affect David. In 2002, Brian Reimer, David’s twin brother, died from a toxic overdose of alcohol and antidepressants. David was also unable to heal from
his traumatic childhood, claiming that he felt sexually damaged (Colapinto, 2004). Despite monetary security from profits related to his story (told by Colapinto in his biography of David entitled *As Nature Made Him: The Boy Who Was Raised As a Girl*), David suffered from chronic turbulent family problems. Coupled with this, when his wife announced that she wanted to separate from him because of his emotional instability (particularly Major Depression), he committed suicide (Colapinto, 2004). The controversy regarding this case clearly illustrates the complexity of the psychological response to child rearing in the determination of a core gender identity, yet affirms the importance of environmental variables in shaping a child’s gendered self as paramount.

In her writings, Lev noted that the “literature is replete with examples of ‘failed’ sex reassignments” (2004, p. 357). In her discussion of the “John/Joan” case, she proffered, “In all fairness, a thorough reading of Money’s research … [shows that he was] aware of the interaction of biology and the environment, nature and nurture” (2004, p. 118).

Money’s clinical work and influence. It is important to reflect on Money’s influence on the transsexual community. In the early 1970’s, Green and Money published a clinical text based on their work at the gender clinic that had been set up at Johns Hopkins University in 1966 (Denny, 2004). This text illustrated the various programs utilized by the hospital to assist transsexuals, including “physical, psychological, and social aspects of the program the authors called ‘sex reassignment’” (Denny, 2004, p. 27). The medical model stated:

The transsexual model was primarily a medical one; it held that transsexualism was a form of mental illness. It was variously argued that the desire to change sex was caused by repressed or denied homosexuality (Socarides, 1969, as cited by Denny, 2004), perversion (Wiedeman, 1953, as cited by Denny, 2004),
masochism (Wiedeman, 1953, as cited by Denny, 2004), neurosis (Ostow, 1953, as cited by Denny, 2004), psychosis (Bastrup, 1966, as cited by Denny, 2004), character or personality disorder (Spensley & Barter, 1971, as cited by Denny, 2004), brain trauma (Blumer, 1969), or an attempt by the [male] medical establishment to render female obsolete (Raymond, 1979, as cited by Denny, 2004). Theories of causation ranged from individual psychopathology to family pathology to prenatal, perinatal, or postnatal hormone disturbances or chromosomal aberrations. (Hoenig, 1985, as cited in Denny, 2004, p. 27)

Despite the pejorative etiological formulations, transsexuals were now able to find relief and access to health care, even at the expense of being referred to as individuals “trapped in the wrong body” who suffered from a “psychic pain that could only be alleviated by bodily transformation” (Denny, 2007, p. 26). The importance of this point of view is that it allowed patients to receive interventions on behalf of a medical condition rather than a “moral problem” (Denny, 2007). The clinical advice was generally to proceed cautiously with medical interventions such as hormonal treatments and sex-reassignment. Money and his colleagues, however, found that their patients were highly resistant to therapeutic interventions (Denny, 2004). Yet, proponents argued that the best way to treat the disorder was to “treat the brain; to do otherwise constituted collaborating with the mental illness” (Denny, 2004, p. 27). Subsequently, theorists have chosen to expound upon or repudiate Money and Green’s work. For example, Stoller elaborated on Money’s coined phrase “core gender identity” to discern between femaleness and masculinity, which will appear later in this module.

*Robert Stoller’s Theory of Transsexualism*

In 1968, Stoller argued the developmental dynamics of transsexualism, which he believed derived primarily from “family imprinting” (Ovesey & Person, 1973; 1983). Stoller claimed that a “core gender identity” is developed, which is derived from: “(1) the physiology and anatomy of the genitals; (2) the attitudes of parents, siblings, and peers;
and (3) a "biological" force that interacts with the psychosocial sphere" (Greenson, 1966, Stoller, 1968, & Green, 1975 as cited in Lyons 1986, p. 23). Core gender identity and gender role identity are intimately related but are not interchangeable; that is, a tomboy is certain that she is a girl just as a boy who enjoys playing with dolls is certain of his maleness (Lyons, 1986).

Stoller addressed female transsexuality in his second volume of *Sex and Gender*, published in 1975. After 20 years of clinical experience with 13 female-to-male transsexuals, Stoller came to the following conclusions regarding the family dynamics of female-to-male transsexuals:

1) An unfeminine, not cuddly infant; 2) a feminine mother who is affectionately removed, frequently through depression; 3) a masculine father who is present, but does not support his wife in her depression, or encourage his daughter’s femininity. (as cited in Lyons, 1986, p. 12)

He believed, then, that the cross-gender girl would fall into the absentee role of the husband, and that she developed her identity as a defense against the trauma that she experienced by having a mother who was both unavailable and depressed (Lyons, 1986).

Stoller later concluded that psychological deviations of gender, whether femininity or masculinity, fell into two categories; perversion and variant (Stoller, 1996). A perverse representation of gender “implies unconscious conflict; inability to indulge a forbidden, pregenital sexual activity” and manifests in forms of “fetishistic cross-dress” (Stoller, 1996, p. 111). Perversion was further defined by Gillespie as an “a sexual erotic neurosis” that necessitates “cognitive aspects of the psyche” that are manifested by “ego and superego activities” (Gillespie, 1964, as cited by Stoller, 1996, p. 111).

However, variant representations of gender are considered as statistically abnormal, although “not a psychodynamically active, conflict-resolving state” (Stoller,
Stoller argued that sex styles and customs varied from culture to culture, and as such, they are influenced in the context of time and thus tend to be less pathologic. Gender, then, according to Stoller, is “made intra-psychically, not by society,” and he further commented:

Using these terms in a way frees one from labeling a person as perverse according to such external criteria as the sex of the object, the anatomy used, the standards of a culture, or prevalence rates, but rather according to the meaning the behavior has for its owner. (Stoller, 1996, p. 111)

As such, these sexual and gendered expressions can be viewed as “conflict-free mechanisms” (pp.111-112).

Perversion is further understood as a means for resolving unconscious conflict of desired sex objects; they are “changed intra-psychically” or reinvented (Stoller, 1996, p. 112). As a result of initial trauma from a primary object choice, one’s sexual object choice must become less threatening, which requires “disavowal, splitting, fetishization, [and] dehumanization” (p. 112). Stoller provided an extreme example of such a threat in the situation of rape whereby the rapist becomes the victor (1996). Hence, trauma is mastered when the victim becomes the victor. Such circumstances may lead one to categorize or compartmentalize a body part or object (e.g., “breasts, penis), or an inanimate object whose relationship with the original human in only symbolic, such clothing)” (p. 112).

In Stoller’s theory, core gender identity takes root in the primary stage of development, at the beginning of life when psychic structures form preverbally and later become a fixed conviction of sense of self: “I am a male” or “I am a female” (Stoller, 1996). In general, Stoller contended that this identity is dependent on the assignment of sex as well as consciousness of one’s external genitalia. He concurred with Money’s
claim that one’s core gender identity is fixed by the age of 3; yet, he asserted that masculinity and femininity continue to evolve after one’s core gender identity is established (Stoller, 1996, p. 112).

The female transsexual, according to Stoller, is anatomically normal but desires to have a male body and live in the role of a man (1996). For female transsexuals, the anatomical female has had pervasive interests in masculine traits and rarely has lived in stereotypical feminine roles (1989). Stoller further asserted that this becomes evident early in childhood and generally is “uninterrupted by episodes of femininity” (p. 118). In early to late adulthood, such female patients will request sex-change procedures and interventions that will enhance their male characteristics. Of note, Stoller found that sexually abused preadolescent girls have a high correspondence to cross-gendered behavior and gender conflict, although he acknowledged that this adverse experience does not cause female transsexualism (Stoller, 1996).

Stoller acknowledged that clinical formulations of female transsexualism were different from male transsexualism. Notably, neither parent had gender disorders (1996). He conjectured that prevalent masculinity in females suggests “too little mother-infant intimacy and a father who is all-too-present as a model of identification and not used as an object for opposite-sexed love” (1989, p. 110). At the same time, the mothers of female transsexuals were often unavailable in the earlier months due to clinical depression, and in a few instances, Stoller found that the mother-infant relationship was interrupted by the mother’s physical illness or “paranoid attitudes” (1996, p. 119). Stoller concluded that the mother’s inability to fulfill her expected maternal role resulted in significant impairments for the child (1996). In addition to the insufficient mother, Stoller
also found that “girls who become transsexuals are not considered beautiful at birth” (Stoller, 1989, p. 110). In the absence of “good enough” mothering early on, the daughter is deprived of a symbiotic relationship. Consequently, she turns to her father who is somewhat ambivalent towards his daughter unless she takes on a boy-like presentation and role (Stoller, 1989).

**Person and Ovesey and Their Contemporaries**

Person and Ovesey, who published primarily in the 1970s and 1980s, chose to expand the meaning of gender identity to include both “core gender identity” and “gender identity role” (1983, p. 206). Gender identity role refers to the identification with either masculinity or femininity. This then went beyond Stoller’s term “core gender identity,” as previously discussed, which differentiated between sex and gender (that is, the innate sense or self-identification as being male or female, p. 206).

In this context, core gender identity, the female-male polarity, reflects a biological self-image and can be defined as an individual’s self-designation of biological femaleness or maleness. It is the sense of belonging biologically to one sex or the other; that is, the conviction of: “I am female” or “I am male.” In contrast, gender role identity, the feminine-masculine polarity, reflects a psychological self-image and can be defined as an individual’s self-evaluation of psychological femaleness or maleness. It is the sense of femininity or masculinity; that is, the belief: “I am feminine” and “I am masculine,” as measured against societal standards for feminine or masculine. (Person & Ovesey, 1983, p. 206)

Person and Ovesey argued that the fundamental task for children of both sexes is disidentification and separation from the mother. They claimed, “If either the male or female child experiences enough disruption in the separation-individuation phase, each may be left with borderline features,” which result from impaired ego development. “But in the male, borderline personality may be complicated by gender aberrations” (1983, p. 216). They suggested that male transsexualism is a result of a fantasized merger
of the mother, a “defense against separation anxiety” (p. 218). In the case of transsexuals, they noted, “core gender identity is ambiguous, not unambiguously female” (p. 218). They emphasized the fact that this ambiguity is not a result of physically abnormal conditions, but rather, an outcome of conflict that occurs during the separation-individuation phase (1983). During this phase, both sexes fear merger with the mother. They concluded:

Normal core gender identity arises from the sex of assignment and rearing. It is nonconflictual and is cognitively and experimentally constructed. On the other hand, gender role identity, both normal and aberrant, is shaped by body, ego, socialization and self-discrepant object relations. Unlike normal core gender identity, it represents a psychological achievement and is fraught with psychological conflict. (Person & Ovesey, 1983, p. 222)

Pauly reviewed 80 different cases of female transsexuals in a literature review. Though family dynamics were not always present, he found that mothers were emotionally distant 80% of the time, cold and rejecting 36% of the time, but yet, 83% of the time, the child perceived a need to protect the mother from the fathers (as cited by Lyons, 1986). The fathers were typically abusive and “hypermasculine.” A significant number of them were alcoholics (64%), sexually abusive (22%), or emotionally troubled (60%) (Lyons, 1986). Interestingly, the father was perceived to encourage masculine behaviors more often than the mother (60% as opposed to 22%) (Lyons, 1986).

In one study of 20 subjects conducted in Singapore, female transsexuals did not appear to have the same psychodynamic origins as Pauly’s research findings (Tsoi & Kok, 1980, as cited in Lyons, 1986). Lyons remarked that Pauly’s findings suggest similar developmental backgrounds between female transsexuals and borderline patients, thus making it difficult to discern the cause of transsexuality with the one
distinction that borderline patients in general do not tend to experience confusing
messages about their gender (Lyons, 1986).

Pauly found that a preferred masculine role emerged as early as the second year
and as late as the early teens. Girls were likely to experience troubles during menstruation
and tended to cross-dress during puberty (Lyons, 1986). The majority of them dated boys
and 48% had had intercourse (Lyons, 1986). Pauly’s findings collaborated with research
conducted by Ehrhardt, Grisanti, and McCauley (1979) as both noted that cross-dressing,
gender confusion in adolescence, and a negative reaction to breast development and
menarche were all significantly higher in the female transsexual (Lyons, 1986, p. 15).
Until 1985, most research suggested that female-to-male transsexuals were involved in
heterosexual partnerships. However, Blanchard was perhaps the first to infer that
homosexual object choice for female transsexuals is likely to be as prevalent as it is in
homosexual male transsexualism.

In research conducted by Murray in which the goal was to measure female
aggression, “clear indications of borderline character structure[s] on the Rorschach of 25
male transsexuals” were found (as cited in Lyons, 1986, p. 16). Psychological testing of
transsexuals found that they tend to be more aggressive, demonstrate poorer object
relations, and tend to have impaired reality testing as well as diffused boundaries (Lyons,
1986). Murray’s work was further substantiated in 1984 by Lothstein, who concluded that
from his research that transsexuals tend to have borderline features and use more
primitive defenses, such as projection (Lyons, 1986).

In research conducted in 1977, Buck found that gender pathology was evident,
and she was able to trace transsexual symptomology back three previous generations,
thus suggesting a different perspective on the origins of female transsexuality beyond the idea of the “unavailable mother” (as cited in Lyons, 1986). Lothstein then elaborated on this idea, submitting that mothers use their daughters as a “container for her own bisexual conflicts, gender confusion, aggression, and hatred of her own femininity, harboring murderous impulses toward her offspring” (as cited in Lyons, 1986, p. 18). The daughter then has no other choice but to identify with the opposite sex. A second scenario is that a daughter does not merely fear her mother’s aggression, but rather, resents her weakness (Lyons, 1986). Therefore, if she identifies with her mother, she will not be able to defend against her father’s aggression (Lyons 1986).

Stoller and Lothstein both inferred that the female transsexual presumes such a position to defend against the father by identifying with gendered notions of masculinity, and thus, the daughter is unable to establish an emotional connection with her mother (Lyons, 1986). However, Limentani argued in 1979 that a girl’s identification with masculinity mirrored more than simply an identification with her father and further characterized the relationship as one in which her father encourages masculinity (as cited in Lyons, 1986). Thus, her separation anxiety in combination with “her fears of engulfment” renders her “unable to experience her body as her own” (as cited in Lyons, 1986, p. 18). An identification with the mother prevents a merging with her mother, yet allows her to “avoid separation anxiety” (Lyons, 1986, pp. 18-19).

Several psychoanalytic theorists have claimed that female transsexual development lies in the preoedipal developmental period (Limentani, 1979; Lothstein, 1983; Person & Ovesey, 1974a, 1974b; Socarides, 1979; Volkan, 1979, as cited by Lyons, 1986). Stoller and Pauly found this evidence in a withdrawn and depressed
mother (Lyons, 1986). From their perspective, the mother is devalued for not having a penis; yet, a penis would help the girl to separate from her mother while at the same time establish a way for her to connect with her as with her masculine identification (her penis). Volkan also suggested that female transsexualism illustrates primitive defensive postures of splitting:

The pretranssexual child attempts to isolate good and bad part-objects by divorcing herself from the “bad” mother-object and identifying with the “good” father representation, the penis. Thus, she splits from the bad object and maintains the good or perfect self-object as well as a connection to the mother. (Volkan, as cited in Lyons, 1986, p. 19)

Many traditional psychoanalytic theorists, Volkan, for example have argued that transsexuals demonstrate a borderline characterological organization, and in fact, transsexuals tend to encompass such personality traits as well as having cross gender identifications (Lyons, 1986). According Lyons, the development of transsexuality is likely to be marked by Margaret Mahler’s Separation-Individuation phase, which occurs in the preoedipal phase, a period of time in which the core gender identity is shaped by dyadic relations (1986). Lyons remarked that these formulations were primarily seen as stemming from the external environment (family dynamics) rather than an internal object relations perspective. Lyons compared female transsexuals to lesbians, considering the components of gender identity: core gender identity, sex roles, and sexual orientation. Her findings concluded that female transsexuals are no more identified with their fathers than other daughters. She also claimed that there is no evidence of primitive internalized object relations. She submitted that female transsexuals have a masculine core gender identity, complimentary to masculine gender identity/sex roles, and this core gender
identity is the result of complex interactions that do not derive from parental relations (Lyons, 1986).

The aforementioned theoretical formulations of gender and sexual identity, as well as female transsexual development, have been presented from a traditional perspective. The following section explores contemporary formulations of gender, gender and sexual identity development with an emphasis on transgender female-to-male and gender-variant individuals. Of note, most of the literature to date has not been written specifically for transgender female-to-male individuals, however an attempt to reflect upon this position will be presented.

*Contemporary Psychoanalytic Thought*

The purpose of this manual is to examine feminist and queer theory and contemporary psychoanalytic perspectives that reflect how various disciplines are either complimentary or offer divergent views of gender identity development, gender roles, and sexuality. The underlying premise of this manual is that, although gender may, in fact, derive from an innate predisposition, the meaning of gender for the patient, as well as for the clinician, is best understood when evaluating the social construction of gender for that particular person: i.e., “the practices of language, culture, and psyche” (Dimen & Goldner, 2002, p. xvii). This manual presents and brings to the forefront literature that is both relevant and theoretically useful in an effort to advance technique when providing female-to-male or gender-variant individuals psychoanalytic treatment. It is not this author’s intent to promote one theory over another.

The following is a review of contemporary psychoanalytic feminist gender theorists’ perspectives, which marks a notable shift from traditional psychoanalytic
formulations in the development of gender, gender identity, gender-role, and sexual identity development. Dialectical tensions and limitations between modern and postmodern perspectives are also presented here. In the modernist view, for example, gender is derived from constitutional factors that establish a core-self; whereas postmodern perspectives claim that gender is fluid and profoundly influenced by internalized cultural experiences. An emphasis is placed on the cultural and theoretical aspects of gender, as well as exploring constructed subjective narratives and their clinical implications.

The first important theorist on this subject is Judith Butler, who is acknowledged as a pioneer in developing the postmodern perspective. In her book Gender Trouble, which was published in 1990, Butler introduced the literary analysis of gender to academic circles wherein she challenged traditional perspectives on gender and sexuality. Her revolutionary ideas continue to invite theoretical scholars to consider how gender (binary gender—male and female) is co-constructed as a result of the primary love object relations. In Butler’s view, gender is more than a social construction; it is a transparency that overlays the sexed body, which is unequivocally influenced by culture (Stukes, 2001). According to Butler:

Gender replaces sexual biology because “there is no reference to a pure body which is not at the same time a further [cultural] formulation of the body.”… Gender is not a natural structure interior to subjectivity but an effect of external linguistic and cultural practices (as cited in Stukes, 2001, p. 393).

Butler argued that the “process of internalization actually produces internality and the ‘distinction between the psychic and social’” (cited in Stukes, 2001, p. 393). Gender, then, “materializes the subject,” is an organizer to the observer, and yet, is “arbitrary and elastic” (Stukes, 2001, p. 393).
Queer theory, which has evolved from lesbian/gay studies and feminist critiques of heterosexuality and patriarchal gender relations, has, in fact, made a significant contribution to psychoanalytic treatment and relational therapy (Kassoff, 2004). It challenges dominant theories of norms among theoretical schools, including psychoanalysis, with regard to gender identity, gender roles, and sexual orientation (Kassoff, 2004).

Corbett, along with most postmodern theorists, accepts the definition of queer offered by French sociologist Michel Foucault’s: an “ideal nonnormative, noncentral citizen, who is generally, though not exclusively, encoded as homosexual, and who articulates his own set of cultural imperatives and introjections, including his own brand of mental freedom” (as cited in Corbett, 2001, p. 315). Corbett, himself, characterized queer as a “late-20th-century reappropriation of a pejorative term for homosexuality,” claiming that “such reappropriation represents the efforts of theorists and activists to assume and empower a marginal position” (2001, p. 314). Further, he asserted that “the aim of vigorously occupying the margin, and boldly being out of step, is to shift the homosexual from the object who is known (the investigated invert) to the subject who knows (the interrogating queer)” (Corbett, 2001, p. 314). Corbett’s ideas will be further elaborated in a later section of this module.

Relational theory, on the other hand, offers a divergence from traditional psychoanalytic thinking in understanding the human experience from biological and innate underpinnings to consider the matrix of the relational context of the patient. With regard to relational theory, Kassoff asserted that it is an “outgrowth of a theoretical shift from a one-person to a two-person psychology, in which the analyst is not just an
observer of the patient” (2004, p. 160). From this perspective, Kassoff argued, Freudian psychoanalysts rely on incomplete and dated theories that fail to consider the intrapsychic value of the therapeutic relationship or the social context (e.g., not all individuals are raised in the “mother, father, child” traditional family). These shortcomings in psychoanalytic formulations also fail to consider the patient’s internal world and fantasied meanings (Kassoff, 2004).

Queer and relational theory have influenced each other and can benefit from one another. They are “capable of passionate connections that can illuminate some of the shadowy corners of our ideas about both gender and psychoanalysis” (Kassoff, 2004, p. 160). Many theorists—including Benjamin, Butler, Corbett, Dimen, and Harris—are openly debating feminist, queer, and psychoanalytic perspectives on gender identity by considering the contradictions between “fluid ideas about gender and normative ideas about mental health” (Kassoff, 2004, p. 160). Goldner and Dimen proffered that “gender identity is a universal false self in compliance with a culturally required two-gender system” (Kassoff, p. 163); whereas, Harris challenged early gender development theories that insist that gender must be “fixed,” suggesting instead that “gender can be coherent but can also mutate over time” (p. 163). For their part, Corbett, Frommer, and Layton emphasized the importance of “subjective experiences of gender, heterosexual, masculine/feminine, active/passive, at the cost of articulating diversity and multiplicity” (p. 163). These new formulations are beginning to serve as a revised blueprint for clinicians to utilize when facilitating treatment (Kassoff, 2004). These theorists’ ideas will be discussed later in this module.
Kassoff wrote, “First, I suggest that queer has superceded the designations of lesbian, gay male, bisexual, and transgender as ‘essential’ psychological (if not sociopolitical) identities, and includes ‘nominally’ heterosexual experiences” (2004, p. 161). She continued by noting that queer theory tends to tease apart one’s identity, by “unpacking ‘our common sense’ ideas of what is unconsciously collapsed into the designation of sexual identity” (p. 162). Sedgwick claimed that:

[Multiple] variables are expected to align along binary poles of male and female, including: chromosomal sex, self-perception of biological sex, masculinity and femininity, being the opposite on all these dimensions of your partner, preferred sexual acts (insertive or receptive), procreative choice (yes if straight, no if queer), sexual fantasies (dominant or submissive), and locus of emotional bonds (should be consistent with sex and sexual orientation). [And,] If these identities are not seen as not strictly consistent to these assumptions, ‘that’s one of the things queer can refer to: the open mesh of possibilities, gaps, overlaps, dissonances and resonances, lapses and excesses of meaning when the constituent elements of anyone’s gender, of anyone’s sexuality, aren’t made or can’t be made to signify monolithically.’ (as cited in Kassoff, 2004, p. 162)

Therefore, from the perspective of queer theory, an emerging identity can become convoluted by different thoughts (e.g., a lesbian with heterosexual sexual desires) and actions (having sexual relations with a man); yet, such contradictions are expected and become a part of one’s unique self-constructed identity (Kassoff, 2004). “One of the most powerful effects queer theory has had on relational psychoanalysis,” Kassoff stated, “is what I call the queering of sexual identity stories” (p. 163).

Kassoff further argued that there are several theoretical claims for gender and sexual development, “including the principle of multiple and shifting identifications and outcomes, and gender development as a compromise formation that reflects cultural splitting” (2004, p. 161). Yet, Bell (2004), offering a somewhat different view, suggested that contemporary psychoanalytic theory “returns to the radicalism of Freud and claims
that mature gender involves the capacity for more fluidity, less splitting, and less rigidity in terms of gender, the body, and sexuality” (p. 148). Bell believed that one should have the freedom to play with gender categories and not feel constricted or constrained by them.

For their part, Chodorow and Benjamin were the first to recognize that gender is both cultural and personal, and they challenged the traditional perspective of heterosexual developmental theories of the psychosexual stage model, which, they argued, tended to merge core gender identity, gender role, and sexual object choice, thus diluting the distinct meaning of these terms. As Dimen and Goldner (2001) noted:

Benjamin (1988) strategically deployed the conceptual remains of polarity “masculine/femininity” into profound questions about underlying “either/or, subject/object” logic of the gender binary itself, while Butler (1990) shifted theoretical attention from the reified “body” to the creation “embodiment,” for example, in her influential view of gender as a “melancholic masquerade.” (Dimen & Goldner, 2001, p. xviii)

Chodorow and Benjamin took issue with the idea of “‘achieving’ heterosexuality through rigid splitting of masculinity and femininity, heterosexuality and homosexuality, assertion and recognition” (as cited in Kassoff, 2004, p. 163). These contemporary theorists incorporated postmodern, feminist, and queer theories into their thinking, all of which debate gender’s nature in both social and individual contexts, gender as it relates to the nature of the self, and finally, gender’s relationship of the body and to sexuality (Bell, 2004). In addition, they considered the current social context in which gender is enacted; that is, for example, women are now more likely to take on stereotypical male roles (e.g., professional careers and politics), while men feel freer to take on domestic roles that are more traditionally female (Bell, 2004). This cultural context also encompasses issues of
gay, lesbian, bisexual and transgender identities, including improving the quality of life for these individuals (Bell, 2004). In 1984, Irene Fast argued:

There is a distinction between objective gender, observed differences in personality, character, or behavior, that tends to differentiate and characterize the sexes, and subjective gender, personal constructions of masculinity and femininity, that constitutes one’s sense of self as gendered. This is important, because it expands our understanding of gender and the ways individuals actually experience it. We understand gender to be both individual and social, but always both. (Bell, 2004, p. 159)

Chodorow and Benjamin noted that gender development is remarkably influenced by a postoedipal phase (Bell, 2004). They argue that a healthy gender includes “one in which individuals need not solely accept the limitations of their gender but may instead sometimes experience themselves as multiply gendered, and other times as only one gender” (as cited in Bell, 2004, p. 158). They also attempted to understand the psychology of gender stemming from biological predispositions with a revisited focus on the body and sexuality, as well as the unconscious factors that shape one’s individual gender identity (Bell, 2004). That is, we may belong to a particular cultural context/group, while at the same time, manifesting varied-gender identifications and behaviors. Chodorow wrote that our unconscious motivates and personalizes divergent “versions of gender, the body, and sexuality” (as cited in Bell, 2004, p. 158). Chodorow further elaborated that, “the existence of cultural and social gender inequality does not explain the range of fantasy interpretations and varieties of emotional casting women (and men) bring to this inequality to account for deviations of gender” (as cited in Bell, 2004, p. 160). The variability in the interpretation of gender provides a basis for understanding the complex relationship between gender, culture, race, and class (Bell, 2004), and one
can see that a broader social context serves to cocreate individual meanings, which traditional psychoanalysis failed to address. That is:

[It expands] our understanding of gender to include cultural, social, familial, and individual aspects. [C]ontemporary feminist psychoanalytic theory focuses on understanding how we can escape from dichotomous categories of gender described and explained so convincingly by second-wave feminists. They do so by borrowing from postmodern (Foucault) and queer theorists Butler, Lauretis, and Sedgewick. Queer and postmodern theorists argue that the dichotomous categories of masculine-feminine, subject-object, active-passive, contained-container, autonomy-dependency constitute our selfhood [while] at the same they severely limit it. (Bell, 2004, p. 160)

These restrictions tend to marginalize the human condition, while at the same time ostracizing diversity amidst our conscious identifications and their behavioral manifestations.

Contemporary theorists tend to view earlier theoretical claims as limited. One such theorist, Donna Bassin, recognized the significance of postoedipal development on gender identity. She claimed that embracing one’s gender includes incorporating cross-gendered aspects of ourselves. She contended that “ego states of transitionality,” wherein the mind and body play with reality, symbolizes the cross-gendered identifications that exist within our polarized gendered selves (Bell, 2004; Dimen & Goldner, 2002, p. 162).

With regard to “arriving” at a gender identity, theorists such as Benjamin and Goldner submitted that a stable gender identity is, in fact, a developmental “accomplishment” that involves a pathological process of splitting (Bell, 2004). Specifically, in this phase a child “develop[s] categories of thinking, that organize his or her experiences—male and female, black and white, can and cannot, subject and object, active and passive, and so on” (Bell, 2004, p. 160). Some have argued that for children
this task is appropriate; whereas, for adults, such developmental arrest does not
necessitate mental health. In fact, Bell stated:

The insistence on black-and-white thinking, splitting, and polarization is not
characteristic of mental health but of psychological pathology. There is some
evidence that rigid sex typing leads to behavioral inflexibility and difficulty
adapting to unfamiliar situations for both men and women, certainly not a
hallmark of mental health. (2004, p. 161)

Bell continued by stating that such rigidity, and defensive splitting, adversely affects
women, in particular, in their social environment (Bell, 2004).

*Judith Butler*

Butler argued that gender and sexuality are often unconscious, culturally scripted
performances of dominant norms (Kassoff, 2004). From her point of view, our gender
and sexuality are constructed as a result of not only who “we are allowed to love, but also
in whom we are *not* allowed to love” (as cited in Kassoff, 2004, p. 163). Thus, gender
identities are developed, in part, by societal expectations: “boys become men through sex
with girls, not boys; girls become women through sex with men, not girls or women”
(Kassoff, 2004, p. 163).

Butler pointed out a contradiction in Freud’s theories: first, in 1917, he claimed
that “grief could be resolved through a decathexis, a breaking of attachment, as well as
the subsequent making of new attachments” (Butler, 2002, p. 4). Yet, 6 years later in
1923, Freud postulated in *The Ego and the Id* that “melancholic identifications may be a
prerequisite of letting go of the object” (p. 4; emphasis added). With regard to this
complex and disputed issue of attachment, Butler offered the following:

For there is no final breaking of the attachment; there is rather, the incorporation
of the attachment as identification, where identification becomes a magical,
psychic, form of preserving the object. And, insofar as identification is the
psychic preserve of the object and such identifications come to the form of ego,
then the lost object continues to haunt and inhabit the ego as one of its constitutive identifications and is, in that sense, made coextensive with the ego itself. (2002, pp. 4-5)

She continued:

There is no full abandonment of the object, only a transferring of the status of the object from external to internal; giving up the object becomes possible only on condition of a melancholic internalization or, what might for our purposes turn out to be even more important, a melancholic incorporation. (2002, p. 5)

From this perspective, loss is preserved in the psyche as a result of internalized disavowed identifications (Butler, 2002). Therefore, “if the assumption of femininity and the assumption of masculinity proceed through the accomplishment of a tenuous heterosexuality, we might understand the force of this accomplishment as the mandating of the abandonment of homosexual attachments” (2002, pp. 5-6). Gender, then, is not a predisposition, as Freud had claimed, but rather, an “accomplishment’ of gender through heterosexual positioning,” which is not without consequence (p. 6). Butler noted “There are losses that accompany mandatory heterosexuality that are not grieved. This results in a ‘culturally prevalent form of melancholia,’ or disavowed grief, which can result in a defensive form of gender anxiety” (as cited by Kassoff, 2004, p. 163). As such, “threats to heterosexuality become threats to gender itself” (Butler, 2002, p. 6). From this explanation, one can better understand the context for such a denunciation of homosexual attachments and how it becomes a trajectory for heterosexual aim and development (2002). In the case of the female child, she will, then, reject her sexual and libidinal desires toward her mother and shift them toward her father. Subsequently, she will shift her desires toward her father and eventually transfer them to other men. Butler argued:

For if we accept the notion that the prohibition on homosexuality operates throughout a largely heterosexual culture as one of its defining operations, then it appears that the loss of the homosexual objects and aim (not simply this person of
the same gender, but any person of that same gender) will be foreclosed from the start. (Butler, 2002, p. 9)

Butler’s use of the term “foreclosure” was intentional as a portrayal of the complete prohibition and disavowal of a nonheterosexual love and further suggested that this “foreclosure had consequences that went far beyond individual melancholia and loss:

When certain kinds of losses are compelled by a set of culturally prevalent prohibitions, then we may well expect a culturally prevalent form of melancholia, one that signals the internalization of the ungrieved and ungrievable homosexual cathexis. And where there is no public recognition, or discourse through which such a loss might be named and mourned, then melancholia takes on cultural dimensions of contemporary consequence. (2002, p. 9)

Therefore, it could be concluded that the greater the grief, the more a person identifies rigidly with their gender, and the more masculine or feminine they become in accordance with their assigned sex at birth (2002). Heterosexuality, then, is acquired as a result of defending against homosexual attachments. A disavowed grief, then, introjects such love as if it could never happen. Butler contended that there is possibly a more culturally sensitive approach to understanding this process:

When the prohibition against homosexuality is culturally pervasive, then the “loss” of homosexual love is precipitated through a prohibition that is repeated and ritualized throughout the culture. What ensues is a culture of gender melancholy in which masculinity and femininity emerge as the traces of an ungrieved and ungrievable love—indeed, where masculinity and femininity within the heterosexual matrix are strengthened through the repudiations that they perform. In opposition to a conception of sexuality that is said to “express” a gender, gender itself is here understood to be composed of precisely what remains inarticulate in sexuality. (Butler, 2002, p. 10)

Butler then tied this repetitive conditioning to the development of guilt whereby internalized superego ideals—in this instance, homosexual attachments and actions—punish the ego (2002). Butler argued from Freud’s perspective, “It is not that one treats oneself only as harshly as one was treated but, rather, that the aggression toward the ideal
and its unfulfillability is turned inward, and this self-aggression becomes the primary structure of conscience: ‘by means of identification [the child] takes the unattackable authority into himself’” (Freud, as cited in Butler, 2002, p. 12). Butler continued to elaborate on this idea of melancholia, noting that “in the superego, [it] can become a gathering place of instincts, … [thus], when the melancholy is the refusal of grief, it is also always the incorporation of loss, the miming of the death it cannot mourn” (2002, p. 12). Further, “the prohibition on homosexuality preempts the process of grief and prompts a melancholic identification that effectively turns homosexual desire back onto itself” leading to “self-beratement and guilt” (2002, p. 12).

Although, Butler illustrated the consequence of “compulsory production of heterosexuality,” she also cautioned that any rigid forms—homosexual or heterosexual—with regard to gender and sexual identification result in melancholy (Butler, 2002, p. 13).

In her book, *Gender Trouble*, Butler submitted that gender is, in fact, largely performative; that is, in spite of innate predispositions, gender is basically produced and enacted according to conventional norms, which, clearly, are complimentary to heterosexual gender performances. She wrote, “there is no gender that is ‘expressed’ by actions, gestures, or speech, but that the performance of gender was precisely that which produces retroactively the illusion that there was an inner gender core” (2002, p. 13).

Butler offered the propensity towards cross-dressing or drag as an illustrative example of this point: we can see how “psychoanalysis [is] linked to gender performativity and how performativity is linked to melancholia” (2002, p. 14). Yet, Butler noted, “Psychoanalysis insists that the opacity of the unconscious sets limits to the exteriorization of the psyche” (2002, p. 14). Another way to look at cross-dressing (as a
performance) from a psychoanalysis perspective is to perceive it as “what is barred from the performance, what cannot or will not be performed” (p. 14). Butler further clarified the context for understanding drag as a performance:

The relation between drag performances and gender performativity in *Gender Trouble* went something like this: when it is a man performing drag as a woman, the “imitation” that drag is said to be is taken as an “imitation” of femininity—the “femininity” that is imitated is not itself understood as being an imitation at all. And yet, if one considers that gender is acquired, that it is assumed in relation to ideals that are never quite inhabited by anyone, then femininity is an ideal that anyone always and only “imitates.” Thus, drag imitates the imitative structure of gender, revealing gender itself as an imitation. (2002, p. 14)

Butler acknowledged that this explanation of gender identification as a performative concept is somewhat limited in scope. That is, it does not consider how “forms of disavowal and repudiation come to organize the performance of gender,” nor how the phenomenon of gender melancholia is related to the practice of gender performativity (2002, p. 14). Butler then speculated that perhaps this performance can be understood from a psychoanalytic conceptualization of “acting out,” which is related to the denial of loss (2002, p. 15). “Where there is an ungrieved loss in drag performance,” Butler wrote, “perhaps it is a loss that is refused and incorporated in the performed identification, one that reiterates a gendered idealization and its radical uninhabitability” (p. 15). She further elaborated:

What it does suggest is that the performance allegorizes a loss it cannot grieve, allegorized the incorporative fantasy of melancholia whereby an object is phantasmatically taken in or on as a way of refusing to let it go. Gender itself might be understood in part as the “acting out” of unresolved grief. (p. 15)

Therefore, gender play and enactment can be viewed as an attempt to negotiate a cross-identification. Butler stressed that this interpretation is not an attempt to understand
or explain homosexuality, but it suggests an adaptive way to “allegorize[s] some set of melancholic incorporative fantasies that stabilize gender (p. 15):

Drag exposes or allegorizes the mundane psychic and performative practices by which heterosexualized genders form themselves through the renunciation of the possibility of homosexuality, a foreclosure that produces a field of heterosexual object at the same time as it produces a domain of those whom it would be impossible to love. Drag thus allegorizes heterosexual melancholy, the melancholy by which a masculine gender is formed from the refusal to grieve the masculine as a possibility of love; a feminine gender is formed (take on, assumed) through the incorporative fantasy by which the feminine is excluded as a possible object of love, an exclusion never grieved, but “preserved” through the heightening of feminine identification itself. In this sense, the “truest” lesbian melancholic is the strictly straight woman, and the “truest” gay male melancholic is the strictly straight man. (2002, p. 16)

Therefore, drag, from Butler’s perspective—or other gender-“deviant” enactments—can be considered gender melancholia as a result of loss rooting in conventional claims that homosexual or gender-variant longings are aberrant. Such beliefs are subsequently taken in to the point of “acting out” (Butler, 2002). Butler concluded that one becomes gendered by the psychical process of melancholia resulting from culturally ascribed conventional attitudes.

How, then, can we make use of Butler’s ideas that gender is the consequence of culture? Is it possible that transgendered individuals simply revolt against such cultural mores by performing—or acting out—unorthodox and unaccepted gender behavior that tends to disorganize and shock heterosexual and homosexual individuals, calling into question their own gender and sexual identity? Considering Butler’s ideas for female-to-male individuals, femininity is a “disavowed” identification and the repudiation of a homosexual attachment, which ultimately leads to masculine identifications in an effort to preserve the loss of the father. On the other hand, perhaps, does Butler’s theory suggest that a transgender identity is an effort to renounce or
“repudiate” “her” own homosexual attachment to her mother? Whatever the case, it could be argued that such gendered presentations become “unperformable” in the center of both heterosexual and homosexual worlds of gendered expectations. Another issue at work here is how these ideas infer both a gendered development as well as sexual identity development; as for the female-to-male individual the meaning of gender in relation to one’s sexual relationships needs to be considered as it cannot be presumed to be heterosexual.

*Muriel Dimen*

Like Butler, Dimen’s work is rooted in feminist and psychoanalytic theory. In Dimen’s view, gender is an incorporation of cultural representations, which inevitably organizes the self (Dimen, 2002). In her essay, *Deconstructing Difference: Gender, Splitting, and Transitional Space*, Dimen attempted to understand anatomical differences in gender both by analyzing a “set of relations” and claiming that “at the heart of gender is not ‘masculinity’ or ‘femininity’ but the difference between them” (2002, p. 41). Gender can be best understood in terms of splitting; that is, splitting off the ego and splitting off the object by occupying the transitional space between masculinity and femininity. “What gender seems to denote is one thing; what it actually connotes is another” (p. 42). A clinician’s ability to deconstruct gender is best achieved by analyzing the inner psychic life of a patient. That is, “‘gender’ denotes the psychological and social dimensions of the biological category of sex” (p. 42).

[The] category of sex is not transparent but it is itself a dense weave of cultural significance, and the contrast masculine/feminine, as the representation of what psychoanalysts commonly refer to as “the anatomical difference,” addresses a variety of matters, not all of which are germane to sex, gender, or the genitals. (p. 43)
She expounded further, “This slippage from sex to culture not only provides us with our understandings of gender as personally experienced but informs gender as social institution” (Dimen, 2002, p. 43). The ramifications, in Dimen’s view, are even greater:

Another elision, equivalent in power to that from sex to culture, informs what we might term the mutual definition of selfhood and gender identity, such that problems of self may come to be coded in terms of gender, and those of gender, terms of self. (p. 43)

Dimen’s point here is an important one: the “self and gender inhabit one another.” For instance, an emotion might be organized intogendered categories (p. 43). Subsequently, one may lose aspects of oneself through such identifications. Dimen argued that this problematic relationship of selfhood and gender identity would not arise if they were structurally different. She argued:

The intrapsychic proximity of sense of self to sense of gender identity often obscures, not to say deepens, the complexities of gender representation generated. At the same time, the contrast masculine/feminine, by collapsing many representations of selfhood that are unrelated to gender, can disguise, and even create, dilemmas of self as well. (p. 43)

Dimen noted that conventional splits in masculinity and femininity are mirrored both in culture and in psychology: Pleasurable activity finds meaning in masculine accomplishment, whereas pleasure achieved in passivity is based on the feminine. Such dichotomous sex role behavior has been interpreted clinically as “splitting”: a man’s fear of being feminine and a woman’s fear of being masculine. A patient’s behavior, then, may be seen as ego-dystonic. At times, we feel “out of gender,” and, consequently, an anxious response is elicited that can typically be categorized into a strong identification of feeling masculine/strong or feminine/weak (Dimen, 2002, p. 44).

Thus far, Dimen has noted the alignment of femininity with passivity and masculinity with activity, illuminating the ubiquity of these dichotomous relationships:
“masculine/feminine and to each other as well—self/other, preoedipal/oedipal, infancy/adulthood, autonomy/dependency, superiority/inferiority, heterosexuality/homosexuality” (2002, p. 45). Gender is no longer an absolute entity, but rather, a “set of interacting forces, so gender looks to consist not of essences but of complex and shifting relations among multiple contrasts of differences” (p. 45). At times, these “contrasts remain distinct, at other times they intersect, and at still other times they fuse and exchange identities” (p. 45).

In some instances, issues around self and gender are impacted by how activity and passivity are related to sexual difference. For example, a woman may become uncomfortable with her own “activity,” which could elicit unwanted anxiety; that is, she may become anxious or uneasy as a result of being active (i.e., masculine), and from a psychoanalytic perspective, this may illicit fears of homosexuality or dependency (Dimen, 2002). Conversely, “gender-neutral qualities of self, such as activity and passivity, can reciprocally organize and thereby evoke sexual and gendered splits” (p. 45). In other words, remaining neutral may circumvent the need to identify with or desire the other gender. A defensive posture against painful affects may take the gendered form and role of an individual stuck between masculinity/masculine and femininity/feminine. Because of previous dynamic relations, then, these individuals may remain split in other aspects of their lives, e.g., internally in their body or mind or externally in the workplace. The therapeutic relationship is not exempt: splitting is also likely to occur in the transference/countertransference therapeutic dyad (Dimen, 2002).

Dimen (2002) argued that the developmental trajectory of gender is the result of multiple cultural messages of difference, that is, one introjects dichotomous messages of
masculinity and femininity exchanged through relational dynamics. She asserted that if one only looks at the polarities of femininity and masculinity rather than the “contrasts” between them, one sees the gender as “fixed essences.” However:

[If] we enter the space occupied by their difference, we can see more clearly other differences that, though not necessarily related to sex, in fact secretly construct gender. What I have done in that space is examine the gender dualism as it shiftingly intersects other dualisms, any pole of which, rigidly clung to, may also signal splits in the self. (p. 50)

Gender identity may, in fact, disguise splitting; yet, a “focus on the space between the poles can reveal and help to dismantle these splits” (p. 50).

Dimen has provided us with another important dichotomy between masculine and feminine in which the male is equated with “I want,” and the female is equated with “I want to be wanted”:

Our culture has two patterns for desire, one for males and another for females. The first pattern honors, masculinizes, and makes adult the felt experience of “I want.” The second demeans, feminizes, and infantilizes the state of being wanted, the felt experience of “I want to be wanted.” This dualism between wanting and wanting-to-be-wanted intersects not only the contrast masculine/feminine but that between subject and object and results in a primary contradiction that I have termed “Subject-as-Object.” (Dimen, 2002, p. 50)

She further elucidated this idea of subject as object, writing: “Subjects, in our cultural and intrapsychic representations, are men. The subject says, ‘I want.’ The subject, ‘Man,’ desires” (p. 50). Though men acquire power by being empowered subjects, women are also subjects. Yet, “At the same time through splitting that occurs equally on cultural and psychological levels, women are also expected to be objects” (p. 50). The term object here is not the analytic concept of internalized intrapsychic objects, but rather, it signifies “thing” in cruder sense. “As inanimate things, women are represented to be without desire, to be targets of the subject’s desire. If subjects want,
objects are there to be wanted” (2002, pp. 50-51). From this perspective, women develop femininity as a result of a “compromise formation,” the expectation that women are expected to be both subjects and objects (p. 51). This dual-edged femininity creates its own dilemma—“the subject of one’s own desires,” yet, one that is not dependent as an “object of being desired by others”; thus, it is “torn or suspended between two positions” (Dimen, 2002, p. 51).

Dimen also addressed the aggression that exists relationally between women. She illustrated this female hierarchy in the following example of a female clinician treating a female patient:

[T]he juncture of caring and authority is one member of the dyad, that is, the analyst, painfully juxtaposes the most primitive dimensions of the mother/daughter relationship to the complications of femininity’s social construction. The profound longing for maternal nurturance conflicts with an equally deep repudiation of women’s subjectivity and authority, itself rooted in simultaneously, infantile love, and hate, gender-identity formation, and conventional sexual stereotyping. (Dimen & Shapiro, as cited in Dimen, 2002, p. 53)

Dimen submitted that a cohesive nurturing relationship may, in fact, be nothing more than an anxious response or a reaction formation to preoedipal destructive wishes to destroy or compete with the mother. This relational style may then inhibit a therapeutic exploration of unresolved aggression and evokes a “false mutuality” or “merging a common solution to splitting” (2002, p. 53).

The answer to splitting is never simply the recall of the forgotten pole of any split but, in [Benjamin’s] phrase, the tension of holding “the paradox of simultaneity.” This paradox is essential to both development and treatment and is a paradox that is potentially pleasurable, as it represents the Winnicottian transitional space where play occurs. ... Play being laborious when splitting dominates (Winnicott, 1971), when the ‘inability to “play with reality… result[s] in using reality as a defense against fantasy.” (Bassin, as cited in Dimen, 2002, pp. 54-55)
This simultaneous holding, Dimen argued, is “intrapsychic as well as intersubjective.”

The pleasure of play “lies in the repeated oscillation between reality and fantasy; indeed play loses its piquancy when it settles into either reality” (2002, p. 55). Dimen refuted Laplanche and Pontalis’s (1973) argument, which stated:

Within desire, this pleasurable oscillation takes place between want and need. Desire is conventionally defined as [a] wish, emergent in the psyche, and is thereby absolutely distinguished from need, rooted in drives. (as cited in Dimen, 2002, p. 55)

In contrast, Dimen wrote:

I see the longing that characterizes desire as engaged with both want and need. … In other words, adults split. Via the intersection of the contrast want/need with adulthood/infancy, activity/passivity, and masculinity/femininity, they effect what I have termed the gendered divorce of want from need with undeniable, serious consequences for their own wellbeing. (pp. 55-56)

Dimen remarks that although our mental health is typically viewed by our needs being inferior to desire, she suggested that there is a “necessary, creative tension in the space between want and need. How else might we negotiate Fairbairn’s (1952) paradox of ‘mature dependence’ than to feel both want and need for the other?” (Dimen, 2002, p. 56). Dimen asserted:

Autonomy and dependence, activity and passivity, heterosexuality and homosexuality, body and mind, selfness and otherness, subjectivity, and objectification, superiority, and inferiority, want and need. … [T]hese apparent polarities are but different moments of the self, and the passage between which might be regarded as pleasurable, even though we leave the preferred polarity. … [T]he solution to the problem of splitting is not merely remembering the other pole but being able to inhabit the space between them, to tolerate and even enjoy the paradox of simultaneity. (Dimen, 2002, p. 56)

The idea of “difference” is a “paradoxical space that selfhood itself inhabits” (Dimen, 2002, p. 56). Dimen intentionally left out masculinity and femininity from the above list of contrasts, stating that she is not sure “what they are,” noting, “The content of gender or
the number of gender in any given system remains cross-culturally variable” (p. 57).

Dimen recommended further investigation into “the same case for the possibility and pleasures of gender multiplicity” (2002, p. 57).

By moving masculinity/femininity more into a continuum than a polarity, the question of definition of these terms is left wide open:

If masculinity and femininity were to be regarded as different moments of the self, what would each moment mean to a particular self? What is masculinity? What is femininity? In other words, I question these terms because, although we can name everything we think they are, on examination their meanings become uncertain. Therefore, … [we ought] to assume nothing about gender other than it is a socially and psychologically meaningful term, what meanings can we find for it? (Dimen, 2002, p. 57)

However, Dimen did not stop here. She further asserted:

I believe in the reality of gender-identity experience and of gender as an organizer in the psyche; as such, gender is variably meaningful, a variability that generates uncertainty, invites inquiry, and offers richness. This “diagnosis” of uncertainty should not, however, be regarded as a failure of method or theory. Instead, it is a sign of what gender is. Gender, as an internally varied experience, is sometimes central and definitive, sometimes marginal and contingent. (p. 57)

Therefore, gender is unpredictable and fluid. Dimen thus summarized:

The notion of transitional space can help us comprehend what our theory has heretofore been able to handle only by splitting. Gender identity, born in the space of difference between femininity and masculinity, always retains the marks of its birth. Therefore, although gender identity has come to be seen in developmental theory as finalizing differentiation, I would suggest, counterintuitively, that it does more: at one and the same time gender identity seals the package of self and preserves all the self must lose. (p. 58)

Dimen claimed that her exploration of gender and differences confirms Fast’s (1984) earlier conclusion that gender identity offers us the opportunity to evaluate in the other what we do not see in ourselves; yet, gender identity also allows us to discover in ourselves the “overinclusiveness” that we have heretofore renounced “so that we can also recognize it in the other, of whatever gender that is” (2002, p. 58).
In applying Dimen’s “subject-as-object” concept, a clinician should consider the negation of power and privilege (i.e., the clinician) in the room with a transgendered female-to-male patient. The clinician should consider and explore how the patient views his/her sense of gender identity and his/her views that encapsulate one’s feminine qualities as well as one’s masculine traits. Additionally, the clinician should evaluate the countertransference in reference to these qualities of gender, power, and privilege in relation to the self and the patient. (When treating transgender female-to-male patients, this is particularly important with regard to the female clinician considering masculine aspects of the self or the male therapist considering that his masculinity may be seen as threatening.) In short, what is more threatening to the patient: the clinician as an owner of power in achieved professionalism or as merely the patient’s female/male counterpart?

It is also noteworthy to point out that the therapeutic relationship will be particularly strained if the patient presents with a more borderline characterological organization, as this patient will is more apt to rely on primitive defensive strategies, such as splitting and projection, in addition to their gender and gender role presentation. Such circumstances may further complicate the therapeutic treatment. For example, if the patient is requesting a letter for hormone treatment, the clinician should proceed with extra caution when that patient is borderline, which is marked by an unstable identity.

Observing and interpreting these dynamics is crucial in fostering insight for the patient in discovering his/her authentic gendered self. Dimen’s theory offers the clinician an opportunity to reevaluate the space between gender dichotomies, recognizing the similarities, and perhaps, the patient’s adaptive response to internalizing various aspects
of the gendered self. This may be helpful in the analysis of gender and self-relating in the world for the transgender female-to-male patient.

Ken Corbett

One of Corbett’s main arguments was that traditional developmental models are replete with “normative logic of centrality, with limited accounting for the developmental necessity of marginality” (2001, p. 313), which he asserted in his article, More Life: Centrality and Marginality in Human Development. Yet, “postmodern theories of subjectivity overvalue the potential of the margin and fail to account for the significance of similarity and coherence in human relations” (p. 313). He used the limitations of these theoretical perspectives as a catalyst for formulating his five quasi-axioms. The five quasi-axioms he presented captures a new model of developmental theory that: 1). signifies a “process rather than state,” 2). “accounts for the dialogic movement of chaos and coherence,” 3) represents a “developmental hierarchy as a fundamental topology,” 4). indicates a “culture’s need to read patterns” and “a culture’s need for individuals who reach beyond patterns,” and 5). the “interplay between Freud’s two modes of mental freedom” (Corbett, 2001, pp. 322-330). These quasi-axioms comprise a developmental model that utilizes chaos and systems theoretical concepts to suggest “the interplay of centrality and marginality in any given life” (Corbett, 2001, p. 313).

Freud used the term “invert (interchangeably with homosexual) to describe what he felt to be homosexuals’ constitutional reversal of sex roles” (Corbett, 2001, p. 314). Freud asserted that such a position firmly placed the homosexual individual in the margins of abnormality. (As Corbett’s theory both reposites in places and elaborates in others Freud’s ideas, a discussion of Freud’s concept of the invert is presented here.)
As noted earlier, *queer*, in the late 20th century, marked the reclaiming of being an “invert,” that is, something other than normal, weak, and unnatural. Reclaiming the once derogatory word “queer” is an attempt to obtain power:

The aim of vigorously occupying the margin, and boldly being out of step, is to shift the homosexual from the object who is known (the investigated invert) to the subject who knows (the interrogating queer). The queer is held forward as the eccentric subject whose knowledge and capacity for critique derive from his privileged position at the margin. Following such queer reasoning, one would argue that, in the course of the 20th century, privilege has migrated from the center to the margin. (Corbett, 2001, pp. 314-315)

However, despite such efforts of being categorized as an “other,” a queer individual remains in dialectical tension with the heterosexual individual who falls within the normal domain of an “ideal citizen”: “a border between the aberrant-marginal them and the ideal-central us has been constructed around the homosexual subject” (p. 315).

From Corbett’s perspective, in order to understand how one develops mental freedom, an evaluation of this “border” is warranted. Therefore, in Corbett’s model, he chose to:

Focus on the insufficient ways in which mental freedom has been characterized as either marginal or central, along with the further insufficiency of linking centrality with heterosexuality. Through such critique, I argue for a conception of human development and mental freedom that promotes an interplay between centrality and marginality. (p. 315)

“Mental freedom” was originally used by Benjamin (1998) in his redefining Freud’s 1915 description: “that extra piece of mental freedom that distinguishes conscious mental activity” (Benjamin, as cited by Corbett, 2001, p. 315). In Freud’s view, mental freedom implied that “freedom followed overcoming the pleasure principle of consciousness” (Corbett, 2001, pp. 314-315). Benjamin (1998) further expounded:

This belief corresponds with one of Freud’s two implicit antithetical theories of mental freedom: 1. The *associated mode* is the mode in which freedom is gained by and through association, and one is freed of the unconscious as resistance is
lifted. 2. The reality mode rests on being freed from the unconscious through the organizing authority of the reality principle. (as cited by Corbett, 2001, p. 316)

Corbett contended that, by using Freud’s frame of reference for mental freedom, “the invert reflects the reality mode whereas the associative mode reflects the queer (p. 316).

Freud’s developmental theory is based on the reality model of mental freedom, which infers a model of centrality (Corbett, 2001). Corbett departed from Freud, however, in his conceptualization:

Neither the reality mode nor the associative mode sufficiently problematizes mental freedom, or development—in the same way that neither the invert nor the queer sufficiently problematizes the homosexual subjectivity. (p. 316)

Freud’s relational mode of mastering mental freedom was significantly influenced by his psychosexual stage of development theory. Mastery of the age and relational specific developmental tasks ultimately leads to an intrapsychic organization of reality, an organization of authority that represents centrality or normality (Corbett, 2001). From Freud’s theoretical perspective, the invert will never accomplish this developmental task, thus, forever remaining in the margin. Yet, for Freud, individual developmental trajectories could deviate because of relational dynamics ever so present by “wishes and reconstructions that move unhindered through past, present, and future,” such as can be found in the case studies of Dora, Little Hans, and Leonardo (p. 318). Freud’s developmental model, however, is problematic in that it forces one into a linear model of development (Corbett, 2001). Freud based these conditions on “natural law” and “proposed a theory of serial initial conditions and behaviors (libidinal stages) that become reorganized at successively more complex hierarchal levels” (p. 319). Consequently, this developmental perspective assembles heterosexuality by claiming sexual instinct is motivated solely by reproductive reasons (Corbett, 2001). One could then conclude:
The reproduction of reproduction melds into a “naturalized” notion of the hierarchical reorganization of psychic structure. This manner of “natural” development (reorganization and structure) is then held forward as both the product and progenitor of mental freedom. (p. 319)

Many developmental psychologists and psychoanalysts claim that an individual’s psychical development is not representative of a linear process, and such a model fails to capture idiosyncratic subjective development of character (Corbett, 2001). Corbett contended, “Linear conceptions of development also tidy up the complexity of mental freedom—linearity has a way of confusing the minimalism of order with freedom” (p. 319), and he further argued:

In an effort to capture this human variance and to illuminate the nonnormative margin, postmodern theorists have set out to deconstruct naturalism, disarticulate identification, and relativize normativity. (2001, p. 319)

Returning to the concept of queer, a queer identity strives toward autonomy while challenging societal norms. “Queer is by definition whatever is at odds with the normal, the legitimate, the dominant. There is nothing in particular to which it prefers. It is an identity without an essence” (Halperin, as cited by Corbett, 2001, p. 320). From a queer stance, then, freedom is accomplished by deconstructing normative expectations of reality (Corbett, 2001). At what cost, though, is the pervasive participation of being in a constant state of deconstructing the self in relation to other? Can individuals benefit from “the potential of living in reliable relations with others as opposed to always living through opposition to others” (p. 321)?

Corbett proffered this interesting perspective:

The construction of the invert resulted in the projection of the other as aberrant and outside. The construction of the queer results in the projection of similitude as negligible and outside—similarity is often postmodernly constructed as some manner of autistic white or banalizing narcissistic beige. Each case points to the failure of both the Freudian and the postmodern efforts to sufficiently heed the
complex interimplication of centrality and marginality—of similitude and difference. (Corbett, 2001, p. 321)

Corbett’s argument here is that both of these theoretical claims are limited, and he offered his five quasi-axioms as a new means for understanding development. Corbett used the term “quasi” as “an effort toward improved self-determination as opposed to a set of formulations” (p. 322). He did acknowledge, however, that “identifying axioms as ‘quasi’ is a contradiction, albeit well intentioned, to capture my dual commitment to the contingency of subjective repertoire and the possibility of a developmental vocabulary;” one that might help an individual create a narrative to illuminate the past, present, and future (p. 322). These five quasi-axioms are presented below with a brief synopsis.

Quasi-axioms: 1). A theory that represents “process rather than state,” a “position rather than a stage, of becoming rather than being;” 2.) represents a theory that “accounts for the dialogic movement of chaos and coherence;” 3.) a quasi-axiom wherein the “representation of developmental hierarchy as a multidimensional topology;” 4.) a theory that “accounts for a culture’s need to read pattern, as well as a culture’s need for individuals who reach beyond patterns;” and finally 5.) a quasi-axiom that “promotes the interplay between Freud’s two modes of mental freedom.” (Corbett, 2001, pp. 322-330)

Quasi-axiom 1 suggests, “Positions afford a conceptualization of growth that not only emphasizes regularity but pattern, coherence, complexity, and movement between development periods” (Corbett, 2001, pp. 322-323). Positions can perhaps more accurately reflect developmental narratives that explain the nonlinear trajectories. From this reference, positions not only reflect patterns but infer ways in which these “patterns are modified by the contingent and often paradoxical structure of subjectivity” (p. 323). Though exploring the impact of relational experience as well as accomplishments in achieving developmental tasks are relevant, they too are limited. With regard to his view of childhood, Corbett asserted that:
Childhood must now be reconceived as a resonant yet emergent process, open to oscillation and transformation within the multiple relational worlds constructed throughout a life. Central to childhood’s will be an effort to locate children with an intrasubjective and intersubjective “relational mix.” (p. 323)

He further addressed the concept of time and relationships:

This matrix formation bespeaks the ways in which neither time (past/present/future) nor relationships (one/two/multiple) are conceived as veridical, but rather as fabulous, combined, and perpetually dynamic. (p. 323)

Hence, our histories are constantly being “rewritten” or “overwritten” (p. 323).

“Considering the interplay of variance, context, time, and chance in determining our fates also changes our quest to find cause origins and to provide constitutive explanations” (p. 324). By reframing the question, such as “why is one transgender?” we will now find “multiple, contingent, and indeterminate causes and homes” (p. 325). From this perspective, there are few limits to “why,” but rather, we are now free to explore the “meaning,” looking at “possible causes of specific aspects of a patient’s desires and object relations; however, those meanings and causes are always overdetermined and often contradicted” (p. 325).

The second quasi-axiom, “accounts for the dialogic movement of chaos and coherence,” which tends to recognize upsets between external and internal processes of relating. At first, these patterns are unstable and, at times, tenuous identifications, though, later they will develop into identifiable patterns (Corbett, 2001). According to Corbett, “These patterns emerge between chaos of contingency and coherence of integrative need” (p. 325). Into this concept of patterns, Corbett integrated the ideas of Ogden:

The regulatory persistence of these patterns, however, is not the product of a simple unity; such patterns are not simple maps or simply a matter of hierarchical layering. They are, instead variegated pathways open to the tension of integration and unintegration. (as cited in Corbett, 2001, p. 325)
Corbett offered the complexly layered concept of sexuality as a good example of “chaotic—coherent pattern organization and regulation” because of the “liability to multiplicity” and stability of such a position (Corbett, 2001, p. 325). He noted that postmodern theorists are concerned that multiple identifications may lead to contradictions. This vulnerability, in fact, was noted as a major issue in Training Module I of this dissertation in the section on identities and their conflicts (i.e., discerning gender identities similarities and differences among androgens, stone butch, lesbian, and transgender individuals). Corbett noted that “identities and desires can and do change, but they also persist and, through their relative coherence, resist change” (p. 326). The concept of “self-sameness” suggests that a persistent identity develops over time, although Corbett would assert that it is difficult, if not impossible, to achieve. Rather, identity development is best seen as an ongoing process that is nonlinear:

It is through the chaotic and dialogic repetition of identification, negation, disidentification, incorporation, and introjection that inner regulations, mental representations, and characteristic motivations are internalized. … [it is a] system wherein identifications stimulate intricate feedback loops forming patterns of exchange and transfer. It is through the flow, feedback, and repetition of such patterns that structure and regulations emerge. (Corbett, 2001, p. 327)

The third quasi-axiom is the “representation of developmental hierarchy as a multidimensional topology” (Corbett, 2001, p. 328). This model calls for the reevaluation of traditional developmental metaphors, particularly “metaphors of developmental line and developmental core” (p. 328). Development is actually more like “complex multiple spirals” (Coates, as cited in Corbett, p. 328). Such patterns reflect change and flexibility: “when the pattern itself is past or invisible, the evidence or residue of the pattern remains,” consequently, “chaos builds structure” (p. 328).
From this point of view, Corbett argued that instead of a “core,” which implies a solid state, it is best represented as a web, that is, a “woven network that contains and interconnects in intricate patterns, some of which may be tightly woven (or well integrated), others less so, still others subject to dropped stitches (leading to unintergration)” (2001, p. 329). As core represents notions of hierarchal developmental achievements, a web captures intricate developmental aspects of identity, internalizations within the context of one’s experiences. “We can imagine a weaving, linking, mutually created intersubjectively, as opposed to a core that is completely centered and created within the self” (p. 329).

Quasi-axiom 4 “accounts for a culture’s need to read pattern, as well as a culture’s need for individuals who reach beyond patterns” (Corbett, 2001, p. 329). Corbett acknowledged here that the postmodern “never-ending” deconstructionism fails to underscore our need to be recognized by others (Corbett, 2001). This is, perhaps, at a cost of “social regulation and submission and subordination” (p. 329). Nonetheless, the queer’s “heroic temptation” relentlessly embarks on a “utopian quest” (p. 329). According to Corbett, such omnipotent adventures lead to finding a sense of belonging in “otherness,” an establishment of new social norms and relationships. However, his concern with the “utopian quest” is that it is focused on the future; yet, it is “exquisitely linear” (p. 329). Queer theory, then, fails to recognize a subjective that is “nourished by the unencumbered movement among past, present, and future” (p. 329).

Corbett suggested that this dynamic creates, in some ways, a sense of community and belonging. “Subjects and relations are constructed not only by reaching together toward a future, but also by resting together in the relationality of customs, traditions, and
norms” (2001, pp. 329-330). Though not stated outright, one might conclude that postmodern perspectives are, indeed, polarized. This current author might go so far as to suggest that postmodernism is in reality an American phenomenon that reflects the dominant cultural values of individuality and autonomy. According to Corbett, we need a theory that invokes mental freedom, yet holds a “rhythm of regularity and the structuring potential of relational reverie” (p. 330).

The fifth and final quasi-axiom promotes an “interplay between Freud’s two modes of mental freedom” (Corbett, 2001, p. 330). The associative mode as well as the reality modes ought to “coexist in a mutually preserving and negating relationship” (p. 330). Whereas Freud depicted mental freedom as an either/or condition between reality and associative modes, Corbett suggested that mental freedom is rather reflective of mutuality between the two. Psychoanalytic technique has evolved beyond free association and today includes the concepts of “enactment, intersubjectivity, and mutuality” (pp. 330-331). This is characterized well by Aron:

The meaning of free association can be gleaned only from a deeper understanding of the relation created through the patient’s action. Meaning can be understood only between the patient and the analyst and, more specifically, between the patient’s associations and analyst’s associations, which are in turn fed by the mutuality to the transference and countertransference relationship(s). (Aron, as cited in Corbett, p. 331)

In short, the therapeutic arena is an exchange of realities that are both psychic and material (Corbett, 2001).

In summary, Corbett argued that juxtaposing an aberrant-marginal them against an ideal-central us is nothing short of absurd. His model suggests a much more fluid and less polarized relationship: “interplay of centrality and marginality—the interimplication of reality and association—in any given life” (p. 316). Relating near the borders of
complex systems (for example, near identities and identifications) allows the mental freedom wherein both individuals can exchange in the interplay of psychological health and adaptability. This new model best captures the nuances of human diversity rather than coercing individuals into a traditional model that dominates the “normative logic of centrality” (p. 313) and speaks efficiently to the development and manifestations of gender.

Corbett’s second quasi-axiom raises some concern about shifts in development, particularly for the transitioning female-to-male’s propensity to evolving mind and body gender-identity transformations. Implementing physical change by taking hormones or choosing irreversible surgical interventions could be detrimental to later identifications of oneself when the body has become constricted again from one gender pole to another (male body). A clinician can assess such risks by implementing therapeutic goals; these goals would include the exploration of desires and fantasies, as well as the negation of potential losses (e.g., reproductive abilities and feminine voice, etc.).

Adrienne Harris

Harris conceptualized gender as potentially stable, yet tenuous, and at times, it may have a quality of plasticity. Harris’s ideas, she claimed, have been built upon three decades of thought (she noted that the concept of gender has sparked a plethora of debates that have provided a catalyst for a number of social movements). Gender is “a point of paradox,” she wrote (2002, p. 91). It “can be as core and coherent an experience as any structure of self and subjectivity. But gender can also mutate, dissolve, and prove irrelevant or insubstantial” (p. 91). In her extensive review of contemporary psychoanalytic theorists—including Benjamin, Chodorow, Dinnerstein, and Mitchell—
she noted that they have provided a new medium for psychoanalytic thought and practice where gender has been critiqued as well as deconstructed (2002).

Harris criticized Freud for his inability to find language to capture his patients’ experiences, which ultimately, then, led to his perverse interpretations of the circumstances. She submitted that in gender-ambivalent situations—coupled with language deficits in the interchange by both patient and clinician—a patient loses his/her rights to subjectivity, leaving it far more difficult to capture his or her desires and sense of self (2002). In Freud’s interpretations of Dora and Frau K, Harris contended, “The sexual woman, the object of homosexual desire and the subject of bisexual sexuality, is marginal and degraded” (p. 93). From this perspective, a woman’s sexuality becomes frightening, and subsequently, devalued.

Contradiction is central to her critique of Freud, and she singled out his inconsistencies in *Three Essays* and later in *The Interpretation of Dreams* as these works significantly influenced traditional developmental theory (i.e., psychosexual stages of development). In these essays, Harris argued, Freud both challenged and encouraged patriarchal norms on femininity and homosexuality (2002). As in the case of Dora, Freud identified with her father and then colluded with him in his prejudicial treatment of her homosexual desires and intimate and social relations with another woman. Freud then contradicted this position in *Three Essays* wherein he “traces out the view that sexuality and identity can never be simply some hard-wired, constitutionally driven forms but, rather, that the formation of sex and identity operates like the rules of grammar” (2002, p. 94). Harris cited the prominent linguist Noam Chomsky (1965) in his interpretation of language; he wrote, “Any given sentence has no inherent linkages or simple linear
connections,” and from his perspective “all human language creatively combines elements according to a set of special combinational rules, which permit many selections and arrangements” (Chomsky, as cited in Harris, 2002, p. 94). Based on this theoretical idea, Harris claimed:

If we extend this analogy to the sphere of sexuality, any human experience of sexuality and identity is built on a unique and particular sexual sentence in which the elements of subjectivity, action, and object are never inherent or inevitable. Unlinking aim from object and allowing the play of sexual forms and symbolic meanings for bodies, selves, and acts are the radical core of Freud’s theory of desire and gender. (2002, pp. 94-95)

From her careful analysis of Freud’s writing, Harris noted Freud’s interpretations of gender and sexuality, at times, are problematic, while at other times, present progressive ideologies that promote radical thinking and treatment (2002). For example, when adhering to a more scientific tradition, he supported constitutional factors and developmental classifications of achievement. Yet, Harris wrote, he “also speaks against a politicizing polemic of the nineteenth century that sought to carve out a psychic and social space for homosexual persons” (2002, p. 97). Harris remarked that, for unknown reasons, psychoanalysis has avoided addressing these differing perspectives on homosexuality, despite their polarity. It appears that Freud himself was conflicted about his own ideas. Interestingly, Harris pointed out that gay and lesbian scholars have acclaimed constitutional predispositions to gender and sexuality formulations as an explanation for sexual object choice and homosexual identity (2002). In Freud’s defense, Harris wrote:

Gender identity and sexuality can perhaps be freely investigated only in a social, institutional, and therefore political situation in which everything may put in question and nothing is fixed or "natural.” This utopian possibility was sketched in Freud’s theory of sexuality and was at the heart of his method in the technique
of “free” association. This hope for a freedom to question, this radical skepticism is also psychoanalytic feminism’s deepest utopian vision. (p. 97)

From Freud’s perspective, gender and sexual object choice derive from a complex interchange or relational dynamics as well as identifications. His theoretical argument held that boys and girls must give up their love for their mother, and this negation leads to a displacement of the child’s love for their mother (2002).

In consideration of Freud’s ideas on the development of male identifications—which derive from libidinal desires and masculine protest stemming from fears of aggression—Harris concluded that a girl’s identification with her father must extend beyond envy (2002). Benjamin, opined this best by acknowledging a girl’s benevolent identifications with her father, and conflicts, then, arise when her own identification takes shape (2002). From this point of view, one could deduce that a feminine object resents her Oedipal victory and resigns by shifting her primary object choice—and in extreme situations, she “abandons” her feminine gender identity.

Harris claimed that Freud’s former theoretical ideas do not equate with normative male heterosexual development (2002). Underlying Freud’s waxing and waning of theoretical accounts of gender identification development, Harris noted that Freud’s basic belief held that:

The patient’s love object is a complex solution, a fusion of male and female object choice, the expression of homosexual and heterosexual libido. An object choice ideally represents a world of multiple sexualities and the preserving of all prior forms of loving. The love object technically must be one gender or another, that is, formally either female or male, but unconsciously and symbolically, this object choice is a multilayered, multisexed creation. It is not, of course, that the gender identity of the lover is unimportant, but that it both expresses a powerful resolution of conflicting aims and preserves all elements of the conflict. (2002, p. 102)
The “formal identity terms” of the masculine-identified female with homosexual desires is a homosexual object choice; however, such an identity could be an unconscious attempt to retreat from Oedipal desires and idealize the mother (Harris, 2002).

Harris has opined that, throughout Freud’s essays, we can dispute the work of Fast (1984) who held that one establishes a core gender identity that remains stable over time. Yet, she also acknowledged Coates’ argument that in the case of gender identity issues with boys, such identifications are susceptible to trauma or loss (2002). Harris stated:

The position I am suggesting is one in which gender is neither reified nor simply liminal and evanescent. Rather, in any one person’s experience, gender may occupy both positions…. Furthermore, there may be multiple genders or embodied selves. For some individuals these gendered experiences may feel integrated, ego syntonic. For others, the gender contradictions and alternatives seem dangerous and frightening and so are maintained as splits in the self, dissociated part-objects. Any view of sex, object choice, or gender that grounds these phenomena as categories of biology or “the real” misses the heart of Freud’s radical intervention in understanding personality. … Gender, then, and the relation of gender to love object can be understood only by acts of interpretation. In that way the density of their unconscious and conscious elaborations is brought into the real of language. Only with the reflective narratives on which psychoanalysis depends can we know the complex meaning of “masculine,” “feminine,” “boy,” “girl,” “same,” “different.” (2002, p. 105)

What is refreshing here is Harris’s inclusion of “same,” and by doing so, she holds in mind various identifications and executions of gendered behaviors, both on the polar ends of the spectrum, as well as the overlap that may exist between them.
It might look something like this:

Very Male–Male–Effeminate-Male–Androgyny–Manly-Female–Female–Very Female
Very Masculine—_________________________________________________________Very Feminine

This is similar to the model presented by Halberstam:

Not Masculine________________________________________________________Very Masculine
(1998, p. 149)

Turning now to Harris’s exploration of gender and sexuality in Gender as a Soft Assembly: Tomboys’ Stories (2000), she acknowledged (and this was later echoed by Corbett in More Life: Centrality and Marginality in Human Development, 2001) the value in nonlinear models, such as chaos theory, and presented this particular frame by examining tomboys’ desires, sexual object choice, and gender identity. She believed that gender development is organized around “bodily life,” and this concept is paramount to the female-to-male transgender.

Of note, Harris concurred with Benjamin’s perspective on gender identity development: that it is profoundly influenced by interpersonal relational patterns and the subsequent internalized identifications (Harris, 2000) (this is similar to Corbett’s point of view). On this subject, Harris dissented with Stoller, and this argument was later taken up by Fast. Finally, Harris’s goal point was to provide a better context for understanding “masculinity” in women and bisexuality (Harris, 2000). Though her work may not directly address the female-to-male transgender, her ideas are applicable to the female to male transgender experience.

**Utilizing chaos theory:** “*Gender as a soft assembly.*” Harris opined that a contemporary approach was needed in the analysis of gender. Such an approach, she
believed, should integrate models of gender development by introducing chaos theory to feminist and psychoanalytic theoretical perspectives. In her essay entitled Gender as a Soft Assembly: Tomboys’ Stories, she demonstrated utilizing chaos theory (which is a nonlinear developmental model—gender that is not marked by developmental tasks but rather is influenced by patterns of relationships and identifications (2000). In this essay, she also reflected upon her own tomboyism as a means of interpreting the tomboy narratives, because, from her perspective, tomboys did not fit into “obedient categories” (2000, p. 223). Significant to her work with tomboys, and later in her book titled Gender as a Soft Assembly (2005), she argued that neoclassical and relational psychoanalytic perspectives are divided and restricted by language, which is limited in articulating the nuances of gender (Harris, 2005). A model systems theory, Harris contended, allows “novelty, self-organization, and self-maintenance” (2000, p. 230). She described dynamic systems theory below:

[Utilizing] [d]ynamic systems theory, the forms of chaos theory particularly developed by Thelen and Smith (1991), to imagine these multiplicities of developmental outcomes. Their general systems approach would see phenomenon like gender or sexual desire not as a structure but, rather, as “softly assembled” sets of behavioral attractors whose form and stability would be quite variable, depending on the task at hand, the context, and the individual’s life history and experiences…. Structures (mental and physical) are characterized both by stabilities and by instabilities, and change is nonlinear, by which is meant that the impact of change is not simply predictable and aggregated. Small shifts can disequilibrate a system in gross and dramatic ways, the systems restabilize through feedback that may have features of either randomness or guided searches. This is a theory of human functioning that is deterministic but not causal or teleological. Inherent in this way of thinking about structures is a paradox: human experience emerges from deterministic chaos, from the mutual elaborations of randomness and pattern. (Harris, 2000, p. 230)

From this perspective, gender-variant expressions and identities may vary across situations—and time. And character derives from complex influences, including evolving
and patterned experiences, as well as constitutional factors. In addition, Harris noted: “It is not that all persons have multiple and fluid gender experiences and shifting or labile constellations of experience that come to be gendered, it is only that this variation is expectable within the framework of chaos theory and would alter (though not dispense with) psychoanalytic theory” (2000, p. 230). It follows, then, that gender identity, gendered behaviors, and sexuality have conscious and unconscious influences that are enacted within certain cultural and social arenas (Harris, 2000). Thus, Harris reasoned, “Gender and sex would be inseparable from the interpersonal fields in which they are embedded” (p. 231). She noted that such an interrelation of “gender and desire” is aligned with Feud’s model of psychosexuality (p. 231). Harris concluded:

Sexuality expresses and contains multiple functions: self-regulation; interpersonal regulation; distancing or bridging; conditioning safety or potential destabilization; courting excitement or danger or sealing it off. Forms and functions of desire would not have an obvious or unremarkable relationship to gender. The assemblage of gender experience in sexual life is contingent and emergent, not pre-programmed. Desire and gender may be set up antagonistically or feel seamlessly enmeshed and obvious. (pp. 231-232)

As this new model of character identification and sexuality is used, according to Harris, such a model may illuminate the developmental narrative in which tomboys construct their identity apart from a “nonnormative” (pathological) and “otherness” formulation (p. 232).

A tomboy may present an adaptive “claim for action and mobility” as well as “a site of doubleness and multiplicity itself” (Harris, 2000, p. 223). However, a tomboy may also cling rigidly to an identity wherein the tomboy reflects gender conflicts that may be both “suffocating” and “rigid” (p. 223). Harris stated:

The tomboy plays with gender conventions, crosses gender borders both in pleasure and in pain. She constructs a space between categories, a place to draw a
In brief, tomboys may both embrace and resist social conventions, and they may also become “gender outlaws” (p. 223).

The term “tomboy” has taken on multiple meanings. In fact, “the very name Tom” evokes “uncertainty and marginality” (Harris, 2000, p. 223). “To work on this topic, “Harris confided, “I have had to confront theories of development, ideas about gender and gender identity formation, ideas about language and its relation to identity, questions of voice in scholarly essays” (p. 224). Again, as has been pointed out previously, the complexities of language have great impact—particularly when used by queer, female-to-male, gender-variant individuals, scholars and service providers.

Reflecting on her own female masculinity, Harris noted that, even though she found an outlet in lacrosse and despite the fact that “a highly physical cathexis” could be executed, there are, nonetheless, limits to female-masculine physicality and how seriously one is taken as a masculine/strong female (physical and psychological) (2000, p. 224). Harris noted:

> The concept of mastery came to have a highly physical cathexis for me. I felt in possession of a body image formed and streamlined from the objectifying male gaze that stains and maintains so much in female subjectivity. Body imago and self-state were focused and delineated by the impact of flesh on flesh, muscle to muscle, the body mixup and shocks that do not usually arrive for women outside the fun house or the bedroom. (p. 223)

Although Harris was cognizant to the power of her physicality, she likened such forms of masculinity as related to “Winnicott’s (1950) concept of well-managed aggression” (p. 223).
In reflecting on Harris’s theory and her observations on tomboys as this might relate to transgender female-to-male, one might consider that tomboy identifications merely represent aspects of the self that do not deny stereotypically feminine characteristics, nor does their identity represent a split-off rigid defense of the self. This author conjectures that Harris would recommend that the treating clinician come to know conscious and unconscious aspects of the “Tomboy,” or the masculine attributes in the self, as well as the defended aspects of masculinity (regardless of gender in the clinician), and then consider what is fantastical and what is reality based about such identifications, as well as the power that the masculine privilege might bring. The clinician might also be encouraged to evaluate Winnicott’s notion of a well-managed aggression.

In an effort to look deeper into the meaning of a tomboy’s identity, Harris stated: “Tomboy’s stories and the analyst/listener’s interpretive narratives are all tangled in the rules and conventions of gender and gender growth” (2000, p. 224). Reiterating the words of Adam Phillips (1995), Harris noted: “all symptoms, after all, are states of conviction” (Phillip, as cited in Harris, p. 224). From this standpoint, Harris asserted that:

Behind one tomboy’s “guy” persona is the deep conviction that women are second-class citizens, losers, uninteresting. “Guyness” is the only site of excitement. Within another tomboy’s inner experience, there is the horrifying conviction that the “boy,” a self-state that feels male to her, is a degraded female. (p. 225)

Drawing from the work of Laplanche (1989) (who emphasized the force of maternal seduction), Harris suggested that a tomboy’s masculinity may be, in part, “her rivalry, her fascinated rivalry, or her disavowal and avoidance of men” (Harris, 2000, p. 225). The conscious and unconscious early relational dyads may result in a tomboy’s “body ego
[which], then, may be libidinized through a variety of powerful fantasies and transactions emergent within her relationships” (pp. 225-226).

Harris referred to the Bionian concept, parental reverie, which brings to the forefront “the necessary imaginative work that comes to constitute a space both internal and interpersonal for any child” (2000, p. 226). A tomboy’s identity, Harris contended, may reflect notions of masculinity that have been internalized from either parent. This internalization could, perhaps, represent a loss of masculine identification from the mother, or femininity could be projected and discarded as the result of beliefs that femininity is less than, fragile, or weak (Harris, 2000, p. 226). The tomboy’s persona, then, may be the consequence of holding binary ways of being from both parents at the same time.

The tomboy identity style may present itself in certain contexts, such as sports, or evolve over time:

A tomboy identity can be either moving in time or fixed, transcendent, or terrified: tomboy jock taking cultural and physical space to move and play and express sanctioned forms of motility and aggression; tomboy as excess, as conveyer and bearer of jouissance, containing and expressing both genders, both desires, object and subject. This doubling of identity might have a number of meanings and implications. The tomboy may open a space for herself to move and act, at least in her imagination less rigidly anchored to binary categories and living in the space between masculinity and femininity. (2000, p. 227)

Harris leaves us with an important consideration:

Is the tomboy a developmental anomaly, carrying the leftover rebellion or expansiveness of adolescence into adulthood? Is she a historical anomaly, living as an internal consequence the external socially driven rigidities of gender? ... Will a different history of the tomboy’s body and her body in motion alter the gender implications for young women? (p. 227)

From this author’s perspective, Harris’s treatment and analysis of tomboys may also be relevant to the gender identity development of the transgender female-to-male or
gender-variant individual. Their current interpersonal relatedness patterns may also
coconstruct their gender identifications.

**Bodily expression of female masculinity.** The tomboy presents bodily
contradictions within the realm of cultural expectation, as do transgender female-to-male
individuals. The remarkable difference between the two, however, is that the tomboy is
much less likely to choose to change her body to match her masculine desires and
identifications. Conversely, for many transgender individuals, physical change is the only
refuge, and this relies on the “idealization of medical technology or surgery as phallic
solutions” (Harris, 2000, p. 228). Here Harris referred to Bromberg’s (1999)
conceptualization of the fluidity of gender and sexuality, which he described as: “the
experience of selfhood as a kind of creative interiority that permits permeability of the
boundary between inside and outside, without threat to self continuity” (as cited in
Harris, 2000, p. 227). Thus, Harris concluded, “the tomboy’s identity, a boy in a girl, a
boy and a girl, a girl and more than a girl, a girl whose phallic activities may be dystonic
or syntonic, these are all shifting self-states at play” (p. 227). It is noteworthy here that
this “boy in a girl” and “boy and a girl” could equivalently portray the transposition of
female-to-male transgender and gender-variant individuals that might bring them a sense
of safety and psychological coherence.

However, Harris contended that one such flight from femininity and womanhood
could be the result of trauma. She stated, “Tomboy body ego may function as a defense
against trauma, either remembered or reproduced” (2000, pp. 228-229). A boy persona
may deny knowing and operate in the form of dissociation, which is the body’s defense
against annihilation and vulnerability. Such a defense against “penetration” and being
damaged is warded off with a phallic victory (p. 226). “A tomboy may oscillate between rigidity and activity as bulwarks against memory or fear of annihilation. The body braces the psyche and frames ways of seeing and being seen” (p. 229). From Harris’s perspective, one might choose to construct masculine bodies as a means of gaining control, an embodiment that would protect one from the external world.

The following issues regarding bodily sex will be addressed briefly. For the transgender female-to-male and gender-variant individual—which would definitely include asexual and stone butch women—a fear of vaginal injury, penetration, or vaginal hunger is undoubtedly marked by shame or anxiety (Harris, 2000). Harris argued that female sexuality theories are incomplete—both neoclassical and relational ideologies on female superego formation, female gender identity based on interpersonal pregenital and genital experiences. These theories hold that (a) the body is treated as a “phenomenon rather than a bodily ego that is emergent in the process, both intrapsychic and interpersonal,” (b) there is minimal exploration to the “interpersonal dimension in the constituting female bodies and femininity,” and (c) sexual identity development does not capture the complexity in which psychic and sexual behavior are construed (pp. 234-236). Thus, such frameworks would fall short in conceptualizing the complexity of a transgender individual’s inner psychic life, fantasies, and behaviors, whether masturbatory or interpersonal. In short, Harris submitted that a chaos theory would best account for multiple experiences—gendered and cross-gendered—over the course of the lifespan. (Though a theoretical review of female sexuality is beyond the scope of this project, the interested reader is referred to writings of Diane Elise for further review.)

Female Masculinity
Female masculinity has been looked at from in a number of ways. Traditional theorists would contend that transgender female-to-male individuals are likely to be perceived as female masculine women and transmen inhabiting a privileged identity because of their strong masculine identifications and presentation. Neoclassical perspectives, such as McDougall’s (1980), have interpreted female masculinity as exhibiting “quasi-psychotic and perverse refusal of reality, one that paradoxically acknowledges and refuses paternal power” (Harris, 2000, p. 241). Yet, female masculinity has also been considered as a defensive identification with the father, as penis envy, and as competitive rivalry with the father (as was discussed earlier in this module).

Feminist psychoanalytic relational theory and postmodernist theorists have refuted these gender theories that have developed around the concept of a binary system. A number of authors have offered their critiques (viz, Dimen, 1991, 1995; Flax, 1990; Goldner, 1991; and Harris, 1991, 1997). Harris summarized their criticisms well: “Sprung loose from these binaries, gender practices and sexual practices then come to be multifunctional, often in the service of relational as well as intrapsychic needs and agendas” (2000, p. 242).

In order to think about gender from a new theoretical framework—rather than looking at the “role of language” alone—we need to look at the “role of speech, specifically the practice of naming or not naming one’s experience” (Harris, 2000, p. 242). By reexamining the language, we will undoubtedly achieve a better understanding of gender “categor[ies],” how they are constructed, and “how complex, contradictory and multiply configured the categories used to describe gender will turn out to be” (pp. 242-
243). “Gender designations such like boy or girl are more like cognitive categories” (Harris, p. 243), and the multiplicity of categories and their relationship to bodily awareness and genitals is far more convoluted than we once thought. Harris noted:

Body schemas, including the experience of genitals, interrelate with gender consciousness in evolving and nonlinear ways. Psychoanalytic theory has focused on noting the press of the body on representation, but, as I have been arguing, it is important to see the impact of representation on body scheme. (p. 243).

Finally, Harris asserted that gender and sexuality are, in fact, interwoven. For instance, the “doubleness of identity” for the tomboy may represent complicated connections between identifications and desire (2000, p. 244). Harris argued that traditional formulations leave marginal “conceptual space for bisexuality,” and this space is considered a “provisional transitional space to be renounced in various ways” (p. 244). She suggested that we “reintroduce an old idea of psychoanalysis—that nothing once desired or brought into a relation of attachment and longing is ever fully relinquished” (p. 244). With regard to Harris’s ideas and concepts on the tomboy position, her arguments may perhaps also mirror, to some extent, the loss of repudiation of her feminine self, identification with either parent, and ungrieved loss for the female-to-male transgender (Harris, 2000).

By refusing monolithic models in understanding gender and sexuality, Harris believed the feminist psychoanalytic work could move forward in its’ thinking. She invited scholars to shift toward a deconstruction of formulations, while at the same time, recommending that they not discard Freud’s “contradictory model” (Harris, 2002). Rather, she wrote, “we might try to hold to a paradox. What is persistent is that gender and sexuality are fluid and unsettled and labile” (p. 113).
What can be consistently addressed is the disruptive and complex and multiply determined developments that end up in adult identity and adult love. Giving up commitments to a bifurcation of normality and abnormality where object choice and identity are concerned means that other criteria can be watchfully considered. (p. 113)

Here she advocates, along with Corbett, incorporating the chaos theory. Harris cautioned, that, despite the “revitalized vision of the complexity of gender structure and sexual object choice, there is still the problem of politics, culture, and power” (2002, p. 113). She also cautioned that:

Freud’s theory of the construction of the relation of sexual aim and object, of the free play of associations and symbolic meaning that arise for any child in regard to the body can sound remarkably idealistic. (p. 113)

And she advocated the following. “What is needed” Harris wrote:

is a theory that recognizes the social power of categories like gender and sexuality in both conscious and unconscious experience but can also account for the way in which these categories, at certain moments, lose salience and become more porous. (p. 113).

Benjamin’s work, Harris felt, nearly accomplished this task. Yet, she asserted, we still need a theory that invites masculine- and feminine-defiant markers, as well as a theory with “reified categories.” From her perspective, a careful analysis of Freud’s “radical model of sexuality as theorized in the essay on homosexuality in a woman, can be one crucial resource in such a project” (2002, p. 114). This author is perplexed as to why Harris is not the one to carry out this important undertaking.

In her second paper presented here, Harris concluded that tomboyism may indicate either an adaptation or loss. She wrote: “Tomboyhood, tomboy life, and tomboy love may operate in many ways; tomboy as outlaw and as conformist, tomboy as symptom and as developmental solution” (p. 245). What is evident is that rigidity of gender identity and gender role is problematic culturally as well as personally or
individually (Harris, 2000). This author concurs with Harris, especially with regard to
clinical practice: “Gender and desire, and their varied arrangements, can usefully be cast
in a set of narratives of great flexibility” (p. 245).

Utilizing chaos theory to conceptualize that “softly assembled behavioral
attractors,” we may come to realize that gender, “while diagnostically and perhaps
socially problematic, is a vehicle for a particular skilled task that a child must resolve,
namely, the securing of stable interactions and internal stability in another person”
(Harris, 2003, p. 240). In summary of what has been suggested here, in these
circumstances, chaos systems would lead us to conclude that “feeling solidly one gender
continuously, variations in genderedness, demarcations like a latency tomboy identity, or
multiple (gross or subtle) differences in one’s gender—would be theorized as emergent,
social, and interpersonally constructed” (Harris, 2000, p. 236). Finally, Harris’s ideas
signify “gender and body ego gender constructions as forms of compromise formation
(p. 240).

In short, the shift in contemporary psychoanalytic formulations has evolved
because patriarchal traditional developmental theories are no longer relevant for some
cultural groups, and the importance of the role of the countertransference from the
observer/analyst/clinician is undoubtedly exchanged consciously and unconsciously in
the treatment. As Harris noted, “Tomboys’ stories told through the prism of feminism, of
relational theory, and of chaos theory, are a venture in [a] direction” that avoids dated
approaches to interpretation of the norm” (2000, p. 245). She further asserted that “a
tomboy’s gender construction, desire, and character are not universal or transhistorical
forms” (2000, p. 229), but rather, dynamic intersections between environment and
constitution; that is it is “context dependent,” influenced by dyadic relational patterns (p. 231).

As Kassoff noted, an important component of relational theory, a therapist’s conscious and unconscious countertransference, is paramount in the treatment (2004). Consequently, a clinician is bound to engage unconsciously in enactments related to gender identity and sexuality. Relational theory also is concerned with the internal and external experiences of one’s identity and identifications (e.g., gender), yet, is also influenced by coexisting aspects of one’s identity (i.e., sexual orientation, ethnicity, class, religious or spiritual values, and beliefs, etc.). In treatment, from a relational theory perspective, a clinician’s identifications may be a form of reference for the patient, as well as for the therapist. As Harris noted, relational theory helps one understand the internalized identifications of one’s identity, (e.g., aspirations, anxieties, and fears).

In summary, the analysis of the aforementioned contemporary perspectives illustrate the notable gaps within and the revisions that have been made from traditional formulations, with regard to the consideration of one’s constitution and cultural environment, psychoanalytic and developmental perspectives, and coupled with feminist, queer, and postmodern theory. Chaos theory has been presented as the best means for illuminating and addressing the multiplicity of developmental trajectories. This theory, it has been suggested, can best capture the phenomenon of gender and sexuality. These collective contemporary perspectives on gender and sexuality, then, are able to illuminate the many prisms from which we view our patients’ fantasies and needs. It is clear now that gendered bodies, gender identity, gender role, desires (sexual aim), fantasies, and sexual object choice—like so many other aspects of an individual’s identity (e.g., ethnic,
sexual, religious/spiritual, etc.)—take on multiple identifications and endlessly shift one’s psychological, emotional, and intersubjective experience. This is then manifested in expected and unexpected patterns, particularly for the female-to-male transgender and gender-variant individual as they challenge basic intrapsychic and embodied notions of gender and sexuality.

The following module will address the clinical concepts and criteria for gender dysphoria, transsexualism, and gender identity disorder according to the *Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV, 1994)* and *Psychodynamic Diagnostic Manual (PDM, 2006)*. The module will also provide a discussion from transgender individuals and their allies point of view according to these pathological implications of gender non-conformity and diagnoses.
Training Module IV

Gender Identity Disorder: Female-to-Male (FTM); Transgender/Transsexualism

The remaining modules will shift from psychoanalytic formulations. In this module, clinical conceptualizations regarding gender dysphoria, transgender/transsexualism, and gender identity disorder are clarified according to the views of the mental health and other professional communities. A review of the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV, 1994) is provided, as well as the Psychodynamic Diagnostic Manual’s (PDM, 2006) criteria and symptomological features that are used to determine a diagnosis/disorder related to gender. The discussion of these texts is followed by a brief discussion of the reflections of transgender individuals and political advocates regarding these clinical diagnoses and pathological labels.

The intent of this module is to inform the clinician of the clinical nomenclature used with transgendered individuals as well as to reflect upon the transgendered community’s response to these classifications. This module also addresses the realities of such diagnoses from the perspectives of the psychiatric, psychological, medical, and surgical professionals who treat them. Commentary is also offered on the Standards of Care of Gender Identity Disorders (6th ed.) published by the World Professional Association for Transgender Health (formally known as the Harry Benjamin Gender Identity Dysphoria Association’s). A discussion will also be offered from the transgendered community itself and its understanding of the transgendered individual’s clinical needs vis-à-vis their gender identity issues.
This module informs the provider of the various clinical points of view regarding diagnostic and symptom taxonomies that tend to shape deprecating—as well as more benevolent—perceptions of transgender gender expression. The module also introduces the reader to clinical diagnostic classifications outlined by the *DSM-IV* and supported by the World Professional Association for Transgender Health.

*Gender Dysphoria, Transsexualism, and Gender Identity Disorder*

“Feeling trapped in the wrong body”: This complaint, voiced by distressed individuals traditionally referred to as transsexuals, brought gender issues to the attention of mental health professionals. These individuals often presented with gender dysphoria, a clinical term that refers to unrelenting mental pain and anguish wherein individuals experience psychological distress because their psychic-gendered state is incongruent with their physical characteristics and body presentation.

Transsexuals are most often viewed as gender dysphoric, as they are distraught about their ascribed gender at birth and its corresponding gender role. Israel and Tarver (1997) pointed out that some gender-conflicted individuals may repress these feelings. However, “When conflict with one’s gender identity is triggered (such as by a life change or personal crisis), the discomfort for many persons may reach crisis proportions” (p. 7).

Fisk first coined the term dysphoria in 1973, which connotes the Greek meaning “hard to bear” (as cited in Lev, 2004, p. 10). While Steiner (1985a) defined gender dysphoria as that “sense of awkwardness or discomfort in the anatomically congruent role, and the desire to possess the body of the opposite sex, together with the negative affect associated with these ideas, namely anxiety and reactive depression” (as cited in Lev, 2004, p. 10). Gender dysphoria presents with clinical symptomology because
conventional pressures disavow cross-gendered behaviors (Lev, 2004). Consequently, gender-variant individuals can present with multiple “reactive symptoms,” which include anxiety and depression, as well as “dissociation, suicidality, sexual dysfunction, substance abuse, self-mutilation, or even intense hostility toward other differently gendered people” (p. 10).

Not all gender-variant or transgender individuals experience gender dysphoria; however, most experience at least a few of the symptomatic features, which include “insomnia, isolation, dysthymia, anxiety, weight loss or gain, and work or school difficulties” and relationship difficulties (Lev, 2004, p. 10). Israel and Tarver asserted that professionals and laypeople alike often mislabel individuals as gender dysphoric, and in fact, they noted, “Once an individual has self-identified transition goals or has established a self-identified transgender identity, she or he is no longer considered to be gender dysphoric” (p. 8).

It is important that the medical and mental health professionals acknowledge that gender identity development is a process, which, at times, is slowed; it is a “natural, life-long process that is experienced by all individuals of all genetic, cultural, ethnic, and socioeconomic backgrounds” (Israel & Tarver, 1997, p. 8). Further, “professionals wishing to classify an individual for medical or mental health treatment are encouraged to utilize a medical or mental health diagnosis appropriate to actual symptoms” (Israel & Tarver, p. 8).

Lev advised:

The term gender dysphoria … [should] not be used as a diagnostic label but as a clinical descriptor, a way to articulate the discomfort associated with gender variance within a culture that has rigid gender rules. Gender dysphoria is not a synonym for ‘transsexual,’ nor should it be used to describe gender-variant people
in general; it is only a useful term when applied to people who are experiencing actual dysphoria. (pp. 10-11)

During the 1950’s, transsexuals entered the professional arena in increasing numbers, aspiring to live their lives in the cross-gendered role from their gender assigned at birth. According to Denny, “Gender Identity is the private experience of gender role, and gender role is the public expression of gender identity” (1994, p. xxi). The DSM-III diagnosis of Transsexualism was attributed to individuals with the following criteria: those who experience distress related to their ascribed gender role for at least 2 years, coupled with the desire to transition from one’s birth sex to obtain secondary characteristics of the opposite gender (pp. xxi-xxv). Though not all transsexuals chose to undergo medical and surgical interventions to transition to the opposite sex, they tended to meet the following diagnostic criteria:

1. Individual has felt prolonged discomfort with anatomic sex. 2. Individual has experience living in the opposite-sex role. 3. Individual is determined to undergo surgical restructuring of genitals. 4. Individual selects procedures to physically alter sexual characteristics to stimulate those of the other gender. 5. Gender identity disorder appears to be permanent and constant over time. … 6. Individual has no intersex or genetic abnormality [sic] 7. Gender identity disorder is independent of, if not caused by, any other mental disorder. (Schaefer, Wheeler, & Futterweit, 1995, as cited by Lev, 2004, p. 172)

It is important to note that the same year homosexuality was removed from the DSM—which was the result of a political advocacy to depathologize homosexual sexual behavior—the diagnostic category transsexualism was introduced into the DSM-III in 1987 (Lev, 2004). It has been argued that maintaining diagnostic categories that pathologize gender non-conforming behavior is of consequence to individuals, as well as marginalized groups who may not have any mental health issues. Following, transsexualism was later assimilated into the broader categories of sex and gender
identity disorders in the *DSM-IV* (Lev, 2004). Though much controversy surrounds the previous diagnostic categories, as well as Gender Identity Disorder, pathological interpretations of gender-variant presentations have been criticized by various advocates of oppressed sexual minority movement groups who sought to remove homosexuality from the DSM-IV.

Gender Identity Disorder was formulated to identify a group of individuals as mentally ill. Of significance, providing a diagnosis was later found to be used by transsexual individuals to access medical treatment to alleviate their psychological discomfort from their physical embodiment. The diagnostic category Gender Identity Disorder was developed to identify, and thus be able to evaluate, clinical features of individuals who suffer from gender-related issues. This diagnostic label led to the “legitimization” and “recognition of gender identity disorders [which] affirmed them ‘as conditions worthy of evaluation and treatment’ and acknowledged … sex reassignment surgeries ‘as legitimate treatment and not an elective cosmetic surgery’” (Pauly, as cited by Lev, 2004, p. 171). However, Israel and Tarver argued that, “There is no reason why psychiatrists and other mental health professionals cannot be charged with the responsibility of recognizing gender-identity issues without the necessity of labeling them as disorders” (1997, p. 25). They asserted that practitioners ought to “diagnose and treat only that which is disordered and diseased” (1997, p. 25).

*DSM-IV Diagnosis*

The *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (APA) was in its fourth revision in 1994 (*DSM-IV*). As mentioned previously, in this edition, the diagnosis of transsexualism was replaced with
Gender Identity Disorder. The diagnostic adult profile requires four of the following criteria: 1.) An individual presents with features of persistent cross-identifications without desires to achieve cultural advantages to being the other sex. 2.) Insistence or repeated desire to be one of the opposite of their birth sex. 3.) Preference for cross-gendered stereotypical attire. 4.) Persistent preference for cross-sex roles or being the opposite sex in fantasy (DSM-IV, 1994, p. 581).

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequently passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex. (DSM-IV, 1994, p. 581)

In addition, the diagnostic criteria specifies that an individual engages in cross-gender activities, demonstrates constant discomfort with their sex or sense of incongruity in the gender role of that sex, wherein such state causes significant social, occupational, or impairments in functioning and is not concurrent with any intersex condition (DSM-IV, 1994).

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to stimulate the other sex) or belief that he or she was born the wrong sex. (DSM-IV, 1994, p. 581)

Thus, the DSM-IV gender identity disorder diagnosis suggests that there is a sense of “inappropriateness” about gender (p. 581). A clinician should not rely solely on the review of the diagnostic profile presented here, but rather, refer directly to the DSM-IV when evaluating diagnostic qualifications for official or legal documentation.

Differential diagnoses includes Transvestic Fetishism, which designates cross-gender behaviors and engagement in enactments that elicits sexual desire, Gender Identity Disorder Not Otherwise Specified (NOS), which can include individuals with
congenital intersex conditions and/or individuals with gender problems (i.e., persons who seek hormonal treatment, yet have no intentions to undergo genital reconstruction). The major issue suggested here in the Gender Identity Disorder NOS is that not all transgender individuals feel distressed about their varied body conditions or feel as if they are in the “wrong body,” and as suggested elsewhere, identify solely as men. Therefore, the category fails to capture the limitations of medical options for female-to-male and transsexual men. Some transgender individuals may find psychic comfort by implementing more moderate interventions by means of change of dress, and adopting mannerisms and sex roles. Importantly, multiple surgeries are costly, masculine presentations vary; that is, whether the individuals have breasts or not, penises or not, as well as other female-bodied parts does not mean that they are disordered. However, the argument in support of the DSM-IV diagnosis of Gender Identity Disorder as a mental health disorder is that it provides a formal diagnosis that is recognized by insurance companies as they accept mental health and medical providers’ clinical documentation based on medical necessity, thereby approving therapeutic and medical interventions.

Israel and Tarver recommended against using the DSM-IV’s diagnosis of Gender Identity Disorder. While they acknowledged that the purpose of the DSM-IV is to capture the more emotionally troubled group of transgender individuals, they emphasized the fact that “many transgender persons do not evidence gender-associated confusion or emotional distress” (1997, p. 24). There is general consensus among gender specialists (professionals who commit to extensive study on gender and sexuality research, training, consultation, and care) that Gender Identity Disorder will be removed from future revisions of the DSM. However, others counter these positions, opining that transgender
individuals may benefit from such mental health diagnostic labeling in that they are able to obtain psychological and medical support (Israel & Tarver, 1997). Despite the shift in depathologizing gender variance, however, Israel and Tarver conceded that traditional protocols that include pathologic connotations and profile criteria may continue to be utilized by paraprofessionals (1997). They argued:

We advise that these pathologizing references be removed from texts, diagnostic tools, research and treatment protocols, and client medical charts or clinical files. Inclusion of such material further stigmatizes transgender individuals. (Israel & Tarver, 1997, p. 25)

They further asserted that making use of “deprecating material or references to transgender persons or needs is also unnecessary in filing insurance claims” (p. 25).

They continued:

Psychiatric and psychotherapy insurance claims may utilize any DSM-IV diagnostic category that reflects the true nature of the problem being addressed by the support process. These categories might be, for example, adjustment disorder; major depression; personality disorder; and so forth. (Israel & Tarver, 1997, p. 25)

Israel and Tarver also contended that documentation intended for genital reconstruction surgeries or any other surgical procedures should merely state the “need based on medical necessity” (p. 25). Though Israel and Tarver concurred with the DSM-IV’s listing of rule-out disorders, holding that disorders such as Transvestic Fetishism may exhibit similar symptomatic features, they nonetheless contested these conditions are remarkably different gender identity concerns.

Psychodynamic Diagnostic Manual: PDM Diagnosis

The Psychodynamic Diagnostic Manual (2006) was developed to expand upon the DSM-IV “taxonomy of diseases or disorder,” and to rather, provide the “taxonomy of people” based on psychoanalytic formulations (p. 13). The intentions of the PDM are to
understand characterological personality organizations and “tie the phenomena, identified and categorized, to any overarching theory of mental functioning” between “normal” and pathological paradigms of functioning (p. 13), coupled with the evaluation of the subjective experiences of symptomatic patterns. There is an effort to view persons in an idiosyncratic manner and find meaning to “symptoms, behaviors, traits, and affects, attitudes, thoughts, fantasies, and so on” (PDM, 2006, p. 13). This diagnostic framework is intended to capture an individual’s adaptive range of functioning as well as cluster abnormal commonalities among specific groups. Thus, the PDM is remarkably different from the DSM-IV’s systematic approach and attempts to illustrate an individual’s range of functioning. Rather, the PDM evaluates the spectrum between healthy and personality disordered functioning and range of mental health functioning, which includes interpersonal relating patterns, expressions of feeling states, defenses or coping strategies, and self-awareness of these aforementioned positions, as well as subjective symptomatic difficulties and moral judgment capabilities (PDM, 2006).

According to this clinical perspective, the PDM is better able to capture what may be more adaptive for female-to-male transgender and gender-variant individuals by first evaluating their personality styles (P AXIS: Personality Patterns and Disorders), then, considering mental health functioning (M AXIS: Profile of Mental Functioning) and finally, symptomatic issues (S AXIS: Symptomatic Patterns: The Subjective Experience) (PDM, 2006). Although a thorough review of AXIS P is beyond the scope of this project, it is indisputable that a patterned personality style will more or less impact the subjective experience and management of one’s symptoms, which undoubtedly maintains or hinders these perceptions and mental health functioning. Because AXIS S has a subcategory,
S308.3 Gender Identity Disorders, similar to that of DSM-IV’s, the subsequent section will review its formulation.

Gender Identity Disorders (S308.3), which falls under “Symptom Patterns: The Subjective Experience” category of the PDM, is reviewed briefly here. The PDM acknowledges that society has adversely affected sexually diverse individuals, which has “burdened our understanding of divergent sexualities and our efforts to help people who suffer, or cause others to suffer, because of their sexual psychology” (PDM, 2006, p. 129). The PDM states:

Differentiating disease states from normal human variability is hampered by the popularity or demonization that a diagnosis acquires in a particular society at a particular time, by theories that generalize about a biologically determined goal of maturity applicable to every individual, and by phenomena of fluidity and adaptation that may create different sexual responses at different ages and in different situations. (PDM, 2006, pp. 129-130)

The PDM acknowledged that the DSM-III-R (1987) did not include Gender Identity Disorder as a sexual disorder; however, the subsequent edition, published 7 years later, the DSM-IV, placed sexual and gender identity disorders in discrete sections. The PDM asserts that that “because in lay usage the term gender has replaced sex, this seems unfortunate: ‘Sex’ refers to a physiological state, while ‘gender’ connotes a psychological experience” (p. 130). Similar to Israel and Tarver (1997), the PDM’s position is that “many transgender individuals do not report significant psychological suffering and do not cause suffering to others; therefore, there is debate among professionals regarding whether or not such individuals warrant a diagnosis” (p. 131). The manual advises professional to consider all aspects of an individual’s functioning before making pathological diagnostic classifications according to gender (2006).
The PDM cautions that some transgender individuals who present with gender identity disorders may also present with acute distress, such as self-mutilation gestures, suicidal thoughts and fantasies, and they may also be isolated communally. The severity of their psychological suffering makes these individuals vulnerable to substance abuse and addiction (2006). The PDM also acknowledges that “cultural patterns of sexism may play a significant role in disparity” among gender-troubled individuals (p. 131).

The PDM identified and described the following categories that need to be assessed for Gender Identity Disorder: cognitive patterns, affect states, somatic states, and relational patterns. In these discrete divisions of functioning, an individual with Gender Identity Disorder is likely to be functioning as a means of adapting to profound distress and dysfunction. Cognitive patterns for transgender individuals generally do not exhibit distortions in reality testing (2006). However, it is also noted that “people who suffer on the basis of the disparity between their psychological and morphological gender may be deeply and constantly preoccupied with that discordance” (p. 131). The manual underscores the importance of being able to distinguish between individuals with psychotic delusions and individuals in distress who are gender identity disordered. Individuals with gender identity disturbances may exhibit affective states that include depressed moods, and at times, suicidal ideation. Individuals often express “negative and aggressive feelings toward gendered body parts” (p. 131). The PDM states that transvestite and cross-gendered individuals may tend to feel internally different (i.e., feelings that range from harmonious to tormented) when embodied in one gender versus another. Somatic states of gender-disordered individuals include an “intense focus on and discomfort with selected body parts that are viewed as ‘not me’” (p. 131). Finally,
It is important that the professional reader consider a comparison of a *DSM-IV* diagnosis to a PDM diagnostic formulation. The PDM formulation is likely to profoundly affect the clinician’s professional judgment regarding overall functioning and treatment goal needs for transgender female-to-male and gender-variant individuals. The PDM’s classification offers a multifaceted conceptualization of an individual’s emotional and behavioral functioning. Hence, it provides an impression of an individual that marks their idiosyncratic subjective experience, as well as evaluates both adaptive and pathological aspects to one’s individual character and overall functioning.

*Transgender Perspectives Regarding Diagnosis*

The transgendered liberation movement, which is supported by transgender individuals, their partners, families, friends, and allies, challenges diagnostic categories that contribute to the ideology and enactment of oppression in regard to one’s gender and sexuality. The movement extends beyond the historical, political, and academic realms regarding gender-variant characterizations. It takes into consideration the mental health communities as well who work with mental diagnoses, such as Gender Identity Disorder, which, they believe, pathologizes gender variance (Lev, 2004). This opinion is captured well by Wilchins (1997), who wrote, “‘Gender dysphoria’ is ‘a term used by nontranssexual shrinks who write surgery letters’” (as cited in Cromwell, 1999, p. 25). According to Cromwell, many transgender individuals believe that it is, in fact, the nontransgender persons who have gender dysphoria (1999).
Transgender individuals argue that clinical language and categories have pathological connotations that may infer that individuals seeking psychotherapeutic and medical interventions are not capable of making their own informed decisions (Cromwell, 1999). For example, the Standards of Care include in its definition of the term transgender, persons who have no intentions of changing their bodies and fail to acknowledge that there are significant differences between transgender male-to-female and female-to-male transpersons (Cromwell, 1999). Finally, the most troublesome for transgender individuals is that both the DSM-IV and Standards of Care infer that all female-bodied, masculine-identified transpersons are aberrantly mentally ill (Cromwell, 1999).

Diagnostic categories of mental disorders are not absolute. Lev contended:

The boundaries of diagnostic criteria are by definition vague, and decisions of categorical inclusion or exclusion are not based solely on science but constructs and beliefs. The line between mental illness and mental health function and dysfunction is a judgment call that is at best imperfect. (p. 149)

She continued by noting that diagnostic categories and qualifications are frequently revised, thus constantly “shifting the boundaries of disease and disorder” (p. 149).

Nonetheless, the DSM has, perhaps unintentionally, become a primary tool for managed health care systems to communicate to insurance companies and approve treatment interventions (Lev, 2004), rather than the initial intention of its publishers, which is to assist mental health professionals in understanding psychological disturbances that lead to impaired functioning and treatment planning. In fact, one of the major criticisms of the DSM is that it is not reliable across various trained disciplines and among clinicians (i.e., subjective interpretations of patients’ symptomology may lead to different diagnoses). Lev noted, “Approval for transsexual surgeries is dependent on the
reliability of diagnosis of gender identity disorder and the ability for the diagnosis to be used in a similar manner by various clinicians” (p. 152).

The role of the “gatekeeper” presents a formidable barrier to gender-variant individuals. The gatekeeper is, in essence, the professional in charge of the analysis of transgender or gender-variant circumstances, and based to their his/her judgment, the clinician yields the power to dictate (approve or disallow) treatment interventions. This position is particular problematic for those gender-variant individuals who wish to express their gender identity through various bodily mediums that include self-determining interventions. For example, some transgendered men may choose to have a chest reconstruction/bilateral mastectomy but refrain from partaking in hormonal interventions. Therefore, gatekeepers or professionals need to take into account these examples of personal choice of varied bodily states that challenge the general clinical understanding of the human condition as based on a two-sexed system. This system fails to acknowledge the risks of surgical and hormonal surgeries, even if self-identified and self-determined.

Thus, practitioners working with transgender and transsexual individuals must not rely solely on the gender identity disorder descriptors and subcategories in the DSM-IV to ascertain symptomology that leads to psychotherapeutic and medical intervention. This narrow view may be proof both inconclusive and careless, and it may not be in the best interest of their patient.

In the next module, Clinical Implications and Intervention, an introduction to the work of Harry Benjamin, a pioneer in working with transsexual and gender-variant individuals that lead to the development of The Standards of Care and its treatment
guidelines will be discussed. These guidelines have also been established according to
*DSM-IV* formulations. The module will also address psychoanalytic techniques and
intervention specific to this population, as well as pertinent issues for treatment.
People seek psychotherapy for a number of reasons, and often the initial “presenting problem” is only a camouflage for the real reason they are seeking treatment. The patient’s true concern is only uncovered during the therapeutic process. The intent of this manual is to guide clinicians in their work with female-to-male transgender patients with gender-related issues. Often by the time this population finally seeks mental health support, the individual is under a great deal of emotional pain and distress, just as any self-exploration comes with a great deal of uncertainty, ambivalence, and apprehension. In the case of the transgender female-to-male patient, the individual’s concerns may be multiple: fears of loss (e.g., family, partners, children, and friends), self-image and body issues, impaired sexual functioning, as well as depression, anxiety, isolation, and marginalization. It is important to keep in mind, however, that the transgender female-to-male person seeking treatment is not always doing so because he/she is emotionally troubled by his/her gender or sexuality differences.

The following module will discuss clinical implications and interventions by reviewing mental health concerns, the role of the clinician, and introducing the work of Harry Benjamin, which lead to the clinical guidelines set forth by the Standards of Care. A brief commentary on the guidelines, as well as managed care concerns, and legal issues will be provided. It will be followed by a discussion on psychoanalytic technique and intervention (e.g., careful consideration of transference/countertransference issues and making use of intake assessments). The initial intake assessment process identifies the patient’s needs: this then informs the clinician of specific clinical and mental health
problems and will be used in developing a case formulation for working with the individual, which, in this case, is a transgender female-to-male and gender-variant individual. Correct assessment with this population is both complex and critical, as their specific needs may easily be lost within the multiple clinical issuers presented e.g., the management of anxiety and depressive symptoms. An incorrect assessment will hinder the clinician’s insight and clinical approach in treatment, risking empathic failure on the part of the clinician, pathological interpretations of gender-variant expressions, maltreatment practices, and possibly unethical treatment. Comorbid pathology as well as crisis and at-risk individuals will be discussed. A final section in this module discusses cultural considerations, which are equally critical to successful treatment of this population.

Clinical and Mental Health Issues

Transgender individuals are no different than any other individual with regard to personal life crises and major life-changing events (Israel & Tarver, 1997). However, persons with gender-related issues are more likely to experience a variety of mental health problems, such as adjustment, depression, anxiety and posttraumatic stress disorders. Mental health providers must carefully consider the true nature of these patients’ difficulties. Unfortunately, many health care providers believe transgender female-to-male and gender-variant individuals comprise a mental disorder because of their unique gender qualities; even more unfortunate, many transgender individuals have embraced or internalized this illness model (Israel & Tarver, 1997). Lev stated:

The list of mental health disturbances that gender-variant people are thought to suffer from is exhaustive. Almost all writers discuss this population in terms of “illness,” “pathology,” “disorder,” “condition,” and “problem” and identify clients as demanding, manipulative, controlling coercive, and paranoid. Gender-variant
people are identified as impulsive, depressed, isolated, withdrawn, anxious, thought-disordered, and suffering from narcissistic, schizoid, and borderline personality features. They are perceived as immature and egocentric with profound dependency conflicts, although natal males are almost always seen as more disturbed than natal females (with the exception of Lothstein, 1983, who views females as equally disturbed). (2004, p. 189)

According to Lev, this includes many skilled and supportive clinicians as well as those who qualify as neither (viz., Bockting & Coleman, 1992; Gosselin & Wilson, 1980; Holtzman et al., 1961; Person & Ovesey, 1976; Sperber, 1973). Lothstein (1983) went so far as to suggest that female-to-males have primitive defense structures related to borderline characterological personality structures (as cited in Lev, 2004).

Lev underscored the importance of correctly diagnosing this population because she noted that gender identity disturbances can “mask more serious mental health problems or may be a less significant part of pervasive psychopathology” (2004, p. 190). For example, Brown (1990) outlined diagnostic conditions, such as schizophrenia, and body-dysphoric disorder, as well as clinical problems such as homophobic homosexuality, and noted when transgender individuals with these difficulties should not receive hormonal or surgical interventions (as cited in Lev, 2004). Most of the current research is based on distressed patients who seek treatment in community-based clinics who tend to be most likely to experience gender identity disorders or gender dysphoria, as well as other debilitating mental health disorders.

Israel and Tarver (1997) and Lev (2004) advocate that clinicians should support this population’s idiosyncratic needs to self-determine their gender identity regardless of various gendered expression or coexisting mental health problems. This author endorses this position with regard to treatment.
Role of the Clinician

Traditional etiological perspectives, pathological diagnoses, and diverse approaches to treatment of transgender individuals based on a model of illness have all served to discourage nonconforming gender and sexual minority groups from seeking treatment. By putting aside these various perspectives and formulations and focusing instead on developing an empathic and collaborative therapeutic alliance, the clinician is much more likely to establish a long-term trusted relationship that fosters therapeutic healing. Coconstructed treatment goals and interventions are also likely to improve the quality of the treatment as well as the patient’s functioning and quality of life. It is important to note that some individuals may no longer continue treatment once their gender identity has become congruent. Lev advised that the role and position of the clinician should be “based in advocacy, education, and support,” as well as defining and incorporating an interpretative framework with etiological meaning from the perspective of the patient rather than from the observer (i.e., the trained professional) (2004, p. 185).

A number of criteria have been identified as being most critical in assessing the “true transsexualism” (Lev, 2004, p. 186). She indicated:

Age of onset of gender dysphoria, substance abuse, marital status, comorbid mental health problems, level of anatomical dysphoria, criminality, assumed postsurgical homosexuality, psychoanalytic assessments of childhood issues, ability to successfully pass, and threats to suicide as a valid determiner of the “seriousness” of the applicant have all been fodder for the psychological assessment process utilized to approve transsexuals for medical treatments. (Lev, 2004, p. 186)

This author suggests the following recommendations in adapting to working with transgender female-to-male and gender-variant persons.
1. Do no harm. In the American Psychological Association (APA) Ethical Principles and Code of Conduct for Psychologists, Principle E: Respect for People’s Dignity states:

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologist are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (APA, 2003)

2. Immerse your thinking into a nonbinary world where there is no longer a dichotomous categorical system (male/female, masculine/feminine, dominant/submissive, power/vulnerability, give/take, passive/active, etc.), but rather, one that is more representative of a nonlinear model, a spectrum of possibilities.

3. Be mindful of your role as a clinician. Transgender individuals often feel persecuted in adhering to the Standards of Care, which requires a licensed professional assessment of their readiness to receive irreversible hormonal and surgical medical interventions by surgeons and endocrinologists. Often transgender individuals feel that they have to report what clinicians need to hear in order to obtain the care they desire. Clinicians should be cognizant of the fact that they are pejoratively known as “gatekeepers” and are often viewed by this population as individuals who wrongly hold the power to
approve their access to care and interventions that allow them to self-
determine their own gender identity expression.

4. Do not rely on patients to educate their individual providers on the complexity of transgender issues. This includes remaining abreast on transgender phenomena, language, political, social, and legal issues as well as trends in the community. It is important to thoroughly read and revisit the various modules of this manual.

5. Honor the patient’s right to self-determination.

6. Make decisions that are not based on the traditional frame of transgender as pathology when asked to write letters of recommendation for hormonal and surgical interventions, sign legal affidavits to confer sex/gender status, and collaborate care efforts with various personnel per a patient’s request (e.g., providers are often asked to write a letter to a boss or employer to explain personal circumstances and need for accommodations).

7. Finally, seek out consultation with a gender specialist when feeling beyond your scope of expertise regarding clinical issues, negative countertransference issues, as well with any other clinical uncertainty in providing care.

Israel and Tarver (1997) also have recommended that professionals use labels sparingly, contending that premature self-determined labels on behalf of the individual may lead to irreversible consequences; ideally, individuals should spend considerable time reflecting on their circumstances and wishes (1997), and labels tend to foreclose such necessary self-exploration. Israel and Tarver also cautioned against:

1. Care providers who stop listening once they decide an individual falls with a subpopulation.
2. Encouragement of an individual to conform to models that are inconsistent with the individual’s needs or self-identify.
3. Individuals who feel they may want or are ready for hormones or surgery, and aggressively pursue such, when in actuality they are only experiencing a few coming-out highs in relation to a new self-discovery of gender identification.
4. Transgenderists or transsexual individuals who feel pressured to conform to stereotypes in order to please friends, partners, or care providers and thus receive support, hormones, or surgery that may not be right for them. (1997, p. 14)

Transgender or androgynes also should not be coerced into adhering to rigid gender identifications:

Neither transgenderist nor androgyne individuals should be required to conform to transvestite, transsexual, or other stereotype or support models. The end result could be misdirected focus on Genital Reassignment Surgery rather than integrating their actual gender identity needs. (Israel & Tarver, 1997, p. 16)

Unfortunately, traditional etiological perspectives have caused many negative consequences, including misguiding clinicians and leading gender-variant individuals to rehearse roles and memorize and incorporate diagnostic features into their presentation in order to effectively influence their clinicians to support their presumed needs, much of which are rooted in fear of denial of supportive services or not receiving letters of recommendation. This can lead to a new gender script that solicits acting out behaviors on the part of the patient and inadequate care on the part of the practitioner. “As a consequence, harmful external forces may impact the gender-exploring individual through moral condemnation, refusal to communicate, physical or emotional violence, professional misdiagnosis, or inappropriate clinical care” (Israel & Tarver, 1997, p. 21).

Although power dynamics cannot be simply eradicated in a therapeutic relationship, understanding the nature of the professional role and the power that it holds will enhance a clinician’s ability to openly address and explore these power dynamics with their patients, thereby minimizing the patients need to collude with the
aforementioned roles and improving that clinician’s assessment of the patient’s need for care.

Transsexual Treatment History: Harry Benjamin

Benjamin was a remarkable endocrinologist who demonstrated that he was clearly ahead of his time when he acknowledged that psychotherapeutic interventions could not “cure” transsexuals. As an alternative treatment, he developed a medical model that would provide empathic care, as he believed that “transsexuals could not be ‘cured.’ i.e., they could never become comfortable within the gender parameter of their bodies” (as cited by Lev, 2004, p. 29). He also believed that intersexed children should not be surgically altered to cure the ambiguity of their genitalia (Lev, 2004).

Benjamin is renowned for identifying the psychiatric condition, transsexualism, which he defined as an “individual’s wishes to manifest the primary and secondary sex characteristics of the non-natal sex and live as a member of that sex, and modifies his or her body with hormones and surgery” (Denny, 2004, p. 26). Benjamin claimed that although biological underpinnings impact female transsexualism, one’s early childrearing is paramount (Lyons, 1986). Benjamin came to his conclusions after working with hundreds of men and women who lived in “misery” in their birth “skin” (Denny, 2004).

Early in his career (circa 1966), Benjamin claimed that transsexualism was the result of a biological condition (Ovesey & Person, 1973) and that these patients could be sufficiently treated through medical interventions that would satisfy their desires to transition to the opposite sex (Denny, 2004). Benjamin’s work evolved over time, exploring power differences between the sexes and ways in which the child’s relationship
with the mother, the primary object, is convoluted with identifications and separations from a “devalued” gendered person in a male-dominated society (Bell, 2004).

Benjamin’s legacy was ensured by a former patient, Reed Erickson who founded the Erickson Educational Foundation (EEF), which in turn funded the Harry Benjamin Foundation, an organization committed to education on transsexualism (Lev, 2004). Later, Erickson established the Harry Benjamin International Gender Dysphoria Association (HBIGDA), a professional organization committed to research and empathic treatment for persons with gender-related problems (Lev, 2004). HBIGDA was recently renamed the World Professionalism Association for Transgender Health, Inc. (WPATH). Notably, WPATH publishes the scholarly *International Journal of Transgenderism*, a journal committed to educating professionals and advancing knowledge of gender issues, improving the quality of care in both the medical and psychological communities, as well as fostering social and legal acceptance of hormonal and surgical interventions (of note, these interventions came about as a direct result of HBIGDA’s efforts, WPATH, 2001). WPATH has also successfully promoted Benjamin’s *Standards of Care*, a manual of comprehensive ethical guidelines for the treatment of patients with gender-identity disorders, which is currently internationally accepted (WPATH, 2001). Today, there are many private physicians who perform gender-related surgeries and nearly 40 gender clinics worldwide (AES Web, formally HBIGDA, Lev, 2004) base their practices on Benjamin’s *Standards of Care*.

*Utilizing Standards of Care*

The World Professional Association for Transgender Health’s (formally known as The Harry Benjamin Gender Identity Dysphoria Association) *Standards of Care of*
Gender Identity Disorders (6th ed.) was last revised in February 2001. The intent of this manual is provide a general consensus of practices among professionals and provide guidelines for professionals who work with persons with gender identity disorders and their families, as well as to provide relevant social institutions with reliable up-to-date information (2001). The committee who published the Standards of Care submitted that the goal of all psychotherapeutic, endocrine, and surgical therapies is to provide treatment that fosters “lasting personal comfort with gendered self in order to maximize overall psychological well-being and self-fulfillment” (2001, p. 1). They also advised that their recommendations be viewed and used as flexible guidelines in the treatment of persons with gender identity disorders. It is important to note that their recommendations are, in fact, minimal in nature and are often contested and modified by individual practitioners and agencies alike. In these cases, the committee strongly advises that such modifications be legally documented, explained to the patient, and that they be solely based on the idiosyncratic needs of the patient (e.g., anatomical, social, and psychological).

According to the Standards of Care, individuals who meet the qualifications for the DSM-IV’s or the International Classification of Diseases-10’s (ICD-10) Gender Identity Disorder, present with the following impressions:

A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist during a person’s development, become so intense as to seem to be the most important aspect of a person’s life, or prevent the establishment of a relatively unconflicted gender identity. The person’s struggles are then variously informally referred to as a gender identity problem, gender dysphoria, a gender problem or a gender concern, gender distress, gender conflict, or transsexualism. (p. 2)
Individuals may suffer from these troubles as early as preschool, may “reflect various
degrees of distress and dissatisfaction with sexual identity, sex and gender demarcating
body characteristics, gender roles, gender identity, and the perceptions of others” (p. 2).

The *Standards of Care* outlined the typical course of Gender Identity Disorder:

> The therapeutic approach usually includes three elements or phases (sometimes
labeled triadic therapy): a real-life experience in the desired role, hormones of the
desired gender, and surgery to change the genitalia and or other sex characteristics. (p. 3)

The manual also pointed out that other trajectories, though not scientifically
substantiated, have found that individuals do not participate in this triadic treatment based
on gender identity disorder alone:

1) Some carefully diagnosed persons spontaneously change their aspirations;
2) others make more comfortable accommodations to their gender identities with
medical interventions; 3) others give up their wish to follow the triadic sequence
during psychotherapy; 4) some gender identity clinics have an unexplained high
drop-out rate; and 5) the percentage of persons who are not benefited from the
triadic therapy varies significantly from study to study. (p. 3)

Importantly, the committee noted that not all individuals partake in all three elements of
the triadic treatment plan. Typical trajectories include 1) Hormones; 2) Real-Life
Experience and 3); Surgery. However, for female-to-male transitioning patients, the
course of treatment might be 1) Hormones; 2) Breast surgery; and then 3) Real-Life
Experience (2001). The committee cautioned mental health professionals who work with
individuals with gender identity disorder to pay close attention to the following
guidelines:

1. To accurately diagnosis the individual’s gender disorder;
2. To accurately diagnosis any co-morbid psychiatric conditions and see their
appropriate treatment;
3. To counsel the individual about the range of treatment options and their
implications;
4. To engage in psychotherapy;
5. To ascertain eligibility and readiness for hormone and surgical therapy;
6. To make formal recommendations to medical and surgical colleagues;
7. To document their patient’s relevant history in a letter of recommendation;
8. To be a colleague on a team of professionals with an interest in the gender identity disorders;
9. To educate family members, employers, and institutions about gender identity disorders;
10. To be available for follow-up of previously seen gender patients (2001, p. 6).

The committee also advised mental health professionals to be careful in distinguishing between eligibility and readiness, the criteria for which can be found in the Standards of Care. They advised the clinicians to adhere to their step-by-step eligibility recommendations noted above before writing a letter that supports hormonal and surgical interventions. In general, female-to-male patients need one letter to begin hormone treatment or to undergo chest reconstruction. Such a letter should include the following information:

1. The patient’s general identifying characteristics;
2. The initial and evolving gender, sexual, and other psychiatric diagnosis;
3. The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent;
4. The eligibility criteria that have been met and the mental health professional’s rationale for hormone therapy or surgery.
5. The degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance;
6. Whether the author of the report is part of a gender team;
7. That the sender welcomes a phone call to verify the fact that the mental health professional actually wrote the letter as described in the document.

The organization and completeness of these letters provide the hormone-prescribing physician and the surgeon an important degree of assurance that the mental health professional is knowledgeable and competent concerning gender identity disorders. (2001, pp. 7-8)

(A sample letter will be provided in Appendix B.)

In addition, clinicians are instructed to follow through with the outlined recommendations in order to support an individual who desires sexual reassignment.
surgery. For example, the patient is expected to live full-time in the preferred gender for 12 months prior to genital surgery. The treating professional should take care to document that the real-life experience has indeed occurred during this time. This real-life experience is important as it is designed to help the patient adjust psychologically to his/her transformation in his/her confirmed gender identity and role. It is important to note that a second letter of recommendation for genital surgery is required from a psychiatrist or clinical psychologist who has had extensive training in evaluating comorbid issues (2001).

The manual states that psychotherapy is not necessarily a prerequisite for “triadic therapy,” although, in many cases, it is instrumental in supporting transitioning individuals during all phases of change. The most critical element here is that the practitioner educate the patient on the range of treatment options, as well as help the patient to set realistic goals that consider both work and personal relationships and goals that will help to stabilize a patient’s initial discomfort. Some gender clinics may refer patients for treatment, and it is important to note that each patient’s needs vary in terms of length of assessment and exploration for personal growth. Treating professionals, agencies, and programs should each set their own time increments.

Only after a therapist has established a good working relationship with the patient should they begin to work on the initial goals. It is important to note at the outset that “no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all vestiges of the person’s original sex assignment and previous gendered experience” (p. 12). An additional important point to note is that “psychotherapy is not intended to cure the gender disorder. Its usual goal is to achieve a long-term stable life style with
realistic chances for success in relationships, education, work and gender identity expression” (p. 12). A therapist’s role should be supportive; yet, the therapist should also actively explore with the patient the multiple options that might be right for his/her unique needs. A “collaborative therapeutic relationship” will enable patients to share their “thoughts, feelings, events, and relationships” (p. 12). The continuation of the psychotherapeutic relationship is often an important source of ongoing empathic support for an individual as he/she settles into the transition to his/her aspired gender identity and gender role and finds personal comfort over the ensuing months.

Multiple aspects of gender identity concerns, diagnostic features, treatment recommendations, and protocols in the assessment of facilitating support and psychotherapy are reviewed in the Standards of Care, as well as specific information on potential symptoms and side effects following treatment (e.g., hormone side effects) and options that the provider needs to know when treating these posttreatment conditions. It is not the intent of this manual to review all of the contents of the Standard of Care. Providers are encouraged to refer to the manual itself, which can be downloaded from the World Professional Association for Transgender Health’s website (www.wpath.org) provided free of charge in PDF format.

Psychoanalytic Technique and Intervention

Transference and Countertransference

Traditionally and into the present, psychoanalytic treatment considered important the patient’s positive, neurotic, and erotic transferences, which are rooted in the patient’s own past relational experiences, being projected onto the therapist. From this perspective, a therapist’s countertransferential reactions were considered an obstacle to treatment. The
task was to keep at bay these feeling states evoked in the clinician by remaining in a neutral stance, and the clinician was encouraged to seek his/her own supervision or analysis to deal with these issues. A radical shift took place in contemporary psychoanalysis, and now the practitioners are actively incorporating the patient’s projections into the therapy. These absorbed feeling states that are experienced by the therapist refer to relational dynamics often enacted with a patient, or with projective identification experiences (i.e., feelings a patient intends to evacuate, unconsciously, from the self into the psyche of the therapist). It is now considered that these countertransference experiences guide therapists in their understanding of a patient’s circumstances. Nancy McWilliams (1999) stated, “Patients create in their treaters conflicts that are parallel to those they have struggled with all their lives, and then they watch to see whether the therapist can model a new way of resolving them” (p. 105).

A relational style, one in which the therapist is able to reflect on his or her own affective reactions—as well as those exchanged both consciously and unconsciously throughout treatment by the patient—is essential to the success of contemporary psychoanalytic treatment. However, there are times when these feeling states are not accurately read by the therapist. Here, contemporary practitioners have the sometimes difficult task of sorting out that which the patient is bringing to the treatment as a part of his/her psychological process and that which the therapist is bringing as a result of his/her own unresolved conflicts. In such situations, both the clinician and the patient are simultaneously working with their unconscious and conscious feeling states, attitudes, and unresolved relational difficulties. While the therapist is expected to work with these projected transferences and his or her own countertransferential responses, patients must
rly on the therapist’s ability to contain and manage any reactionary feelings that might arise that would likely mirror the patient’s experience of repetitious enactments that recapitulate trauma and impede positive treatment outcomes.

Turning now to Winnicot’s (1975) “Hate in the Countertransference,” he acknowledged that certain characterological organizations and defensive structures in patients elicit strong feelings in providers; this is particularly true with feelings of hate. Such alarming reactions belong to the provider, and they represent the provider’s own previous relationships and repressed identifications. Although Winnicott was referring primarily to his work with psychotic patients, he asserted that therapists need to see “thoroughly” through their countertransference in order to have “objectivereactions to the patient” (p. 195). At the same time, a provider must not deny the hate within himself toward the patient because only by confronting that hatred, can he/she have an objective view of the patient that can then be revisited and interpreted. Winnicott noted that such work may, in fact, never ensue because the patient does not have sufficient “good experiences” that are needed to internalize such interpretations. The important point in Winnicott’s theory as it relates to the transgender population is that the therapist working with these individuals must become cognizant of any unresolved personal confusion regarding the patients’ or clinicians’ gender, gendered practices, sexuality, and beliefs, as well as any feelings he/or she may be harboring of rage, disgust, or shame. If the therapist is not aware of these feelings, they are likely to be enacted through repeated inappropriate aggressive interpretations on the part of the therapist, or the therapist may deny services altogether, which may ultimately be in the best interest of the patient. It is also notable that providers may become involved in “border war” enactments (that is, whether or not a
patient should transition), which may occur when the provider bases his/her opinions of body image and expressions, body types, or need to force individuals into a binary gendered system. Again, it cannot be overstressed that any provider who cannot contain and manage negative countertransferential feelings seek consultation or personal treatment, or refer the patient to a trusted colleague (as per the APA’s Code of Conduct cited earlier).

Transgender female-to-male patients may bring ambivalent transferential feelings into treatment. They may be wary of seeking mental health services and approach treatment in a guarded and even resentful manner due to the historical treatment of sexual minorities. A therapist, especially when knowledgeable about transgender issues, might also be apprehensive about his/her own motivations and interests in working with transpersons. Yet, a therapist’s knowledge and comfort should be evident in the ease with which he/she conveys professional biases, and at times, personal experience. However, self-disclosures should be considered on a case-by-case basis and should not be the consequence of the clinician’s own anxiety or need to reassure the patient (e.g., “My friend is transgender,” or “I have a gay sibling”). Some female gender-variant individuals are ambivalent about their intentions to transition, that is, they are ambivalent about being perceived as solely male. The patient needs an empathic supportive environment to reach clarity on the gender identity that embodies a gender expression right for him or her.

Being mindful of positive, loving, and supportive countertransference feelings makes it easier for the therapist to monitor disingenuous reassurance, quick and misguided diagnostic impressions, as well as any unforeseen blind spots in the treatment. It is particularly critical that clinicians not make hasty decisions regarding letters of
referral, as these letters may result in irreversible hormonal or surgical treatments.

Though the role of neutrality is important in making informed clinical impressions that guide treatment, positive and supportive countertransference feelings toward a patient will also positively affect the therapeutic alliance, the duration, and the success of the treatment. A relational experience in which a transgender female-to-male and gender-variant individual is able to internalize acceptance and understanding will foster new benevolent relational identifications and, hence, a sense of self that is embraced according to their true identity.

**Intake Assessment**

As with any patient who enters a clinician’s office, the “presenting problem” is not always as transparent as the concerns that bring the patient into therapy. Transgender and gender-variant individuals must be careful not to fall victim to preconceived notions when seeking treatment. For example, a patient may be requesting psychotherapy to receive symptom management; however, he/she may also be hoping to discover various insights about his/herself as these may affect the quality of the patient’s life. Thus, a clinician must not readily assume that a female-to-male transperson is seeking therapy to obtain a letter with the intentions of transitioning to a male-gendered body. To reiterate, it cannot be overstressed that transgendered individuals may seek treatment for reasons that have nothing to do with their transgender identity. Transgender individuals may be seeking therapy to explore their gender and sexual identity, or they may be dealing with personal problems (i.e., depression, anxiety, sexual, work/career, familial and social problems). Further, this author would like to point out to treating professionals that not all transgender female-to-male and gender-variant individuals seek psychotherapy with
(a) gender dysphoria or gender identity disorder, or (b) with comorbid AXIS I conditions such as depression and anxiety disorders, or (c) with AXIS II pathology even though they might be seeking treatment for concerns regarding their gender or sexual identity. The transgender female-to-male and gender-variant male community is quite diverse, and even the numerous labels and categories used here may not reflect how one’s particular patient identifies. As Griffin Hansbury summarized in his essay “An Introduction to the Transmasculine Identities” (2005):

The real differences among the various identities are based less on how many testosterone injections one has had or which surgeries one has opted to undergo, and more on how each person interprets his or her identity—how she or he perceives himself or herself and how he or she wishes to be perceived by others. Someone may identify as a Transsexual Man yet still maintain his breasts and forgo testosterone. Another may choose to undergo a mastectomy, take a low-dosage testosterone, and identify as a Passing Woman. (p. 245)

A brief intake assessment may be beneficial in obtaining information that may not have been initially reported during the first phone call or initial sessions. Such information may be helpful with a case formulation. For example, inquiring about how an individual identifies and noticing the language/concepts he/she uses to describe him/herself and his/her experiences in the world may go a long way in preventing alienation by the clinician at the beginning of treatment. Such an instrument may also be useful in reporting information that would be difficult to articulate when beginning treatment with an unknown provider. However, a more traditional approach (open ended) to taking a patient’s history is not recommended, because such an intake instrument can obtain demographic information not initially reported and such facts may otherwise go unaddressed. Finally, an assessment can readily assist the clinician in understanding how the patient identifies him or herself at the current moment and his/her circumstances.
without bringing any countertransferential judgments to the onset of the therapy, as naiveté and negative responses on behalf of the clinician may foreclose a corrective emotional experience. It has been discussed earlier how such judgments may prove detrimental to the developing alliance. With an awareness of one’s judgments and an ability to know what they are about internally and then put them aside, a therapist is more likely to convey a sense of knowledge and competence to the patient.

Lev (2004) summarized as follows:

People seeking services for gender-related issues fall into three broad categories: (1) clients who are struggling with gender-dysphoria feelings; (2) clients who are expressing gender variance and seeking letters of referral for medical treatment; and (3) clients who are presenting with family-related issues. This last category includes the gender-variant person as well as his or her loved ones who seek treatment because they are struggling with their significant other’s gender issues. (p. 204)

A semi-structured questionnaire is provided in Appendix A, which may be used to guide for an initial assessment as well as developing a case formulation for psychotherapeutic treatment in working with transgender female-to-male and gender-variant individuals.

Case Formulation

This manual offers a number of tools for clinicians so that they may be better able to organize their thoughts and proceed with effective treatment. These tools include an intake assessment, and a case formulation based on dynamic interpretation that would include a personal, psychosocial, familial, and social history as well as an assessment of an individual’s identifications, affects, defenses, relational patterns, self-esteem, cognitive patterns, attitudes, and beliefs, as well as strengths. Module III has offered a psychoanalytic contemporary perspective. In addition, the preceding and subsequent
modules compliment the themes presented here. The goal is a successful treatment, which is made more possible when all the critical information has been gathered and carefully reviewed and considered.

Another important element in the evaluation process when working with transgender female-to-male individuals is to explore the limitations of surgical interventions, the risks of scarring and reproductive capacity loss, as well as the health related complications that may arise. Importantly, despite surgical procedures, one still remains at risk for breast cancer or ovarian cancer, as well as other serious illnesses, significant to their hereditary traits. As Cromwell pointed out, “Many [transgender individuals] have trouble understanding why some want to deny so vehemently (in many cases) that they were born female and socialized as women” (1999, p. 30). Such an attitude may have life-threatening consequences.

*Managed Care and Legal Issues*

Transgender individuals who intend on transitioning run into difficulties when encountering the healthcare system. They find that there is a general unwillingness to care for their needs. Most insurance companies do not cover claims related to hormonal and surgical support. In metropolitan areas, many community health clinics offer care for lower-income individuals by providing hormonal therapy; however, surgical procedures are generally not funded. Working and middle-class individuals who can afford healthcare often find insurance companies refusing to cover medical procedures unless they are deemed “medically necessary” (Lev, 2004, p. 187). Such criteria may lead instead to a mental health diagnosis, which is in conflict with civil liberties (Lev, 2004).
One exception is the healthcare provided to city employees in San Francisco, California, as they are eligible to receive benefits to assist in their surgical process over an extended period of time.

Private and employer-provided insurance programs seldom cover genital reassignment surgeries, except when no exclusionary policies exist and medical needs have been identified by a professional (Israel & Tarver, 1997). Insurance companies tend to deny benefit compensations and classify such procedures as “experimental” (pp. 90-91). Israel and Tarver suggested that when considering surgical procedures, one should carefully review various healthcare benefits and work with providers, whom, at times, may be able to find “loopholes” in their policies (p. 91). Transgender individuals are encouraged to consult with several providers and inquire how they can assist in providing documentation or billing to receive partial or full claims for care.

Lev argued that sometimes meeting medical necessity includes changing legal documentation:

Changing legal paperwork regarding sex designation—birth certificates, names changes, driver’s license, passports, and marriage licenses—create potential judicial minefields regarding issues of same-sex marriage, “fathers” giving birth to their children, and whether one’s legal status should depend on surgical sex completion or the social gender one presents on a daily basis. (2004, p. 187)

In addition, legal changes often depend on mental health professionals’ affidavits that state that the individual has lived as the cross-gender according to their birth sex or has been approved for hormonal and surgical interventions (Lev, 2004). Lev pointed out, however, that bigendered individuals would not qualify for such legal changes due to their inability to conform to living in the “opposite sex” (p. 187). These collateral efforts
challenge traditional roles of the therapist and the therapeutic “frame” generally put into practice by clinicians, and therefore, calls upon clinicians to “bend the frame.”

Dual Diagnosis and Comorbid Disorders

Transgender individuals may present with comorbid conditions, such as depression, adjustment, anxiety, and posttraumatic stress disorders. In fact, despite gender concerns and issues related to their gender identity, individuals might be suffering more from depression and anxiety rather than distress regarding their gender. They also may be suffering from more severe mental disorders, such as schizophrenia or psychotic disorders, and it is as important to assess for these as with any other population (Israel & Lev, 1997). Though many mental health problems can be addressed in private care settings, more serious disorders and debilitating symptoms may require complimentary medication regimens. It is important to note however, that some clinicians may be licensed to prescribe medications. It is imperative that providers rely on professional knowledge and training regarding diagnostic clarifications. Practitioners should refer to the DSM-IV and the PDM for diagnostic clarification and adhere to the requirements set forth by the American Psychological Association or other licensed associations that mandate legal and ethical treatment with regard to a variety of mental health issues.

Crisis and At-Risk Individuals

Individuals often seek treatment feeling hopeless or overwhelmed by their internal conflicts and environmental situations. This particular population of gender-variant individuals is more likely to feel alienated and experience “mental disturbance[s], including anxiety, panic attacks, obsessive-compulsive disorder, depression, manic episodes, impulsive behavior, eating disturbances, sleep disorders, sexual paraphilias, as
well as martial problems, histories of childhood trauma, and chronic unemployment” (Lev, 2004, p. 189). Additionally, they are more likely to grapple with substance abuse, sexuality issues, and interpersonal problems. Transgender female-to-male and gender-variant individuals may also, at times, feel suicidal or engage in self-harming behaviors. This large array of possible symptoms and diagnoses often leads to inaccurate diagnostic impressions and a mismanagement of care.

An individual who is in crisis is, first and foremost, in need of containment, and this manual encourages clinicians to embrace a harm reduction model, that focuses on reducing the harm to one’s self. Then, once he or she is stabilized, he or she will be in a better position for going forward by attending to self-care and participating more fully in treatment. Clinicians should rely on their skilled expertise in the management of any clinical and mental health crises, formal training, and legal obligations. It is important to note here that transgendered persons are particularly vulnerable to suicidal distress and are more likely to have experienced or have been exposed to trauma, or be victims of harassment and assault. Limited economic resources and upsetting states of being are likely to compromise an individual’s ability to accurately reflect on his/her circumstances. Immediate referrals to psychiatric care, assistance with emergency protocols in your area, such as accessing Mobile Crisis, developing safety plans, and provision of frequent sessions should be implemented when necessary. Marginalized groups such as transpersons in crisis are at risk for further mental health decompensation, substance dependency, homelessness, and further victimizations.

As Kessler and McKenna articulated:
Transgender people (even those who are publicly “out” on stage, in print, or among trustworthy others) know that unless they do what it takes to get a male or female gender attribution, their physical safety may be in jeopardy. (2000, ¶ 10)

Individuals may also put themselves at high risk by engaging in unsafe sex. Devor (1993) noted that FTM transsexuals are often quite naïve as they go out for “Exploration, risk, adventure, danger—all stereotypically masculine attributes” (p. 311); they will put themselves at risk as they become increasingly confident in their manhood, and they may also act irresponsibly out of their fears of rejection, thus, making them vulnerable to contracting STD’s and HIV (p. 312). Lastly, FTM’s who do not receive supportive services might resort to using street hormones, also placing them at greater risk for contracting various diseases (e.g., HIV due to sharing needles).

Cultural Considerations: Age, Class, Ethnicity, Sexuality, and Religious Affiliation

Bruce Smith and Nadine Tang

Clinicians working in mental health—particularly therapists who work from a psychoanalytic framework—are increasingly challenging traditional views, which necessitates consideration of our perceived differences among “race, ethnicity, religion, social class” (Smith & Tang, 2006, p. 296). This section is concerned with the meaning of differences, how they affect our lives, and how they influence psychoanalytic treatment. Smith and Tang (2006) noted that “today, analysands—and more and more analysts as well—are increasingly diverse, and we are confronted with the necessity of dealing with different social identities and fantasies about these differences in the consulting room” (p. 295). Differences between the patient/therapist dyad and the patient’s subjective experience in the world are unquestionably shaped by the patient’s multiple identities, though these identities may not always be accurately observed by the
viewer. Smith and Tang (2006) proposed a “taxonomy for social identity” and suggested that these “different identities” have impact on the transference-countertransference relationship in treatment (p. 296). Smith and Tang also suggested that reflecting on differences invites the exploration of the dichotomy of difference, which should first be looked at through the lens of “similarity” (p. 296).

The authors considered Leary’s 1999 argument that social identities are dependent on an audience; therefore, identities become “performative” (2006, p. 296). They made an important observation, stating:

The meanings that each of these identities might have necessarily takes into account what it means not to have them…. One’s own cultural forms are considered “normal” by most people; it is only when contrasted with the practices of other groups that the idea of other ways of being emerges. (p. 296)

In 1996, Levenson examined the concepts of self-revelation and self-disclosure. Smith and Tang took these concepts and modified them. Levenson was “primarily concerned with the revelation or disclosures of attitudes, reactions to the patient, or countertransference” (1996, pp. 296-297). Smith and Tang extended these terms to refer to “exposure of elements,” that is, the social identities of the therapist (pp. 296-297). Self-revelation, according to Smith and Tang, refers to social markers that passively reveal aspects of the self with regard to the therapist (2006). One example they provided was the therapist implying marital status by wearing a wedding band; the patient may or may not be conscious of this disclosure. However, this author points out that wearing a wedding band today no longer exclusively denotes that one is in a committed partnership. This author also wishes to point out that providers may unknowingly exhibit social cues that may be read as stereotypical features of a group with which they do not identify or belong. Alternatively, disclosures are “deliberate statements” made by the therapist that
reveal personal information such as “sexual orientation, marital status, or religion” (Smith & Tang, 2006, p. 297). Therefore, whether known, projected, or disclosed, aspects of a therapist’s or of a patient’s social identities influence the therapeutic relationship as well as the environment in which the patient explores his/her fantasies.

Smith and Tang divided social identities into three categories: (a) “Identity Revealed: The Innate and Visible,” (b) “Silent Identities: Innate But Invisible,” and (c) “The Chosen: Voluntarily Adopted or Achieved Identities” (2006, pp. 299-304). Smith and Tang also contend that social identities vary in degree to which they are visible and adopted by an individual. Individuals’ needs vary with regard to a therapist’s personal disclosures, and these may directly affect the transference-countertransference relationship (2006). The three identity classifications, along with their clinical implications, are discussed below as they relate to the experience of transgender and gender-variant individuals.

In the first category, “Identity Revealed,” markers of social identity are innate and invisible. A primary example of this taxonomy includes race and gender (Smith & Tang, 2006), and except in the case of biracial and mixed-race individuals, patients will be aware of the therapist’s race and gender (2006). Also, identifying characteristics, such as names, imply gender, although these are not “infallible markers” (p. 297). However, names may also misrepresent one’s racial or ethnic identity or the therapist’s gender self-identification (e.g., some names, such as Kim or Chris, are not distinct to one gender; also, name and names may be influenced by marriage or name changes). Though the authors admitted they do not focus on gender issues specifically, this author suspects that most often transgender patients perceive clinician’s gender based on specific identifying
markers (masculine and feminine names, characteristics and mannerisms), except, of course, in the case when practitioners and patients have gender ambiguous presentations. Therefore, when working with transgender individuals, gender can be both innate and invisible.

With regard to racial identifications, Smith and Tang (2006) poignantly stated:

To begin with there is no agreement as to what constitutes race. It is accepted by most anthropologists that, biologically, there is no such thing as race. Rather it is a social construct used to describe individuals who share certain physical similarities and geographical origins of ancestry. (p. 299)

Individuals have multiple identifications that may shift their experiences over the course of a lifetime and within a treatment.

Smith and Tang concurred with Leary’s argument that “racial similarity or difference between patient and therapist is an important fact in the treatment, whether or not it is addressed directly” (Leary, 2000, as cited in Smith & Tang, 2006, p. 300). Leary’s racial enactment concept “characterize[s] those interactions in which societal fantasies and assumptions about race are replayed in the therapeutic encounter” (p. 300). This author concurs with Leary’s theory, and suggesting further that gender also influences enactments that are based on “physical embodiments and stereotypical” features (2006, p. 301).

Smith and Tang’s (2006) second category, “Silent Identities,” is characterized by innate aspects to one’s identity that may not be transparent, and these silent identities are often at the core of an individual’s sense of self, such as sexual orientation (p. 303). These social identities also include cultural heritage and social class of origin. Although names do indicate certain cultural categories, only speculative information is, in fact, revealed. Such identities are often difficult to identify despite mannerisms or presentation
and merely elicit assumptions. In these instances, a therapist’s true social “silent identity” is unknown and may be a source of conjecture.

This category poignantly illustrates the transgender-identified experience. Gender identification may or may not be innately driven (biological), but the essence of a gendered self is a central part of the self. Yet, there is room for false assumptions on behalf of both the patient and the therapist, and such misidentification may lead to treatment issues with regard to the transference-countertransference relationship (Smith & Tang, 2006, 2006). The example offered for this category is of a gay male therapist who wears a ring similar to a wedding band; the patient may assume that the therapist is heterosexual. If the patient, then, unwittingly makes homophobic remarks, there is bound to be countertransference issues and the therapist is likely to feel “attacked” (Smith & Tang, 2006, p. 304). According to Leary (1999), “passing leaves the therapist in the position of living a lie, and perhaps of experiencing a personal attack that cannot be discussed” (p. 304). These silent social identities lead the clinician to ponder self-disclosures. This author suggests that each clinician will need to address such identity disclosures by considering the impact on the transference-countertransference relationship on a case-by-case basis.

The third social identity category, “The Chosen” refers to the identities that are “achieved or adopted more or less voluntarily” (Smith & Tang, 2006, p. 304). These “chosen” identities include religion, political affiliation, and marital and parental status, as well as achieved socioeconomic status. Though these may be paramount to one’s identity, they are not at the core of one’s personality development; that is, they “rarely alter one’s fundamental identity” (p. 306). Therefore, a more traditional psychoanalytic
approach to treatment might indicate an exploration of the patient’s projections and fantasies regarding a therapist’s achieved or acquired social identities, and such self-disclosures would be minimal, thus, having less clinical impact on the transference-countertransference relationship.

Notably, when therapist’s identity is obvious, the patient may make a conscious choice to discuss these social factors; conversely, when such social identities are not readily observable, it may be advisable for the therapist to disclose them, particularly if they are inclined to evoke strong negative transference-countertransference feelings in the clinical relationship (2006). Misunderstandings, intense negative feelings, and attitudes encompassing silent identities could lead to an empathic failure.

Shared social categories such as racial and gender identity may, however, have “exaggerated similarities,” or it may result in “pseudospeciation,” a concept coined by Erikson in 1968 wherein the “communication is all but impossible, and the chasm between groups of people is impossibly wide” (as cited in Smith & Tang, 2006, p. 302).

In short, Smith and Tang believed that race, ethnicity, and gender are core aspects of the self that are fixed, and even when one ascribes to theoretical claims that gender identity is fluid, one’s gender is fundamental to his/her identity (2006). They summarized:

Core identity as the cards that one is dealt at birth and over which one has little or no control. These are also aspects of one’s identity that tend to be rooted in the experience of the body, which is of course, the crux of ego development. (Freud 1923, as cited by Smith & Tang, 2006, p. 305)

Clinicians and patients collaboratively make assumptions and evaluations on innate and visible identities, as well as innate but invisible social identities, and such attitudes, biases, and stereotypical beliefs about various racial/ethnic, gender/sexuality
orientation groups are likely to have a profound impact on treatment (not to mention the patients’ lives). Crucial to the success of the therapy is a constant reflection about the enactments that are brought upon by the patient’s projections in the transference, as well as the countertransference responses to the patient, particularly when they are enacted within the therapeutic relationship. Enactments are a foreseeable part of treatment, what the clinician and patient communicate both verbally and nonverbally, and these processes capture sensitive clinical issues that need to be addressed for this population. Altman (1995) argued from a relational perspective:

The analytic work might equally well be compromised by failure to take directive or gratifying action with a patient who is especially sensitive to deprivation. …The practical realities of a patient’s life may require that the therapist get involved. …From a relational point of view, such gratifying actions do not necessarily compromise an analytic stance, mitigate against the development of transference, or render the transference unanalyzable (p. 63)

The point this author is making here is that when working with transgender individuals, clinician’s will be called upon to “act” by supporting patient’s in letter writing, submitting letters to physicians, as well as to enlighten employers to patient’s circumstances.

Patients tend to choose therapists because of their “outward manifestations” of social “signifiers” (Smith & Tang, 2006, p. 307). However:

The therapeutic relationship implies a sense of we-ness. This we-ness is not necessarily an undifferentiated derivative of the early mother-child dyad (Winnicott 1971), but rather a more mature sense of connectedness with the other. It is axiomatic that in order for there to be a we, there needs to be a they. (p. 307)

Smith and Tang concluded:

In short, we can conceive of a continuum of similarity/difference in social identity; and patients will locate themselves along that continuum in terms of how they wish to experience the relationship—on the basis of the need for a
connection with the therapist, on the one hand, and for a secure boundary, on the other. (p. 308)

Though the work by Smith and Tang was not originally intended to speak directly to the identity of transgender population per se, their discourse on “differences” significantly illustrated that transpersons have multiple social identities; gender, gender identity, race, class, culture, and so on that are intertwined. It is imperative in contemporary psychoanalytic work with diverse groups to explore these “differences” as well as the “similarities,” within therapeutic dyads (Smith & Tang, 2006).

**Developing Cultural Consciousness**

A patient’s ethnicity, race, age, class, sexuality, religious affiliation, and physical abilities should be considered as with any patient in treatment. Each of these discrete identifications and taxonomies plays a crucial role in one’s experience in life and one’s internal psychic reverie. The following presents issues particularly relevant to the transgender female-to-male population.

**Transgender Youth and Older Adults**

More than any oppressed adult group, transgendered youth are perhaps the most alienated within our society, and they are often “indistinguishable from other youth,” thus directly influencing their vulnerabilities to mental health issues (Israel & Tarver, 1997, p. 132). Further, “the overwhelming message from family, adult society, and youth peers says that gender nonconformity is a sick, mentally unstable condition to be feared, hated, and ridiculed” (p. 132). Therefore, youth are more likely to hide their cross-gendered feelings than risk being ostracized. Though very little has been written about older adults transitioning or “coming out” during mid-life as a transgender male, their experience is
likely to intensify a major life change that one would expect to manifest by adding stress to their work, family, and social life.

*Socioeconomics*

Socioeconomic status profoundly affects individuals in our society. Most transgender female-to-male men are working class individuals, who, because of their financial means and status, are likely to be limited in accessing resources, including long-term psychotherapy and surgical interventions (e.g., chest reconstruction and phalloplasty). Clinicians need to be sensitive to these financial limitations and not impose clinical judgments based on the realities of their financial circumstances.

*Transgender Ethnic and Racial Minorities*

Transgender ethnic and racial minority individuals may encounter different types of responses regarding their gender identity, transition process, and status from their peers and family, which is impacted by their age, family generation, and socioeconomic background (Israel & Tarver, 1997).

An example of one common support theme that differs among ethnic groups is the reaction of peers within an ethnic community to an individual’s transgender identification. In African American, Asian or Pacific Islander, or Latin American context, for example, heterosexual male and females commonly will stereotype gay males and lesbians as not being a part of their ethnic community because they assume that all people of color should be heterosexual. (p. 128)

Transgender ethnic minority individuals tend not to disown or place higher value on one identity over another (e.g., race and gender). However, they are pressured by both social groups to do so. It is essential for providers to be wary that racism exists in the transgender community, and that tensions exist between ethnic and transgender community groups. For example, Caucasian female-to-male individuals will benefit by inheriting privilege and power, whereas African American individuals will inherit the
racist and socially unjust views against Black men in our society. These polarizing experiences cannot simply be ignored in treatment:

Although not all transgender persons of color are trapped on the lower rungs of the socioeconomic ladder, it is imperative that professionals and transgender community alike recognize that people of color sometimes face disproportionately higher rates of victimization, unemployment, substance abuse, HIV infection, prostitution and other difficulties. (Israel & Tarver, p. 130)

Though sexuality was discussed in Module I, it is important to revisit this issue here as it relates to sexual minority transgender female-to-male and gender-variant individuals as they are likely to be marginalized in the community as well:

Transgender individuals (as well as their nontransgender counterparts) may explore and develop a spectrum of sexual orientations ranging from attractions to members of the opposite sex to attraction to those of the same sex. One difference between transgender and nontransgender individuals’ sexual orientation is that for the latter, it is more likely to stabilize near puberty. Some transgender individuals may not have benefited from this process and may feel (though not necessarily always express) uncertainty concerning their sexual orientation at or about the time that they are exploring gender-identity issues. (Israel & Tarver, 1997, p. 44)

Therefore, clinicians should not deny any self-exploration that a patient may need to do, and importantly, clinicians should pay particularly close attention to any negative or adverse countertransference feelings resulting from their own identification and sexual practices.

In summary, all facets of one’s identity have a tremendous impact on how one views oneself and relates in the world. Each particular aspect of one’s identity has a unique impact or importance, depending on the individual. Additionally, some aspects of one’s identity may shift as emerging identifications occur. Gender, age, ethnicity, sexuality, generational and relational status, religious affiliation, and physical limitations in many ways are set, yet at times, they are fluid, constantly evolving despite their innate nature.
In the next module, the process of coming out as transgender and transitioning process and body transformation options will be presented.
Training Module VI

Transitioning: Identity and Body Transformation; the Significance of Passing

The following module presents the various means in which individuals embrace and find psychic comfort with their masculine identity and bodied gender. The task is to inform the practitioner of the various options available for transgender females-to-males and transsexual men. For example, some transgender individuals may refrain from hormonal and surgical interventions to alter their physical characteristics and bodied presentation due to concerns about its impact on their health. These individuals transition merely by announcing their gender status, usually changing their name, dressing in masculine clothes, and adopting masculine mannerisms and pronouns for reference. A growing number of transgender individuals, particularly youth, identify between both genders and tend to embrace a fluid-gendered presentation. Yet, for some, living in both genders and presenting ambiguously is too taxing on their mental health and functioning in everyday life. Transgender females-to-males and transsexual men who have an overwhelming desire to live in the opposite gender transform their bodies from their assigned female birth sex to a male body with the intention of being recognized and experienced as male. These individuals may have psychological concerns that rely on their ability to “pass” as male and long for a sense of continuity between body and mind. This section summarizes the ways in which transgender female-to-male and transsexual-identified individuals modify their gender through the expression of their name, adoption of gender status (e.g., request to be referred to as he and him), mannerisms, and physical body attributes. The overall intent of this module is to
demonstrate the unique choices that individuals make to embrace various schemas in order to achieve psychic comfort in the home of their physical embodiment.

*Changing Gender Identity and Names: Coming Out*

Gender identity exploration is often precipitated by gender dysphoric states followed by soul-searching self-disclosures. No particular linear model is followed between self-awareness and self-disclosure. It is important to note that self-disclosure of one’s transgender identity does not come without consequence, and transgender issues never fade away (Israel & Tarver, 1997). In fact, “The most significant mental health and social support issue faced by transgender individuals resolves around the disclosures of one’s transgender status and needs to others” (Israel & Tarver, 1998, p. 48). Disclosure of one’s newly discovered gender identity may have profound social consequences, which may include the loss of community, friends, partners, and family. Consequently, most transgender support groups provide “disclosure-oriented advice,” (p. 48) and there may be times when there are no tangible advantages to self-disclosure. It is strongly advised that a patient not disclose his gender identity status to significant others or people in his daily life (i.e., coworkers, partners, and family members) without developing a plan and support system. This is especially true during times of crisis (Israel & Tarver, 1997). One should be mindful of the multiple reactions that come with self-disclosure, which may include confusion, rejection, and hostility. These reactions may lead to serious psychological distress for the transgender individuals, and supportive community and mental health services should be organized or even already in place.

At the same time, self-revelation can be a time of excitement and psychic relief in which the individual experiences a better understanding of his feelings and feels a sense
of empowerment. Though some individuals may experience a “coming out high,” they too are encouraged to take care in disclosing their newly found gender identity, as others may not fully understand the meaning and implications of such a change, or they may simply not need to know about the individual’s coming out. In fact, during this phase, transgender individuals themselves may have a limited understanding of the enduring impact their transition may have on their psychology, as well as on their experiences interpersonally in their day-to-day life.

Once a transgender individual comes to terms with his new gender identity, he is encouraged to reflect on the outcomes of disclosures and explore how this disclosure might affect important persons in his life, recognizing that this is a process and an adjustment for others as well. He should also consider seeking support from professionals and from peers, when possible, and develop a “safety plan,” a well thought out plan that considers one’s physical safety boundaries and support networks in the event of psychological hurt. Finally, the patient should be encouraged to continue to reflect upon himself and how his experiences affect him (Israel & Tarver, 1997).

Disclosing one’s new gender status is often a very emotional time in one’s life. The patient needs to help loved ones come to terms with his new gender status and educate them about what it means in terms of gender and sexuality issues. Families and friends might also find support in their own individual therapies or seek support from a group called Parents and Friends of Gays and Lesbians (PFLAG); PFLAG is a community-based peer support group with the purpose of working with gay, lesbian, bisexual, and transgender individuals and their families. It will also be important to inform family and friends how one wishes to be identified, such as assuming a new name.
and requesting that male pronouns be used. This is a crucial part of being able to internalize a new gendered psychological cohesiveness. Notably, the adjustment to the name and pronoun change, as well as communicating to friends, family and community regarding one’s gender identity status is not easily achieved for most individuals, even in the case of transgender persons who have supportive friends, family, and providers. Also, it will be important to articulate and insist upon certain language (e.g., male pronouns) with those who refuse to accept the transgender individual. A list of services that include educational, peer support, legal and advocacy, medical and mental health is provided for transgender female-to-male, gender-variant individuals, their families and allies in Appendix C.

Transgender Female-to-Males Who Do Not Use Hormonal and Surgical Interventions

Transgender men who refrain from hormonal and surgical interventions for personal and medical reasons (e.g., cost, medical risks, and gender nonconformity attitudes and beliefs) choose to live in the margins and space between the binary divide. Griffin Hansbury (2005) stated:

There are many reasons someone may opt not to take testosterone. There are health issues to consider: uterine, ovarian, and cervical cancer (potential problems that can be avoided all together with a full hysterectomy); polycythemia, the overproduction of red blood cells; liver disease, hypertension; high cholesterol; and cardiovascular disease. (p. 257)

As if these risks do not warrant enough concern, whereas a full hysterectomy might seem ideal, most insurance companies will not approve such medical procedures. In those cases, a patient would have to pay for a full hysterectomy out of pocket.

Hansbury continued:

Some transmasculine, Genderqueers [a term that refers to the multiplicity and emerging of identities] do not like the idea of taking on all the male secondary-sex
characteristics—they might like to grow a mustache, but don’t want male-pattern baldness (who does?). For others, their female, feminist, activist, or transgender identity is so crucial, they don’t want it to disappear behind the “straight male” scrim of testosterone. Still, they identify as transmasculine and for the No-Hos [No-hormones], the dilemma becomes how to achieve trans visibility when, without the effects of testosterone, they remain invisibly transmasculine. For some the answer is to take low doses of testosterone (becoming Lo-Hos) to achieve a comparably lower level of masculinization, where they can strike a balance without going over the edge into the controversial province of “straight, white, male;” but this solution does not always resolve the dilemma, as they often remain androgynous—a desired, but a problematic state to be in. (2005, pp. 257-258)

*Body Modification: Binding, Packing, and Piercing*

Transgender individuals tend to express their gender identity through various body mediums. The importance of “passing,” that is, “blending in and becoming unnoticeable and unremarkable as either man or woman” (Cromwell, 1999, p. 39), is idiosyncratic, and the means by which one implements change that generally results in psychic comfort varies.

Female-to-male and transsexual men may explore alternative body modifications and typically do so by binding their breasts, wearing penile prosthetics, applying facial hair (with theatrical make-up), and obtaining piercings. For example, multiple piercings in the labia region may enhance scrotum-appearing features. This method of “genital modification is relatively inexpensive and accessible” and typically does “not compromise sexual and excretory functions” (Cameron, 1996, p. 54). The binding of breasts is described in the Hudson’s FTM Resource Guide as follows:

*Binding:* the process of flattening one’s breast tissue in order to create a male-appearing chest. The type of materials and methods used for binding will vary depending on the size of an individual’s chest and the overall build of his body. Some trans men don’t bind at all due to personal preference, comfort issues, or because they may have small chests. Some use different methods of layering clothing to help hide their chests. Some bind only on certain occasions; some bind all the time. (Hudson’s FTM Resource Guide, n.d.)
Reference list as follows:


It is important to note that female-born individuals may develop disfigured breasts or abrasions due to extended periods of binding. Further, binding is also used to prevent or slow breast development as well as to conceal female breasts.

Some transgender individuals use phallic prosthetics, which is described below and is referred to as “packing”:

The process of creating a male-looking and/or male-feeling bulge in one’s crotch. This can be accomplished through a home-made or store bought pants stuffer, or through a realistic-looking prosthetic device. A packing device may be referred to as a “packer” or “packy,” or as an “STP packer” if it can also be used to pee through while standing up (STP= Stand to Pee). Some guys simply refer to their packer or prosthetic as a cock and balls, a dick, etc. (Hudson’s FTM Resource Guide, n.d.)

Hansbury noted that a midground is a common choice: “More and more, Genderqueers are seeking a comfortable place in the middle, outside any and all boxes. Many eschew gender-specific pronouns, or, conversely, they embrace ambiguity” (2005, p. 258).

Although Hansbury refers to this particular group as “genderqueers,” this manual includes the aforementioned group of individuals under the umbrella term transgender or gender-variant. It should be noted that transgender individuals who limit their external masculine presentation may struggle daily in coping with their external conventional world where confused passersby become readily anxious by their nonconforming behavior, and clinicians should be aware of these frequently experienced unpleasant moments, which may result in mild to severe psychological trauma.
Transitioning

Other transgender female-to-male and transsexual men are persistent in their desire to live full time in the opposite gender, choosing to implement as many behavioral and bodily modifications as possible to be perceived as men. These individuals often seek psychotherapy for the sole purpose of meeting the necessary recommendations of the Standards of Care. One recommendation is that they carry out a real-life test assessment that is conducted by a professional who is able to witness firsthand the individual’s aspiration to present in a cross-gendered role and embrace gendered traits of their desired gender. This real-life test protocol is generally required before a candidate can obtain chest reconstruction and hormonal administration, as it provides a good indication of an individual’s readiness for aesthetic and Genital Reassignment Surgery (Israel & Tarver, 1997). The specific criteria and extent of time in which an individual should live in the desired gender role before undergoing any physical interventions is best determined by referring to the Standards of Care recommendations, as well as the judgment of the treating professional and the patient. Although a predetermined time frame may work for some patients and does encourage the patient to conform to stereotypical gendered behavior, it is important to note that some individuals will not be able to adhere to such real-life enactments because they cannot simply “pass” in the community without hormonal and aesthetic (chest reconstruction) interventions (Israel & Tarver, 1997).

Many transgender female-to-male and transsexual men ultimately wish to live full time in the role opposite of their birth sex as a female, exercising behavioral interventions such as cross-dressing and gender role reversal of stereotypical social behavior. They may choose to undergo a number of physical treatment interventions, which include body
sculpting, taking hormones (testosterone), dermatological care (as testosterone may cause acne), aesthetic treatments such as chest reconstruction, “top surgery” (medically described as bilateral mastectomy), and surgical treatments such as Genital Reassignment Surgery (GRS). A number of GRS options are available for transsexual and female-to-male transgenders, and they include hysterectomy, oophorectomy (removal of both ovaries), salpingectomy (removal of the fallopian tubes), phalloplasty (creation of phallis), metiodiplasty (freeing of the clitoris that resembles a phallic structure), and revisions. It is important that the patient is fully aware that GRS alters one’s reproductive capacity, and these procedures are not reversible. Israel and Tarver proffered that surgery on one’s genitals and reproductive organs would more accurately be described as transitional genital and reproduction change process rather than by the previous term Sex Reassignment Surgery, which infers that only genital change determines a person’s “sex” (1997).

*Hormone Therapy: Testosterone*

Hormone therapy is generally recommended to transgender and transsexual men, and, at times, gender-variant individuals, that is, individuals who live in between the margins of the binary gender divide, who wish to alleviate symptomatic issues, which may result from an individual’s psychic instability due to conflicted and incongruent psyche and body states (i.e., desire to present and be perceived with more masculine attributes). “The use of hormones by transgender patients is intended to provide a sense of psychological and emotional fulfillment and to enhance the secondary sex characteristics of the desired gender” (Israel & Tarver, 1997, p. 56). The basic facts about sex hormones are presented below:
Human sex hormones such as estrogen and testosterone are both secreted by all individuals. They are secreted in different amounts, however, depending on the person’s biological gender. Normally, estrogens and testosterone exert their effect on target tissues when they bind to specific estrogen or androgen receptors in these tissues. This process results in the development and maintenance of secondary sex characteristics, reproductive function, and sex organ viability. (Israel & Tarver, 1997, p. 57)

Hormone treatments, such as testosterone, bind to an individual’s receptors and produce secondary sex characteristics. “Men and women have different ratios of sex hormones as well as a concentration of receptors specific to their biological sex” (Israel & Tarver, 1997, p. 57). Therefore, an individual’s secondary sexual characteristic change in response to hormones is, to a large degree, dependent upon his/her hereditary and physical metabolism (Israel & Tarver, 1997).

Harry Benjamin’s International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders (HBIGDA SOC) now referred to as the World Professional Association for Transgender Health (WPATH) Standards of Care suggested that “cross-sex hormonal treatments play an important role in anatomical and psychological gender transitions process for properly selected adults with gender identity disorders” (p. 13). Hormones play an important part in changing physical characteristics that facilitate a real-life experience as well as psychological and body congruency.

Hormonal regimens for transgender female-to-male and transsexual men tend to be quite successful in the development of masculine traits that include “facial hair, increased muscle mass, male-pattern hair growth, and thickening of skin with injections of testosterone cypionate or testosterone enanthate (200 mg twice monthly),” and they also cease menses (Israel & Tarver, 1997, p. 67). Permanent changes include “deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair”
Cypionate is prescribed frequently because it has been found to produce the most masculine characteristics (Israel & Tarver, 1997). However, oral regimens are uncommon as they have been found to have little impact on physical change and often are overprocessed by the liver (Israel & Tarver, 1997).

Testosterone regimens are administered by transdermal patches or by intramuscular injections. The patch is generally prescribed as an alternative to injection treatments and is applied on “backs, abdomen, or on the upper arms or thighs” (Israel & Tarver, 1997, pp. 57-58). The patch tends to provide a “consistent delivery system [which] eliminates the peaks and troughs” and also tends to eliminate mood swings better than intramuscular treatments (Israel & Tarver, 1997, p. 68).

Individuals who use intramuscular treatment generally receive hormonal administration and monitoring by physicians for the first three months. Thereafter, an individual may self-administer testosterone. Although it is highly preferable to use single-use needles, when cost is an issue, needles may be reused following proper cleaning procedures (Israel & Tarver, 1997). The maximum effect of testosterone hormone regimens may not be evident for 2 years, and heredity may limit the tissue response to hormones. Although the patient with unsatisfactory results may wish to increase his/her dosage, this is contraindicated because this does not change the limitations of the effects (WPATH, 2001). Changes effected by testosterone treatments that are reversible include body weight and distribution, particularly in the hip region; body strength; sociability, and sexual libido (WPATH, 2001). Changes effected by testosterone treatments that are not reversible include body hair and voice change. Side effects and risks from testosterone use vary and are also impacted by heredity as well as
“age, metabolism, pre-or-coexisting health issues, and other factors” (Israel & Tarver, 1997, p. 57):

The major risks associated with excessive doses of testosterone are increased cholesterol and higher lipids levels; heart disease, including myocardial infraction; mood changes (irritability or depression); male-pattern baldness; acne; and cessation of menses within three months of continual usage. Smoking increases the risk of coronary heart disease in FTM individuals using testosterone. (Israel & Tarver, 1997, p. 68)

It is also important to note that side effects can be emotional in nature. These include mood changes and bouts of unmanaged aggression that are likely to lead to conflict referred to as “roid-rage.” These rages do, however, tend to diminish once the body has become accustomed to the hormonal changes. Commonly described emotional experiences include a rapid escalation of anger that at times seems unmanageable. Clinicians can help patients become cognizant of identifying overwhelming states and develop adaptive coping strategies in managing their aggression. Loren Cameron, a self-identified transsexual, offered an illustrative example. He described his anger as “swift” and “instinctual” when referring to an incident in which he witnessed the verbal assault toward a woman on the street; in describing coming to her defense, Cameron stated, “My brain didn’t have a second to consider the consequences before my fist was flying” (Cameron, 1996, p. 20).

Cameron also offered his general attitude about using hormones:

I admit I’ve become very attached to taking the hormone, which is responsible for all my physical attributes, like my facial and body hair and muscle development. I’ve also noticed that it affects my sex drive and emotional states. During the peak part of my cycle, I turn into a randy, greasy kind of guy who is more than a little irritable. (Cameron, 1996, p. 20)
Mood disturbances, such as depression, irritability, and aggression, may also occur during the first 6 months of treatment, comorbid psychiatric conditions may also be exacerbated (Israel & Tarver, 1997).

An additional side effect is acne on the back and chest regions; facial acne is quite rare. Such outbreaks are likely to diminish after the initial stage of treatment, although, at times, a mild episodic outbreak may occur after an administration of treatment. Severe facial acne, when it does occur, can be treated by a physician or dermatologist (Israel & Tarver, 1997).

For many transmen (such as Cameron), declining testosterone is not a viable option. However, the regimen is not readily available to any individual. A number of criteria need to be met. First, a consenting adult patient must demonstrate knowledge of the social and medical consequences of hormone treatment, as well as engage in a real-life experience for three months or participate in psychotherapy with a mental health professional (WPATH, 2001, p. 13). It is important to note that hormone candidates can be referred by professionals for hormonal treatment (following an assessment for comorbid psychopathology and rule-out of psychiatric conditions) in cases in which the individual did not participate in a real-life experience or wish to undergo genital reconstructive surgeries. In all cases, the specific criteria provided in the Standards of Care should be reviewed in detail. Notably, the Standards of Care are not universal and are likely to change overtime.

Many transgender and transsexual men who have been denied coverage for medical services (either through their health benefits or community-based clinics) often resort to “black-market” hormones that they purchase on the street, or they receive
unsupervised hormonal care with incompetent providers (Israel & Tarver, 1997; WPATH, 2001). Further, lack of resources may also result in individuals sharing hormonal doses and needles, which puts them at risk for HIV and Hepatitis C.

With that said, it is important to know and to alert the individual that hormonal treatment is safe and optimal only under the following conditions: “A responsible hormone-administration program includes an ongoing working relationship between the individual and prescribing physician” (p 60). Physicians should also provide education to their patients as this will help to minimize the dangerous consequences that can arise from misuse and abuse. Also, transgender individuals should keep regular medical appointments, monitor hormone levels in the blood and blood pressure regularly, and communicate changes in their health (Israel & Tarver, 1997, p. 57), as this is essential knowledge for health care professionals who monitor the individual’s health and provide advice for self-care issues, as well as for psychotherapists who also need to stay abreast of the health issues of their transgender patients.

*Chest Reconstruction: “Top Surgery”*

Transgender individuals commonly elect to have “top surgery” or a chest reconstruction procedure, as it is often a primary concern of bodily discomfort. It is also felt to be essential in presenting as male and alleviating visible reminders of the biological gender status. As one candidate stated, “Getting rid of my breasts will bring me a piece of mind.” Due to breast size, multiple procedures may be necessary for chest reconstruction, but, typically, a bilateral mastectomy method is utilized for medium- to large-breasted individuals. Another common method is the subcutaneous mastectomy, or “keyhole,” which is used for small-breasted patients. This “keyhole” procedure is
performed by making a small incision along the areola, and the breast tissue is removed through liposuction. Of note, this method of breast reconstruction maintains sensation, in contrast to bilateral mastectomy (Hudson’s FTM Resource Guide, n.d.). The bilateral procedure is more involved as it permanently removes the breast and the nipple or areola. It is typically graphed from “native tissues” and placed according to chest presentation, thus giving the appearance of a male chest. Though scarring is generally minimal, a residual seam remains underneath the nipple region. Individuals who take hormonal regimens may benefit from body hair, which can minimize the evidence of scarring. However, some individuals are more susceptible than others to scarring and raised or darkened scars, for which various treatments and revisions are available. It is important for patients to explore their concerns about chest reconstruction beforehand with their medical team. Cost of chest reconstruction surgery ranges from $1,000 to $8,500, depending on the procedure itself, the patient’s individual needs, the surgeon’s expertise, and the number of revisions required to receive the desired result (Hudson’s FTM Resource Guide, n.d.; Israel & Tarver, 1997). It is important to note that competent surgeons will require a breast tissue analysis for pathology once the breast tissue has been removed. Insurance plans seldom cover this procedure as it is viewed as often viewed as a “cosmetic procedure.”

Genital Reassignment Surgery: “Bottom Surgery;” Hysterectomy, Oophorectomy, and Salpingectomy

A hysterectomy is the surgical removal of the uterus, and what is described as a “radical” or “complete hysterectomy includes the procedure of an oophorectomy and salpingectomy. An oophorectomy procedure is the removal of the ovaries; a
salpingectomy is the removal of the fallopian tubes. Some providers recommend that both a hysterectomy and an oophorectomy be performed within the first five years for individuals who take testosterone hormonal therapy due to a risk of contracting polycystic ovarian syndrome as a result of the hormone treatment (PCOS) (Hudson’s FTM Resource Guide, n.d.), which has been linked to endometrial hyperplasia.

Endometrial hyperplasia occurs when the uterus enlarges, thus placing the individual at risk for endometrial and ovarian cancer (Hudson’s FTM Resource Guide, n.d.). As noted by the Hudson FTM Resource Guide, long-term effects of testosterone on the uterus and ovaries is unsubstantiated because research, including transgender men studies, is limited, and it is unknown whether some individuals might be predisposed to such conditions. A second reason for recommendation of this dual procedure is to reduce the dosage of testosterone treatment, as, once the ovaries are removed, estrogen is no longer produced.

There is no set fee for a hysterectomy, and oophorectomy and salpingectomy procedures add to the cost. Israel and Tarver suggested that, although there are two approaches to the procedure (vaginal and abdominal incision), the intravaginal procedure is preferred because this method tends to be less intrusive on the internal organs (1997).

The cost, which varies depending on the numbers of methods undertaken (e.g., whether oophorectomy or salpingectomy procedures are included), generally ranges between $7,000 and $15,000, and these fees include both hospital and surgical fees. Insurance plans seldom cover these procedures. However, if a patient can convey health-related concerns (e.g., irregular bleeding and Pap smears, polyps or fibroids) they may be able to qualify for coverage for a hysterectomy. This procedure also requires a hospital stay, and depending on recovery trajectories, the number of days spent in the hospital will impact
the overall cost as well (Hudson’s FTM Resource Guide, n.d.; Israel & Tarver, 1997). The risks associated with these procedures also vary, and the patient should be well informed and carefully consider with the surgical provider the risks involved before making a decision. It is important to note that the laws of some states require that the patient change the status of his/her birth sex following hysterectomies performed for this purpose (Hudson’s FTM Resource Guide, n.d.). Of further note, this procedure eliminates a transman’s reproductive capacity.

Metoidioplasty

Metoidioplasty is an enlargement of the clitoral hood, which then becomes foreskin, and it is co-constructed while undergoing hormonal therapy and single or successive surgeries that are aimed at the “freeing of the clitoris from the hood, cutting, and repositioning clitoral suspensory ligaments, and administrating hormones to produce a natural looking microphallus” (Israel & Tarver, 1997, p. 86). The clitoral hood, once released, remarkably appears as a small penis. A urethral lengthening process may be included, which would allow individuals to urinate while standing (Hudson’s FTM Resource Guide, n.d.).

A second option, vaginectomy, is a procedure that closes or removes the vaginal cavity, and this is commonly performed with the metoidioplasty. A complementary procedure includes inserting a silicone prosthetic devise to create a scrotum feature (scrotoplasty). Typically, these three options—the scrotoplasty, vaginectomy, and urethral lengthening—occur simultaneously (Hudson’s FTM Resource Guide, n.d.). Depending on the procedures, surgical techniques will vary, and the number of surgeries will vary as well. In some cases, only one operation is necessary; others will require two
or three. Although the benefits vary, these transmen are able to achieve erections while aroused, and the procedure does not leave visible scarring (Hudson’s FTM Resource Guide, n.d.). There is a significant range in cost, from as low as $2,000 to as high as $18,000 (Hudson’s FTM Resource Guide, n.d.; Israel & Tarver, 1997). In general, revisions are added costs. Insurance plans seldom cover this procedure. As noted earlier, as with any surgical procedure, there are risks that need to be discussed at length and considered carefully with one’s provider. One noteworthy limitation of this procedure is that it does not allow for penetration during intercourse. One transman stated:

I’m not convinced that most women are concerned with the size of a man’s penis (even a guy with a small dick can do a lot of stuff), but I can’t even ejaculate, much less penetrate! It isolates and handicaps me in an invisible sort of way. I’m really angry about it! (Cameron, 1996, p. 46)

Although Cameron felt conflicted about the success of such a procedure, he was nonetheless able to recognize the positive impact of the operation even in the face of these limitations. Although his constructed penis could not function as a “normal” penis, he noted, his loving relationship with his partner helped to improve his self-esteem (1996). Another candidate, stated, “I feel better about having my genitals on the outside of my body.” And he continued by noting that “having genitalia that look somewhat like they’re supposed to helps me feel confident” (Cameron, 1996, p. 49).

**Phalloplasty**

Phalloplasty is a procedure in which a constructed phallus is created from skin grafts taken from the patient’s body. These skin grafts are taken from the back, abdomen, thigh, or forearm areas. This procedure typically involves a urethral lengthening process, which will allow the individual to urinate through the penis. A permanent prosthetic, called a “malleable rod,” is inserted so the penis can become erect,
or alternatively, a temporary prosthetic is inserted with a pump device (Hudson’s FTM Resource Guide, n.d.; Israel & Tarver, 1997).

Testes are often created by inserting silicone implants in the labia region. Phalloplasty techniques and cosmetic results vary here as well. Patients are encouraged to research their options with these procedures, as well as the providers in their area, as benefits, psychological comfort, functionality, and cost are, to a degree, dependent on the provider chosen. Also, patients need to be well informed of the risks, complications, and limitations associated with such a procedure. Again, the cost varies greatly, starting at around $50,000 and going up to as much as $150,000 (Hudson’s FTM Resource Guide, n.d.; Israel & Tarver, 1997). Again, insurance plans rarely cover this medical procedure. It is important to note however, that San Francisco city employees qualify for procedures after an extended period of time. In general, very few transgender patients qualify for private health insurance coverage or government based programs such as Medi-Cal, though Medi-cal will cover some procedures. Transgender patients are encouraged to review their health care plans and seek out legal counsel from community based support groups and legal advocates for more information.

_Postsurgical Concerns_

Transgender females-to-males and transsexual men are strongly encouraged to communicate with their medical providers regarding any medical and postoperative questions, issues, or concerns they may have relative to the assessment and treatment of any follow-up or adjustment conditions. All of these medical procedures that result in transitioned anatomic features and bodily functions need to be monitored for an indefinite period of time, depending on which procedures were undertaken. Another important
consideration in addition to the above (regarding risks, cost, etc.) is a careful review of the surgeon’s postoperative care policies, and these should also be discussed in advance with the medical providers. The transitional and mental health success of these patients is greatly dependent on postoperative care, including both self-care and physician care; that is, it is important that these patients carefully follow the surgeon’s advice and take responsibility for their own physical and mental health. Psychotherapy can offer the patient an important and effective supportive relationship where he can share feelings and experiences that may be overwhelming at times without the worry of being judged, which is often associated with personal relationships. It is extremely important that an individual experiencing complications of any kind or health-related risks have these addressed immediately by a skilled and licensed professional.

As this can be an exciting—as well as an anxiety-provoking time—patients should be able to rely on their medical and mental health providers for help, as they gain confidence and comfort in their new bodies. It is also strongly recommended that long-term health care be considered with a physician who is both transgender friendly and knowledgeable. One should also look to family, friends, and peers for support following these surgical procedures when one is both healing and stabilizing in his new bodies.

The permanent nature of these surgeries requires the utmost consideration. It is crucial that the individual be well informed about all aspects of these procedures. A clinician should encourage a patient to explore his/her options thoroughly and consult with peers and professionals before making a final decision. These transforming procedures also have a profound impact on one’s social, psychological, and bodily presentation and functions (e.g., sexual function), and with that being said, such a
decision should never be made in haste or based on emotional distress or confusion. It is, therefore, imperative that clinicians thoroughly explore with their patient the psychological and physical benefits and limitations, as well as how the transitional process will decidedly impact their personal and professional lives. Transgender and transsexual men who choose hormonal regimens, chest reconstruction, or genital reassignment surgeries are electing to change their physical bodies permanently. And should they disavow their self-perceived gender, their only real option is extensive reconstructive surgeries.

As will be addressed in the final and subsequent module, significant partners, family, and friends are an integral part of the transitional process. Finally, transgender men and transsexuals who elect to use hormonal regimens, chest reconstruction, or genital reassignment surgeries should be informed of the multiple health concerns necessary to live a healthy life (e.g., patients should continue to have annual pap smears to screen for cervical cancer if they have not had a vaginectomy). The aforementioned procedures should be recommended only after carefully reviewing of the previous modules provided in this manual, as well as referring to the WPATH Standards of Care for guidance. It may also be necessary to consult with a gender specialist if a clinician does not feel totally confident in his/her ability to assess, follow the suggested guidelines, or implement the information provided in the preceding modules.
Training Module VII

*Beyond Transitioning: Mourning and Living*

This final module explores the social dynamics involved in one’s transgender identity and transitional process. Familial and significant other partnerships, as well as societal issues, will be addressed, along with important pointers for the therapist working with this population. Transgender and gender-variant individuals often worry that crossing genders will have a negative impact on their ability to relate to others as well as others relating to them, ultimately fearing that they will not be loved. The first job of the therapist, then, is to convey to them that this is simply not the case.

Families, partners, friends, and colleagues can be educated about gender and sexuality issues and, at the very least, come to an intellectual understanding of what their loved one is experiencing. Yet, while it is important to reassure transgender individuals that they are still lovable and that most of their loved ones will come around, it is equally important to acknowledge the inevitability of misfortunate events and tenuous relationships. This module presents a brief discourse on relational experiences common to transgender persons within their social milieu, which are often marked by confusion, rejection, and loss. A first cautionary note for therapists treating transgender individuals is to ensure that they are hearing and understanding the individual’s personal narrative and not projecting their own assumptions onto them, as this is a group of people who are often misunderstood, isolated, and ostracized from others.

*Torn Between Longing and Belonging: Family Relations*

Transgender individuals often grapple with their gender identity conflicts, moving from initial exacerbated symptoms of gender dysphoria and evolving over time to
self-awareness and seeking out education and community support, which then may help them in their decisions to “come out” as transgender. Disclosure of their transgender identity is frequently marked with multiple losses. Often the first of such losses is the loss of their birth families, as many transgendered individuals have been banished or rejected because of their transgender identity. This familial loss is most painful for those who place high value on the family and family life. Though disclosure recommendations were addressed in Module V, psychotherapy provides an often crucial place for transgender females-to-males to reflect on how transitioning or presenting with a masculine identity will affect the quality of their relationships with various family members. Therapy may also provide a place to explore the most optimal way to disclose one’s transgender identity. Family responses vary; yet, even the most supportive parents are often confused and need time to mourn the loss of their “daughter” and the fantasies and expectations they had for her.

Initially, family members tend to deny, withdraw, or become emotionally overwhelmed. A plan should be put in place to help both the transgender patient as well as various family members find emotional support. Transgender individuals are encouraged to allow an organic process to occur. In time, family members will begin to articulate their feelings and identify and negotiate their needs and expectations. The final phase tends to shift to a position of acceptance in which a return to earlier familial dynamics ensues. Sadly, in some situations, transgender individuals lose their family of origin altogether, leaving them to adopt a new “chosen family” that will accept them not only for their gender identity and expression but may also offer them the opportunity to develop quality relationships where transgender individuals can obtain a sense of
belonging. Notably, transgender individuals without such support systems, family or otherwise, may suffer most during culturally significant holidays. Transgender individuals who lack support systems are also likely to have poor mental health and may maladaptively cope with their depression and anxiety by means of sexual promiscuity, substance abuse, or worse, exhibit suicidal ideation or even commit suicide.

*Significant Others: Husbands, Lesbian “Wives,” and Partners*

In their intimate partnerships, transgender and transsexual individuals need to be honest and forthright as soon as possible. Clearly, transitioning interventions do not go unnoticed. As significant partners generally provide their partners with the primary source of support and love, they become critical in “anchoring” their transgender partner emotionally during the transition process, as well as supporting them in a number of practical ways during the medical interventions. In many ways, the reactions and acclimations of significant partners will be dissimilar to the family of origin.

No matter how supportive and involved, they, too, will need to process their partner’s new identity emotionally, coming to terms with their own feelings, thoughts, and beliefs about their partner’s transgender identity. Most notably, after transgendering, transgender individuals may lose their significant partners as their gender identity and sexuality is drastically altered. For example, a heterosexual husband with a transitioning female partner may refuse to be involved in a homosexual relationship, or a lesbian partner may have no desire to be intimately involved with her partner who is now a transgender man. In these circumstances, divorce or separations may exacerbate adjustment distress for transgender individuals. However, couples that remain in their relationships will undoubtedly benefit from couples therapy, which can assist in
navigating their new partnership and sexual relationship. Additionally, a significant partner may need to seek his or her own individual treatment.

*Society*

The “bathroom issue” is poignantly emblematic of the societal challenges facing the transgender individual, as this is the place where one’s sexuality becomes most public. First, this bathroom issue calls attention to one’s gender identity as being at odds with one’s biological sex, and second, bathrooms are restricted to those who fall into those discrete categories, male or female, based on anatomy (Halberstam, 1998, p. 24). Halberstam observed that women in our culture exhibit exhaustive efforts “policing masculine women” (p. 24), and these anxiety-ridden states are further evidence of society’s colluded efforts in maintaining inequality based on gender: “Ambiguous gender, when and where it does appear, is inevitably transformed into deviance, thirdness, or a blurred version of either male or female” (p. 20).

Discomfort with feminine masculinity, masculine women, and transgender men is deeply entrenched in our society. This discomfort runs the spectrum from daily annoyance, as in “the bathroom problem,” (eloquently expressed by Leslie Feinberg in Stone Butch Blues), to larger, more global and all-encompassing problems that include being ostracized by loved ones, therapists, and society at large, and most tragically, being assaulted and sometimes murdered simply because of one’s gender. The spectrum of negative reactions illustrates the deep and primitive fears of gender variance in our society that will persevere until visibility, education, and professional support pave the way for challenging these conventional (and, at times, unrealistic) norms.
Workplace

Transgender individuals will need to make decisions about disclosure at the workplace: If they are an employee in an organization, they will need to determine whether disclosure to either the human resources department or their direct supervisor or boss is advised, and this may depend upon the means by which they tend to transition. Some individuals are able to transition and assimilate into their work environment quite easily. This is especially true in work environments that tolerate female masculinity and in trades that are predominantly masculine (e.g., construction or social services). In some cases, a clinician may be asked to write a supportive letter either to human resources or to the employer to convey the details of the individual’s transition from a professional perspective, thus serving to legitimize the individual’s new identity. Transgender individuals are encouraged to research legal issues with regard to unlawful discrimination and unjust practices. A final note, some transgender individuals choose to make career changes once they are able to “pass” as a man.

Acceptance or Marginalization within the Gay, Lesbian, and Bisexuality Community

Though transgender individuals have become more readily accepted in the gay, lesbian, and bisexual communities, clinicians need to be aware that blatant ignorance still prevails, even among this population. Transgender men are particularly vulnerable in the context of feminists who adamantly oppose their transitional gender status, believing them to be conforming to heterosexual ideals and denying their homosexuality. The source of contention and exclusion may be overwhelming at times and may be most painfully experienced in communities perceived to be more liberal or likeminded. In fact, some of these communities prohibit transgender individuals from engaging in their social
spheres (e.g., the Gay Parade–Dyke March exclusion of transgender persons). So, although not all transmen solely participate in or identify with the gay, lesbian, and bisexual community, even within this community, they are likely to experience strained interpersonal relationships. In short, transgender females-to-males and gender-variant individuals are likely to experience strained relationships among their peers no matter how supportive they may have been in the transition process.

Lessons for the Psychotherapist

Psychotherapy for transgender individuals is likely to be initially replete with themes of loss and mourning. These losses include birth gender identity (which includes the social identities that are connected with it); friends, partnerships, and family; as well as fantasies about being a “real man” (e.g., ability to impregnate their female partners) and loss of being able to lead a “regular” life (e.g., engage in recognized legal relationships).

Clinicians treating this population need to understand that gender and gender-role nonconformity is very difficult, challenging, and often hard to navigate, particularly when one challenges notions of gender and sexuality outside of the male/female binary divide. Many clinicians refuse outright to treat females-to-males and gender-variant individuals, especially if their identities are perceived as fluid or if the patient is hesitent about undertaking hormonal or surgical interventions because of their strong negative countertransference reactions or feelings of incompetence. And in some cases, a clinician will refuse to treatment transgender individuals simply because the individual is involved in homosexual relationships. Treatment of this population is challenging for the therapist, and he/she must constantly reflect upon his or her own biases, blind spots, and feelings
and attitudes evoked in the countertransference. With that being said, an empathic, holding, nonjudgmental, and supportive therapy that enables a transgender female-to-male patient to establish trust is most conducive to fostering a healthy working alliance wherein the patient will feel free to discover his authentic sense of self in the outside world—a world that organizes persons’ first by gender in the relational world with a host of accompanying expectations. As the treatment progresses, this empathic alliance will permit the clinician to explore with the patient both conscious and unconscious underpinnings of the feelings, thoughts, and motivations behind his behaviors and relational patterns. It is important to note that this therapeutic relationship may be the patient’s first relationship as a transgender individual in which he feels free to be open and experience acceptance and love.
Discussion

The singular purpose of this manual is to inform contemporary psychoanalytic practitioners in their treatment of gender radicals and the transgender community. By using this manual as a guide, practitioners will be better able to facilitate the highest standards of care for this heretofore largely misunderstood population. It is hoped that the manual will raise awareness of cultural phenomena and how it affects transgender individuals, as well as to present psychological difficulties and transitioning themes that are often encountered.

The information included in this manual is both practical and theoretical. Topics covered include psychosocial issues, transitioning, and medical concerns for transgender female-to-male individuals. Psychoanalytic theory—as well as queer and transgender theory—is reviewed, followed by a pragmatic discussion and guidelines for putting theory into practice when treating female-to-male patients. The manual has been organized into modules for each subject area. Appendixes are also included that contain an evaluation questionnaire, a sample letter for clinicians who are asked to assess and substantiate a real-life test, and a resource guide.

This contribution is the first of its kind, given that traditional psychoanalytic theory historically has had tenuous relationships with sexual minorities and culturally diverse groups.

The psychoanalytic clinician serving this population cannot do so effectively without being well informed and competent on gender topics, cultural themes, and pertinent societal issues. The clinician must also be able to consider traditional psychoanalytic theory from a transgender population’s viewpoint—specifically, be aware
of its inherent biases—as well as be able to utilize contemporary psychoanalytic perspectives in gender and sexuality development.

The literature review provides a historical account of the transgender community, shedding light on how they have come to be marginalized in the greater culture. It was Freud who first challenged the assumption that gender was solely biological, thus pioneering radical notions about gender and sexuality. Many years later, feminist, queer, and postmodern perspectives challenged the limits of Freud’s psychosexual development theory, which, in essence, pathologizes gender nonconforming individuals and sexual orientation. It is this author’s opinion that contemporary psychoanalytic theory best articulates gender and sexuality development with regard to the multiple social identities that one may hold.

A synthesis of the literature informs the clinician of the value and limitations of traditional psychoanalytic theory and presents a new medium for considering the complexities of gender and sexuality development. A traditional neo-Freudian psychoanalytic practitioner remains primarily concerned with the unconscious fantasies (e.g., wishes and desires) and internal conflicts that motivate patients’ actions, while conceptualizing gender and sexuality development within the context of Freud’s psychosexual development theory. Clinicians who practice from this traditional perspective also tend to minimize the importance of external realities and the social context within which the patient resides.

A leading contemporary theoretician, Ken Corbett (whose theories are discussed at length in Module III), opined that traditional linear models claim “normative” trajectories that fail to represent human variance. He argued further that postmodern
theories overemphasize the importance of subjective experience, and he challenged traditional theory by asserting that deconstruction of the self in relation to another is overestimated. Corbett contended that the shifting and evolving mind may later inhibit new identifications and create contradictions (e.g., gender identity and its inherent conflicts as described in Module I). He presented an alternative nonlinear developmental model that complements an individual’s right to self-determination, cultural sensitivity, yet at the same time, offers a model that grapples with maladaptive postures: “aberrant-marginal them and ideal-central us” (2001, p. 315). He concluded that interplay in between the margins inherently fosters mental freedom that allows for both psychological health and adaptability.

Other prominent theorists presented in the literature review include Judith Butler, Muriel Dimen, and Adrienne Harris, and they have addressed such issues as internalized cultural experience, subjective narratives, and the patient within their social context, as well as family dynamics (both intact and nontraditional familial configurations). It is this author’s belief, however, that contemporary psychoanalytic clinicians do not fully appreciate the importance of constitutional factors, unconscious fantasies, or internal conflicts. Rather, they focus more on the transference-countertransference dynamics within the treatment, recognizing the clinician’s impact on the therapeutic relationship. It is important to note that some contemporary practitioners would argue that one develops a core gendered self, whereas other clinicians believe that gendered states, bodies, performances, or gender roles are fluid.

Importantly, the manual also recommends that a therapeutic relationship with this population is most effective when it is first based on empathy, acceptance, and
attunement with the individual. Within this safe environment, the transgender person can come to terms with his/her gender identity and experience and thus solidify a cohesive sense of self. Such an experience is likely to improve the quality of the transgender person’s life as well as their interpersonal relationships.

It is not the intent of this manual to provide a clear-cut template of how to facilitate a high standard of care for transgender female-to-male and gender-variant individuals as merging both viewpoints of the transgender community and contemporary psychoanalytic theory and practice is simply not possible. Each professional will need to decide whether he/she is willing to treat an individual for the short-term if the patient only wishes to obtain a real-life assessment and produce a letter that supports the completion of the task outlined by the Standards of Care. By simply writing this letter, the practitioner is “bending the frame.” That dilemma is left to the clinical judgment and discretion of the provider, although, clearly, simply obtaining a letter to begin hormone treatment will not lead gender identity conflicts to become ego-dystonic. Self-determination for the transgender individuals—that is, achieving optimal gender identity integration between mind and body—is no straightforward task. The question remains, what does it take to transform gendered distress into ego-syntonic gender identity? “Distortions,” whether psychically or physically reflected in the mirror, gives one but a glimmer of the kaleidoscope of possibilities. The interested reader is encouraged to read contemporary psychoanalytic literature as this manual merely scrapes the surface of a very complex and—by most—poorly understood topic.

An ideal next step would be to conduct a longitudinal study of pretransgendering female-to-male individuals and posttransitional patients, looking at various intervention
markers. A number of comparisons could be made for evaluating transgender individuals, including those with no hormones, those with chest reconstruction and no hormones, those with chest reconstruction and hormone treatment, etc., as well as conducting an in-depth review of psychodynamic history and case reviews. With additional research and attention, interventions will be developed to help this population achieve optimal gender identity integration that will finally free them from their emotional distress and anguish. Finally, perhaps, this unique group will be better understood in the future and will be able to find a more comfortable place in our society.
References


Dimen, M. (2002). Deconstructing difference: Gender, splitting, and transitional space. In M. Dimen, & V. Goldner (Eds.), *Gender in psychoanalytic space: Between clinic and culture* (pp. 41-61). New York: Other Press.


Harris, A. (2002). Gender as contradiction. In M. Dimen, & V. Goldner (Eds.), *Gender in psychoanalytic space: Between clinic and culture* (pp. 91-115). New York: Other Press.


Appendix A

*Semi-Structured Questionnaire*

**Identifying Information:**

Legal Name________________________________ Today’s Date___________________

Chosen Name________________________________ Birth Date___________________

Have you changed your name legally?  Y  N
Have you changed your name on your driver’s license?  Y  N
Have you changed your name on your social security card?  Y  N
Have you changed your name on your birth certificate?  Y  N

*Do you intend on doing so? Please explain:*

________________________________________________________________________
________________________________________________________________________

Social Security Number_______________________

How do you identify your gender?

*Please circle one*

Female  Male  Bigendered  Gender Queer  Intersex  Other

What is your birth sex?  Male  Female  Intersex

Home Phone________________________________

Is it OK to leave messages at this number?  Y  N

Work Phone________________________________

Is it OK to leave messages at this number?  Y  N

Email______________________________________

What is your sexual orientation?

*Please circle one*

Heterosexual  Gay  Lesbian  Bisexual  Queer  Other

*If other please describe:*

________________________________________________________________________

What is your ethnic and/ or racial background?

*Describe:*

________________________________________________________________________

What is your religious or cultural background?

*Describe:*

________________________________________________________________________
Emergency Contact Person_____________________ Phone Number_________________

Relationship to Contact Person________________________

Are you employed? Y N What is your occupation? ___________
What is your current job title: __________ What is your annual gross income? _______
Disabled? Y N Retired? Y N
What is your highest grade or degree earned: _____ Education in years: ____ Year: ____

What is Relationship Status?
Please circle one
Single Partnered Married Separated Divorced Widowed

Where you ever married as your formal birth sex? Y N
Are you currently married as your transgender or transsexual status? Y N

Do you have children? Y N If so, how many children do you have? ____
List Name and Birth Order:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Did you give birth to your children? Y N
Does your child/children reside in your care? Y N
Please explain:
________________________________________________________________________

Are they aware of your gender/transgender identification? Y N
How does your partner feel about your gender/transgender identity?
Please explain:
________________________________________________________________________

Please describe the quality of your sexual life

Do you have any concerns about your sex life? Y N
Please explain:
________________________________________________________________________

Reason for Seeking Psychotherapy Services:
Please explain what brings you in for help at this time
________________________________________________________________________
How can I help?

Gender Issues:
When are your first memories of cross-gendered identifications? Please explain:

How do you understand the origins of your gender/transgender identification? Please explain:

How long have you been living in the role as a man, transgender man, transsexual or genderqueer? Or do you intend on transitioning? Y N

Is your partner aware of your gender identification? Y N NA How have they responded to your transition? Please explain:

Friends Y N Please explain:

Family Y N Please explain:

Workplace Y N Please explain:

Do you tend to use public restrooms? Y N If so what restroom do usually use? Mens Womens Unisex When using public restrooms do you become anxious? Y N Please explain:

Are you currently taking hormones? Y N
Do you anticipate taking hormones in the future?  
Y  N  Don’t Know
Please explain:

________________________________________________________

________________________________________________________

Have you had any surgical procedures?  
Y  N
Are you interest in chest reconstruction surgery?  
Y  N  Don’t Know
Are you interested in any genital reconstruction surgeries?  
Y  N  Don’t Know

Chest Reconstruction/Bilateral Mastectomy
Explain details: (When...where...by whom and did you experience any complications?)

________________________________________________________

________________________________________________________

Hysterectomy
Explain details:

________________________________________________________

________________________________________________________

Phalloplasty
Explain details:

________________________________________________________

________________________________________________________

Do you have any other surgeries that you intend on receiving or have received?  
Please explain:

________________________________________________________

________________________________________________________

Current Living Situation:
Please describe your living situation (Live alone with others, rent, own etc.)

________________________________________________________

________________________________________________________

General Medical History:
Do you have current medical issues? Please explain:

________________________________________________________

________________________________________________________

Do you have any physical disabilities or chronic medical issues? Please explain:

________________________________________________________

________________________________________________________

________________________________________________________

Are you currently taking any medications?   
Y  N
If so explain please explain if they are over the counter or prescription and dose level:
1).
List any supplements, vitamins, or other health-related substances you take at the moment:
1). ______________________________________
2). ______________________________________
3). ______________________________________

**Symptom History:**
Have you noticed a difference in your eating habits?  Y  N
*Please explain:*
________________________________________________________________________

Have you noticed a need to sleep more?  Y  N
*Please explain:*
________________________________________________________________________

Have you had troubles sleeping through out the night or find yourself sleeping less?  Y  N
*Please explain:*
________________________________________________________________________

Do you feel more depressed that you have in the past?  Y  N
*Please explain:*
________________________________________________________________________

Are you experiencing any symptoms that are causing you worry?  Y  N
*Please explain:*
________________________________________________________________________

*The following history inquiries do not tend deviate from standard history assessments: Only pertinent questions to transgender patients are queried here.*

**Family History:**
*Please describe your childhood*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

With whom did you live growing up?
________________________________________________________________________
________________________________________________________________________
With whom did you identify with (e.g., father, mother, and uncle)?

Please explain:

What hobbies or activities interested you?

Please explain:

Would say that you defied stereotypical interests according to your birth sex?  Y  N

In any way, did your gender non-conformity influence your relationship with your family?

Y  N

Please explain:

Please describe the quality of your relationship with your mother and father (caregivers) growing up

Please describe the quality of your relationship with your mother and father (caregivers) now

Mental Health History:
Have you ever participated in treatment before? If so please explain why you sought services, when, with whom and what was the outcome:

Have you ever had suicidal thoughts or fantasies?  Y  N

Please describe your thoughts

If so, did you have a plan?  Y  N

Please explain:

Have you ever attempted to harm yourself in any way?  Y  N

Please explain:
Are you currently feeling suicidal?  Y    N
Do you have a plan on how you might end your life?  Y    N
Do you have the means to carry out your plans?  Y    N
Please explain:
________________________________________________________________________
________________________________________________________________________
____________________________________________________________

Does your family have a mental health history or psychiatric history?  Y    N
Please explain:
________________________________________________________________________
________________________________________________________________________
____________________________________________________________

**Sexual Health History:**
Are you happy with your sex life?  Y    N
Is there anything you would like to change?  Y    N
Please explain:
________________________________________________________________________
________________________________________________________________________
____________________________________________________________

Do you experience erotic stimulation or orgasmic pleasure during masturbation or sexual acts with a partner because of thoughts or fantasies of your role as your desired gender identification?  Y    N
Please explain:
________________________________________________________________________
________________________________________________________________________
____________________________________________________________

Do you have any questions or concerns regarding your sexual life?  Y    N
Please explain:
________________________________________________________________________
________________________________________________________________________
____________________________________________________________

**Substance Use:**
Please explain your family history of substance use/abuse

Please explain your substance use/abuse history
Dates:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
When did you start drinking or using drugs regularly?
_______________________________________________________________________

What drink or substances do you prefer?
________________________________________________________________________

Do you share needles or various instruments to use drugs?  Y  N
With whom do you use drugs or alcohol?
________________________________________________________________________

Do you ever use substances alone?  Y  N
Are you concerned about your substance use?  Y  N
*Please explain:*
________________________________________________________________________

When was the last time you used drugs or alcohol?
________________________________________________________________________

I have been dependent on drugs or alcohol?  Y  N  If so when: _______________
I would consider myself dependent on the drugs or alcohol?  Y  N
*Please explain:*
________________________________________________________________________

Are you in recovery?  Y  N
How do you maintain your sobriety?
*Please explain:*
________________________________________________________________________

Do you have any concerns regarding your substance use?  Y  N
Are you interested in changing your substance patterns of use?  Y  N
*Please explain:*
________________________________________________________________________

**Other:**
Is there anything else you would like me to know?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix B

Sample Letter for Hormone Treatment/Surgery

[Clinician’s Letter Head]
[Name]
[Address]
[Telephone]

[Date]

Dear Sir or Madam,

I am writing on behalf of [patient’s name]’s request for assessment for [hormone/surgery procedure] eligibility and readiness. I am a [professional title] [in private practice or name of community health clinic/agency] and I have been meeting with [patient’s name] for psychotherapy for [duration/frequency of sessions].

During our time together, [patient’s name] has articulated and has come to great understanding regarding his gender issues. He has discussed and explored his gender concerns, and demonstrates the awareness of the associated social, medical, physical, and psychological consequences. I believe that he has realistic expectations and has considered both the benefits and limitations to such treatment. However, without the opportunity to receive [hormone/surgical procedure] treatment [patient’s name] is likely to have deteriorating mental health and psychosocial consequences. He has also been able to sustain [employment or student status]. In addition, he has identified and established gender identity transitional goals and support systems in his psychotherapy.

Though I am not a medical expert, it is my professional opinion that without the [assistance of hormonal treatment/surgery procedure], [patient’s name] will be less able to live in the desired gender role congruent with his psychological gender identity. Treatment is likely to integrate his psychological state of mind and body and improve his emotional functioning. I have assessed for evidence of delusional thinking and impaired judgment and no such psychiatric concerns seem to be evident. I believe that [patient’s name] decision to seek treatment is rational and just, and he is in the position to consent and proceed with treatment. Finally, I am unaware of any reason why [patient’s name] might not be considered and eligible for [hormone/surgery] according to the World Professional Association for Transgender Health Standards of Care.

Please feel free to contact me if you have any questions or concerns.

Regards,

[Clinician’s printed name, professional title and license #]

[Signature]
Appendix C

Resources

Gender Education, Gender Supportive Services & Groups for Transgender Female-to-Male and Gender Variant Men, Their Families & Allies:

**Ark of Refuge Transcending Program**
www.arkofrefuge.org

**Asian Pacific Islander Wellness Center**
415.292.3400 PH  415.292.3400 TTY–San Francisco
510.625.1578 –Oakland  650.669.0482 –Daly City
http://transtrive.org

**Community United Against Violence**
415.333.4357 (HELP)
www.cuav.org/index.php

**FTM Health Guidelines**
http://tghealth-critiques.tripod.com/ftm_ha1.htm

**FTM Information Network**
www.ftminfo.net

**FTM International**
601 Van Ness Avenue Suite E327
San Francisco, CA 94102
1.877.267.1440 & 415.563.5987
http://www.ftmi.org

**FTM Phalloplasty**
www.ftmphallo.com

**FTM San Francisco –Lou Sullivan Society**
www.ftmsf.org

**FTM-Trans Support List**
http://groups.yahoo.com/group/FtM-trans

**Forge Forward FTM/SOFFA Conference**
http://www.forge-forward.org/conference

**Gender Odyssey**
www.transconference.org
Gender Spectrum
www.genderspectrum.org

Gender Talk
www.gendertalk.com

Hudson’s FTM Guide
www.ftmguide.org

John Otto’s FTM Resources
http://www.jotto.info

LYRIC: Building Community & Inspiring Social Change for LGBTQ Youth (24 yrs and under)
127 Collingwood Street
San Francisco, CA 94114
415.703.6150
www.lyric.org

LYRIC Youth Talkline (22 years and younger)
415.863.3636 &
1.800.246.PRIDE

TheNetwork/LaRed
Abuse hotline for the lesbian, bisexual and transgender community
Hotline: 617.742.4911 TTY: 617.227.4911
http://www.thenetworklared.org

OutProud.Org – National Coalition for Gay, Lesbian, Bisexual & Transgender Youth
http://www.outproud.org

Parents, Families and Friends of Lesbian and Gays (PFLAG)
Our Trans Children (Brochure & Supportive Services)
781.891.5966
www.pflag.org

Screw Up
http://screwup.info

Trans-Acadmeics.org
http://Trans-Academics.org

Tranny Boi
www.trannyboi.com
TransGender Care
http://TransGenderCare.com

Transgender Equality: A Handbook for Activists and Policy Makers

TransFamily
http://www.transfamily.org

Transgender San Francisco (TGSF)
P.O. Box 426486
San Francisco, CA, 94142
415.564.3246 –Hotline & 415.839.9448 –Information
www.tgsf.org

Transster
http://www.transster.com

Legal & Advocacy Supportive Services:

Gay and Lesbian Advocates and Defenders (GLAD)
www.glad.org

Gender.Org
www.gender.org

Gender Public Advocacy Coalition (Gender PAC)
www.gpac.org

International Foundation for Gender Education
http://www.ifge.org

National Center for Transgender Equality
www.nctequality.org

National Gay and Lesbian Task Force
Transgender Civil Rights Project
www.thetaskforce.org

Sylvia Rivera Law Project
www.srlp.org

Transgender Law Center
1800 Market Street, Suite 408
San Francisco, CA 94102
415.865.0176
Medical Services:

Community Clinics

 Castro Mission Health Center –Dimensions Queer Youth Clinic (18-25yrs)
 Thursdays 5pm-8pm & Saturdays 12pm-3pm
 3850 17th Street (Between Noe and Sanchez)
 415.487.7500 or 415.487.7589
 http://dimesionsclinic.org

 Lyon-Martin Health Services
 1748 Market Street, Suite 201
 415.565.7667
 www.sfccc.org/clinics/lmwhs.htm

 St. James Infirmary
 http://www.stjamesinfirmary.org

 Tom Waddell Clinic –Transgender Clinic
 Tuesdays: New Patients 2-4 pm, 5-8pm open clinic hours
 50 Lech Walesa (50 Ivy) Street
 San Francisco, CA
 415.554.2727
 http://www.dph.sf.ca.us/chn/HlthCtrs/TomWadell.htm

 Private Practice Plastic, Reconstructive and Genital Surgery
 Michael Brownstein, M.D., FACS
 1001 Mariposa Street, Suite 101
 San Francisco, CA 94107
 877.255.2081 (toll free) or 415.625.3230 (local)
 www.brownsteinmd.com & email: mlb@brownsteinmd.com

Mental Health Services:

 Center for Special Problems
 1700 Jackson Street
 San Francisco, CA 94109
 415.292.1500

 New Leaf: Services for Our Community
 103 Hayes Street (near Market Street) –Client Services
San Francisco, CA  
415.626.7000  TDD: 415.252.8376  
http://www.newleafservices.org

Pacific Center for Human Growth  
2712 Telegraph Avenue  
Berkeley, CA 94705  
510.548.8283  
www.pacificcenter.org

Mental Health Organizations & Committees for Providers  
LGBT Mental Health Syllabus (for providers)  
http://www.aglp.org

The World Professional Association for Transgender Health, Inc. (formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc. (HBGIDA)) –Professional Organization that provides the Standards of Care  
www.wpath.org

Other Websites:

Androgen Insensitivity Syndrome –Support Group (AISSG)  
http://www.aissg.org

Consortium on Disorders of Sex Development (Clinicians, Patients, & Parents)  
http://dsdguidelines.org

Intersex Society of North America  
http://www.isna.org

Transsexual Workers: An Employer’s Guide by Janis Walworth  
http://www.gendersanity.com/empguide.americamericah.html

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