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To cite this article: Lin Fraser (2009) Depth psychotherapy with transgender people, *Sexual and Relationship Therapy*, 24:2, 126-142, DOI: [10.1080/14681990903003878](https://doi.org/10.1080/14681990903003878)

To link to this article: <https://doi.org/10.1080/14681990903003878>



Published online: 19 Oct 2009.



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## Depth psychotherapy with transgender people

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*(Received 21 April 2009; final version received 27 April 2009)*

This article presents an introductory and transpositive approach for doing depth psychotherapy with transgender individuals. Combining contemporary psychodynamic, Jungian and gender identity theory, this approach reflects the unique path of transgender identity development. Transgender identity is not viewed as inherently pathological. Rather, the issues that emerge in psychotherapy with transgender clients, like with all people, are about the self and self-in-relation, negotiating identity with outer reality. For the transgender person, however, psychological issues are particularly related to faulty mirroring during periods of identity construction because the transgender self is often invisible to the outside world. Transgender identity development involves a body/mind mismatch and is affected by social stigma associated with gender variance. Transgender individuals negotiate their transgendered self in a world that sees gender as binary, resulting in a tension between desire, authenticity and avoidance of stigma. A composite trajectory of pre-, during- and post-coming out of transgender identity development is presented and potential therapeutic themes and interventions for each of these phases are discussed. Challenges and resolutions are illustrated by poems from clients of the author's 37 years of clinical experience with this population.

**Keywords:** transgender; transsexual; therapy; identity development; Jungian

### Introduction

This article presents an introductory model for doing depth psychotherapy with transgender people. It is a developmental model based on a combination of: (1) contemporary psychodynamic psychosocial and gender identity theory, (2) Jungian theory and (3) transgender narratives, the life stories people describe in therapy. The model operates from the assumption that the transgender self can be a legitimate, authentic self rather than, as has been suggested in earlier theory, a false self, defense or complex (e.g. Bak, 1968; Fenichel, 1930; Greenacre, 1969; Greenson, 1966, 1968; Ovesey & Person, 1973, 1976; Person & Ovesey, 1974a,b; Stoller, 1970, 1972, 1973a,b, 1975a,b). In other words, this is a non-pathologizing, trans-affirming model of transgender identity. It includes the strengths and problems that might emerge from the unique path of transgender identity development and describes how these concerns might be addressed in therapy. It also addresses a therapeutic stance and associated counter transference.

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Issues that emerge in psychotherapy with transgender people are the same ones that emerge for anyone else, issues of self and self-in-relation, autonomy and connection, identity and intimacy. For the transgender person, however, these issues are both psychological and physical complicated by a conflict between mind and body (gender dysphoria) of unknown etiology. Also, like anyone else, the transgender person has inner and outer issues, inner psychodynamic issues and “out-in-the-world” issues having to do with negotiating identity with external reality.

Grounded in 37 years of clinical experience applying a depth therapy approach to working with transgender people, this article will discuss the issues outlined above as they emerge in therapy and across the life span in pre-, during- and post-coming out phases of transgender identity development. To place this work in the proper context, it is essential to understand the cultural shift that is taking place with regard to transgender people in the USA.

### **Cultural shift**

We are in the midst of a cultural shift regarding attitudes toward transgender people. This is the latest of shifts in which people themselves, who were defined by a dominant culture that put them in categories of inferiority, objected and redefined themselves. It began with the civil rights movement, followed by the women’s movement, then the gay, lesbian and bisexual and now the transgender movement. In each situation, a protest emerged against pathologizing. For example, with women, standard psychodynamic theory held that women had an inferior superego with a lower capacity for moral development, an inferior soul or none at all (Freud, 1905/1962, 1940/1964) and less cranial capacity, which led to poor reasoning. Moreover, women were seen as less grown-up and more childlike than men. Gay men and lesbian women have been in the same position, being defined as other and inferior. Transgender people have been inferred, like women, black and gay people, via sexism, racism and homophobia, to have an inherent inferiority, with the added dimension of psychopathology attached to stigma (as was true for gay men and lesbian women until homosexuality was removed from the DSM in 1973). But the tide is now turning, at least in some areas of the world and among younger people who are more comfortable with gender diversity and fluidity. As clinicians, we are responding to what we hear and see in our practice (the lived experience of transgender people) as well as these human rights concerns, fitting the theory to the people and not the other way around.

### **Background and theory**

My initial contact with transgender people was 37 years ago when one of my first clients was a transgender woman several months pre-genital surgery who came to work on her anger issues. She had transitioned and received support for genital surgery before our work together started, allowing us to focus on other issues. That gave me an opportunity to learn from her about transsexuality unencumbered by gatekeeping concerns, i.e. the fact that an evaluation and recommendation by a mental health professional are required in order to access hormones and/or surgery (Meyer et al., 2001). We continued our work through her surgery and several years post-operatively. This was the beginning of a steady stream of referrals from her and

her surgical program to my clinical practice. As a civil libertarian drawn to depth-work and with a mushrooming gender practice, I had no problem with transgender people defining their bodies and gender expression. Nevertheless, I took very seriously my responsibility as the mental health professional referring transgender clients to physicians for irreversible medical feminization and masculinization as outlined by the prevailing Standards of Care (Meyer et al., 2001) as well as the responsibility required of depth psychotherapy to help people on their individuation path. My interest in serving transgender people has led me in many directions over the years, studying various theories, devoting my doctoral dissertation to the topic (Fraser, 1991), reading and traveling widely with my work in mind, spending two years at the San Francisco Psychoanalytic Institute, being under the supervision of several Jungian analysts for the past 30 years (Drs. Herb Wiesenfeld, Crittenden Brookes, and Jean Shinoda Bolen), and participating as a charter member in the World Professional Association for Transgender Health (then called the Harry Benjamin International Gender Dysphoria Association) and the Bay Area Gender Associates peer consultation group. Moreover, I learned from listening to hundreds of clients' stories over the years. The approach described below is a brief overview of what this culmination of experiences has taught me.

When starting this work in the 1970s, the analytic literature on the topic was limited and what existed pathologized transsexuality (e.g., Bak, 1968; Fenichel, 1930; Greenacre, 1969; Greenson, 1966, 1968; Ovesey & Person, 1973, 1976; Person & Ovesey, 1974a,b; Stoller, 1970, 1972, 1973a,b, 1975a,b). Although informative, useful and interesting, these theories didn't necessarily fit the breadth and depth and surprising psychological health of many of the clients in my practice. Although a critique of the literature is beyond the scope of this article, based on what I was seeing, much of the literature, thoughtful though it was, seemed to be trying to fit people to established theory rather than the other way around. Many transgender people, aside from a mind-body mismatch, seemed quite healthy given the challenges of their outer world. Many transgender people complained that therapists, who operated from psychodynamic theory indicating that the transgender self is a failure to separate, a defense, a false self or even a psychosis and never potentially a healthy part of the self, did not seem to understand the reality of their lived experience. However, this did not mean that psychodynamic theory and therapy were not applicable to the transgender condition. When shifting underlying assumptions and removing the explicit or implicit psychopathology from the development of a transgender identity, this theory can be most useful in understanding and helping the transgender person in psychotherapy.

The following areas of exploration derived from psychodynamic thinking (Westen, 1998) might be useful in working with a transgender person in depth psychotherapy:

- (1) a focus on the development of identity and the importance of relationships, seeking to understand how an individual develops a coherent identity, a strong sense of self and a sense of connectedness, including the capacity for empathy;
- (2) how early patterns of relatedness that develop in childhood continue throughout the lifespan;
- (3) how adaptive unconscious processes and defenses work;
- (4) how representations of the self and others learned in childhood create both distortions and healthy relationships; and

- (5) how relational therapy based on insight, empathy and compassion can modify unconscious or painful processes

Psychotherapy from a Jungian perspective is about fostering individuation, “being who the person is meant to be” (Wheelwright, 1982) and addresses questions of meaning and expansion of consciousness (Stein, 1998). The goal is to help the client develop a healthy self and find meaning in relation to his or her own ego (the self with a little “s”); to others (e.g., intimate partner, family, friends and community); to work; and to the Self (with a big “S,” which some call God or Higher Self).

Individuation is uniquely challenging for transgender people because in order to be who they were meant to be, the person must challenge societal norms, expectations of family and loved ones and what others tell them they are meant to be. They must challenge the generally accepted certainty of the stability of biological sex and gender that most believe to be fixed and immutable. A Jungian perspective works well with transgender people, however, because it is not as concerned with cultural rules and conformity as other perspectives and is about developing who one uniquely is in the larger world. Jungian theory is not so culture bound and can be contextual and relational, which opens a wider frame in which to connect with the Self. Jungians are also not particularly concerned with pathology. Jung said Freud took care of that (Bolen, personal communication, 2004) leaving space for him to focus on health and possibility. Finally, in terms of the therapist’s stance, the bottom line, in my experience, is to believe the person. Like in any good therapy, skilled clinicians assume that the other is an authority of their own experience.

This therapist’s stance, to the extent possible, is one of no preconceived ideas. The therapist and client collaborate on a journey in search of the client’s truth. The therapist’s examination of his or her own beliefs, in this case about gender, transgender, immutability of gender identity and sexual orientation, is important. What is seen clinically may be surprising and challenge preconceived ideas about sex and gender and even the sense of what constitutes an integrated self. The importance of keeping an open mind cannot be overstated.

Using this approach, what has emerged in my practice over the years is that although depth psychotherapy can help people enormously on their individuation path, it doesn’t seem to have as an outcome a “cure” of transgender feelings (other than in a few isolated cases). Depth work helps people live a more authentic transgender life or helps to understand how the transgender identity developed over time. Once stabilized, this identity appears more like part of the authentic gendered self for most people. It indeed seems to be who the person was meant to be. This is not to say that transgender people don’t bring extraordinarily rich and complex inner worlds into the therapeutic environment. The reality is that many have internal lives that are often quite complicated and difficult to sort out. Many are candidates for long-term depth work, including work with the unconscious. Dream interpretation can be especially useful in this regard.

Clients present with a range of cross-gender identification along a wide spectrum. This spectrum includes the more conventional full cross-gender identity, but also partial, even fragmented, parts that may appear compartmentalized. These parts may have functioned potentially defensively early in their development but once stabilized are usually not reversible and can progress to a full cross-gender identity. Generally, depth work does not lead to disappearance of transgender feelings but, rather, to uncovering them. In the case of bi-gendered people this often leads to

a way to manage a psyche that houses two selves in terms of gender identity or in terms of sexual orientation (one orientation toward others and one toward an inner image of a cross-gendered self). In terms of gender identity expression, various outcomes are possible. Options include full or partial transition with or without medical masculinization or feminization and could even include a transgender identity that is not expressed. What is important for the therapist to remember is that, according to the Standards of Care, the “overarching treatment goal is lasting personal comfort with the gendered self in order to maximize psychological well-being and self-fulfillment” (Meyer et al., 2001, p. 1).

### **Transgender identity development and the role of psychotherapy**

The psychological issues that might emerge in therapy will be addressed from a developmental perspective and illustrated by the life path of a composite transgender person. It is important to keep in mind that this serves as only a template, because the clinical picture can be quite complicated depending upon age of onset, degree of transgender feelings, life experience, including significant relationships, and the many other aspects of a person’s life that affect identity.

For the transgender person, the primary concerns are the same as for everyone else: to develop a healthy self and self-in-relation, experience empathy and trust, develop the capacity for intimacy and live an authentic life. The unique challenge for the transgender person, and probably the most important precursor for the psychological issues that emerge in therapy, is that the developing transgender self has been hidden from others. Hence, the person develops that self in secret and alone and, to avoid stigma, often hides this again after coming out. As a result, for many, their unique history remains secret throughout the lifespan. Thus, the developing gendered self is both unmirrored and unsocialized at least in a gendered sense. However, in the midst of the culture shift described above, this is changing as people challenge the binary gender system allowing transgender and other gender-variant people to live more authentically (see also Bockting & Coleman, 2007). Nevertheless, transgender people, like everyone else, must live and negotiate gender in a world that views gender largely as binary, i.e. one is either male or female, man or woman, masculine or feminine. This will be especially challenging for transgender persons whose gender identity does not fit this binary understanding of gender.

### **Early life**

The developmental task according to a variety of theorists (e.g. Ainsworth, 1979; Ainsworth, Blehar, & Waters, 1978; Bowlby, 1969, 1973; Erickson, 1950, 1968) is to develop a sense of a separate self along with basic trust and the ability to attach. In terms of identity development theory, this separate sense of self begins between the ages of 6 and 18 months, in what Lacan calls the “mirroring” stage of development (Kramer, 2002). The child sees itself in the mirror of others who care for him or her; the self is constructed in mirror relationships with others (Goldman, 1993a,b, 2005; Lacan, 1949; Winnicott, 1965, 1971a). Accurate mirroring is required for the development of a coherent self (Kohut, 1971, 1977, 1982). A separate identity is also constructed in the actual mirror, when we see ourselves and say: “Hey, that’s me!” (Kramer, 2002). For most people, the gender that is mirrored by others matches our own self-concept.

According to gender identity theory, male and female gender identity differentiation develops early, before the age of two (Money & Ehrhardt 1972). Aside from being human, gender identity is the bedrock of identity, of a person's sense of self. If it is one thing one knows, it is being a boy or girl. Society mirrors that sense of self, strengthening and teaching us about our gendered self-concept. The process involves a separation from (for boys) or identification with (for girls) mother (Chodorow, 1978, 1994) and this developmental task must be resolved prior to developing a healthy capacity for intimacy. The developmental tasks can be quite different for boys and girls. Boys have a particular challenge in separating from their primary caregiver (Pollack, 1995), since it is more difficult to disidentify than to identify, which can lead to later relational difficulties. Nevertheless, most developmental theories concur that this separation and identification, both in close relationships and in society, however challenging, is important for the healthy consolidation of gender identity.

For the transgender person, this process is especially challenging. Little is understood about the etiology of transgender feelings. Although researchers and gender experts suspect a biological etiology for the condition, there is no theoretical consensus and evidence remains inconclusive (e.g. DiCeglie, 1998; Green, 2004; Lev, 2004; Roughgarden, 2004; Zucker & Bradley, 1995). Moreover, because their transgender identity, at least in childhood, is often invisible, the gendered reflection is wrong, albeit inadvertent. People mirror what they see or what they expect to see. Due to a lack of visibility of gender variance in society and the associated stigma, the child's transgender experience is not mirrored back. What is known is that the transgender person feels transgender or cross-gendered at the core of their being and it is this subjective feeling of gender that defines their experience (American Psychiatric Association, 1994, p. 537). This subjective sense varies from person to person in terms of definition, degree, age of onset, ability to articulate, whether partial or whole etc., but most people have a vague awareness of its existence from an early age at least in retrospect. Hence, negotiating separation and or identification in terms of gender can be quite confusing. For example, for the developing transgender person, how does one identify or disidentify and with whom? Many transgender individuals report feeling confused, not necessarily having a name for the problem (which usually comes later), but generally just remember feeling that something is very wrong in trying to identify with same-sex peers. Listening to their stories, it seems that they don't fit into either male or female standard developmental gender-identity theory because the authentic self is not mirrored.

The resolution to this confusion is to develop the gendered self along dual and parallel lines: one as the self that society mirrors and one that is kept inside and often is secret. There is an internal sense of self that does not match the body. This self develops in secret; nobody sees it. Because it is invisible to others, this self is unmirrored. At the same time, a false gendered self develops and is mirrored by society. These two developmental lines co-exist and develop over time; the person is developing a gendered self that is unseen while society mirrors someone else. This lack of mirroring occurs to a greater or lesser degree depending upon the visibility of the gender variance (see also Bockting & Coleman, 2007).

From a depth-oriented perspective, the central psychodynamic question becomes: How does the self develop when it is unseen? How does it develop when, in fact, other people see who the self is not and actually validate, reinforce and mirror what is experienced as a false-self? And how does the invisible self learn to relate, connect and

trust others? From a developmental perspective it is obvious how difficult this task must be for the young transgender person. Major contemporary object relations' theorists (Kohut, 1971, 1977; Winnicott, 1958, 1965, 1971a,b) expound upon the problems that emerge from faulty mirroring, especially its role in the development of a false self. In fact, much of good psychotherapy in general provides a corrective for faulty mirroring (Personal Communication, August 25, 2003). The good news, however, is that the transgender person is being mirrored in other areas of the self as a human being; hence, the essential self can and does learn to trust and relate. However, because of the unintentional but quite faulty mirroring of the gendered self, this ability to trust and relate is not without potential major distortions.

For the developing transgender person, what happens early on that later might become issues in psychotherapy? They might become shy, isolated, introverted, depressed, mistrustful, a good actor, reactive rather than assertive and very lonely. They might also develop a rich internal fantasy world with a good deal of compartmentalization and self-sufficiency. They could have difficulty locating a core sense of self and try to be someone else, maybe even becoming hypermasculine or hyperfeminine, in an effort to please. They might learn to mistrust their own feelings. Typical feelings might include feeling like an alien, worry about "being crazy" or being "the only one", with a common defense of splitting, as the only way to cope. Others might experience numbness, repression, memory problems or even dissociation. Generally, what is seen are all the things that occur when one has a shameful secret, but in this case the secret is one's self.

### **Adolescence and pre-transition**

During adolescence, aside from self and identity issues, body issues emerge. The development of secondary sex characteristics during puberty might be experienced as a betrayal of the body. This involves giving up hope that "I really am or will grow up to be a man or a woman", that somehow this will occur despite evidence to the contrary. The aversion to the developing body can be accompanied by dissociation, especially with regard to gendered body parts and the development of a lifelong experience of a disembodied self. Many experience themselves as "all-mind", some report an identification with the Star Trek character Data (an android) or being a machine or an alien. Some develop their mind at a cost to their body. Many are very smart and some develop an interest in computers rather than people. Life can feel "like a science fiction movie" when the body parts develop so very wrongly.

Many are quite shy, do not feel they fit in or are socially awkward. Some female-to-male transgender individuals find a place in lesbian culture; male-to-females in gay or geek culture. Many feel isolated and report little dating. Some are asexual or continue to develop their sexual self in secret. They may become fetishistic and become sexually hyperactive with the self. Some male-to-female individuals describe falling in love with an image of the self as a woman and can become quite solitary. Some might develop a relationship with the mirror and do their own mirroring since no one else will. Others carry around a picture of themselves in the preferred gender role prior to transition, similar to carrying a picture of a loved one during a separation as a means to stay connected and attached (Watson, 2002) In this case, the attachment is to that part of themselves that can function as an internal security blanket even if it can't yet be expressed out in the world. Hence, they learn to do for themselves what they can't get from the outer world.



Some male-to-female transgender individuals experience a splitting between their male side (logos) and female side (eros), with all their erotic energy bound up in an Aphrodite archetype (Bolen, 1984) within themselves that is idealized, while their male presentation is concrete, rational and inhibited. Some have few sexual partners and experience difficulty with sex and intimacy, because the body is “wrong”. If they are sexually active, many become adept at sexual role-playing, describing dissociation from gendered body parts. Most experience guilt and shame and feel the isolation of living with a secret.

Nevertheless, this is also a time of finding images that matter, especially representations of other transgender people. It’s a time of developing a self and keeping the hope alive by “searching for tidbits”. Many make good use of imagination and tell themselves: “I can really do this”. It’s a time of developing resilience and patience. In the years before the Internet, Christine Jorgensen’s 1950s successful “sex change” served both as a role model and gave people a name for their condition (Meyerowitz, 2002). Other transgender pioneers, such as gay female-top-male Lou Sullivan (Meyerowitz, 2002), started transgender community organizations offering people a place to meet and receive accurate information about their condition. Today, thanks to the ubiquity of transgender people and information online, information and contacts are widely available. Many join chat rooms and talk worldwide. The transgender community, continually growing, even when virtual, offers a respite to the loneliness and isolation many transgender people face before coming out. The resilience and strength of transgender individuals during this pre-coming out period deserves greater study as it is quite remarkable that many are able to develop a stable sense of a gendered self without being accurately mirrored by others.

### **Coming out**

People often come to therapy just prior to coming out. Many report they “can’t stand it any more”; the pressure keeps building and they need to find out how to live with their transgender feelings. They come to therapy to sort out how they can accommodate these feelings in an authentic way, where on the transgender spectrum they can live most comfortably, what is right for them and whether or not to transition gender roles fully.

Therapy can take a long time as the person sorts out the varying inner and outer influences trying to balance their transgender feelings with the demands of the outer world and the needs of other people in their lives. They are trying to sort out the nature of their authentic self and how much it needs to be expressed in the outer world. Many come to therapy for help in understanding the meaning of their transgender feelings and whether or not these feelings need to be expressed externally. Others have already made the decision that a change in gender role is the only authentic path for them and come for help with this transition. Many have spent years analyzing themselves and are quite sophisticated psychologically. Hence, some need more help sorting out their inner world (who am I?) while others need help dealing with their outer world, work, family and friends (I know who I am, but how do I live out in the world with an authentic gendered self?). In addition to support during a gender role transition, the latter group usually requests evaluation and recommendation for feminizing or masculinizing hormone therapy and surgery (Bockting, 2008; Bockting & Goldberg, 2006; Meyer et al., 2001).

Coming out is also a time of renegotiating love and work. Many wonder who will love them and whether they will be able to transition in the workplace. Transition involves a loss of the old self as well as the loss of some relationships. It involves dealing with gender-related discrimination and stares, “feeling like a freak” and potentially losing all that matters to become who they feel themselves to be. Some may feel that, even though they know they are transgender, transition is “just not worth it”, but many feel they don’t have a choice.

For example, one male-to-female client, who wavered regarding transition for a long time and separated from a spouse in the process, was convinced that “he” can’t make major contributions in his field as he had been doing because “she” would not be taken seriously. But if she wouldn’t come out, she asked herself, could she ever be comfortable with a male body and identity? Clients may go back and forth whether to come out or not to come out for many years.

For those who do transition, this is a time of a second adolescence. Unlike other adolescents, however, the transgender person has the advantage and wisdom of chronological age but without the benefit of peer support. The impact of starting the appropriate hormones is profound; typically, a sense of “rightness” occurs as a result of the physical and psychological changes. Transition is a very self-focused time and can look selfish to others. Meeting other transgender people is key in developing an authentic self-representation.

During the coming out process, transgender individuals are dealing with both relief and fear, especially around stigma and rejection. Unlike the coming out process for gay, lesbian and bisexual individuals, for the transgender person, coming out that involves a gender role transition is very visible; there is no hiding. From the perspective of identity construction, what is seen and mirrored may produce difficulties. The person in transition often looks unusual which may produce alienation. What is experienced may not match the inner image and the reality of the presentation may involve giving up the dream of being like a non-transgender woman or man. Nevertheless, the person may be experiencing rightness in their gender and later their body for the first time.

Some may experience an unexpected shift in sexual orientation. Some may change their object choice in terms of gender, others do not. In either case, this may mean a second coming out as gay, lesbian or bisexual for those previously identified as straight. Others, such as female-to-male individuals attracted to women, may lose their lesbian identification and be considered straight.

Most transgender people going through a gender role transition have to learn how to be in the new role without the benefit of a long period of socialization typical for non-transgender people. They experience an accelerated adolescence based on an image heretofore held only in fantasy without adolescent friendships and social feedback. Hence, they experience a lack of “mirroring” again.

### **Therapy during the coming out phase**

The key therapeutic tasks are, first, to see and mirror the person in their appropriate or approximate gender, either fully or partially and, then, to help them relate authentically in that gender as therapy progresses.

Especially in the beginning, the therapist is working in the pre-oedipal arena of attachment, separation and individuation. During this period of development, empathy and mirroring are needed to develop a coherent self. As described above,

for many transgender individuals this did not occur and, as a result, a “false self” developed. Through the therapeutic technique of accurate mirroring, the client will feel seen, heard and understood (Kohut, 1971). Empathy and mirroring are required to address early developmental deficiencies, providing a therapeutic corrective. As described by Winnicott: “Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen. I like to think of my work this way, and to think that if I do this accurately enough the patient will find his or her own self, and will be able to exist and feel real (Winnicott, 2005, p. 158). This is particularly important in the work with transgender clients. For them, the therapist is often the first person to really see the authentic self even before it actually emerges, to know the secret and literally helping the person come out.

For the transgender person, there is tremendous relief in just telling their story as well as hearing their own story for the first time in a non-judgmental environment. They get to see themselves in their own image instead of somebody else’s. As one transgender client, now 15 years post-surgery, remarked:

**From the moment I made the decision,**

(On the Interstate after my first appointment with you)

I knew it was the right thing to do.

I’ve never regretted it,

never had second thoughts about it,

never wished I’d done it differently

Why?

Because I know who I am,

I’ve always known who I am,

but I was held back by fear based on how I was raised,

thinking this was something I could never do.

**The breakthrough came when someone asked:**

Have you ever talked with someone with experience in this area?

In a roundabout way I found you.

It was the ACT of coming down here and talking to you;

it’s like being afraid of water and then taking the first step.

I don’t remember what happened in the session,

but on the way home,

myself being a conservative Christian,

I really felt RELEASED.

God was saying:

“It’s OK,”

best way to put it: I felt released;

my family, my religion, they felt it wasn’t OK.

And from that moment on:

Never a doubt,

never a regret,

never a second thought.

I went full time June 5, 1992.

Moreover, once they’ve started coming to therapy in the preferred gender role, some clients will never let the therapist see them in the previous role again, often

going to great lengths to come to therapy dressed according to their authentic self. They may visibly cringe if the therapist uses the old name or the previous pronoun. For example, one client is a CEO of a successful company in the male role. Rather than letting me see “him” she prefers phone sessions when her schedule won’t allow her to come in the female role. She hopes to transition someday, but in the meantime, it matters that I see her and relate to her as she sees herself.

The emerging self is very vulnerable and should be treated with great care. This self is young, fragile and inexperienced. It often has been a lifelong fantasy, hidden, cherished and protected. It can also be full of guilt and shame and quite untrusting. When exposed, it can be easily shamed. It may be maligned and seen as a freak outside of the therapist’s office, even hated and subjected to violence and certainly subject to rejection. The therapist and client need to hold the possibility of the shared projection of the dream but also hold the possibility of its loss, or at least the loss of some of it, as the authentic self emerges. One post-transition woman describes her experience this way:

With coming out,  
the challenge is letting go of the desire (to be a real woman)  
and to be OK with who I am,  
and feeling safe with who I am.

There’s an issue of safety

**in claiming who I am.**

People might be violent,  
but I don’t want to live in a queer ghetto.  
Anytime I make a step of outing myself,

**there’s a part of myself that lives,**

but another part dies (the part about really being a woman).

Because there’s more denial pre coming out, the fantasy is I really will be a woman.

**Part of coming out**

allows me to “believe in my dreams,” but it never really happens.

I hope that I can change the way I see myself and that others can too.

“I’m not a man, wish I was a woman, but I’m in-between, so . . . I’m still the same as I was before in that sense,

and I need to construct something artificial to live in the world,  
so I ask myself: Why did I do this,  
if the dream can’t come true?

But now, at least people SEE me,  
and they understand more of who I am.

It would have been easier if I could just come to terms with living in male body space.

It makes me angry that this life I’ve been given and the WORLD gives me only these choices.

**Some people say we’re the future.**

I’d rather not be the future; I’d like to be the present.

Because even with surgery, I’ll be different from every other woman.

My body reminds me of how much I lack.

My gender is a carrot that’s right out in front of me,

**like infinity, I get so close,**

but never there.

All I know is I get closer,

but I'll never arrive.

I'm coming to accept these feelings and my anger,

but there are so few role models out there,

and many that are aren't healthy role models,

and many are more afraid than I am

**So, how do I deal with it?**

I remember:

I'm not my body.

My spirit is genderless,

timeless,

transcendent.

**I have to let go of the boy from the past,**

and the image of the girl, too.

Coming out can be a tumultuous time. With coming out, there is often pressure to move quickly, like a “tempest in a teapot”, and the person is often quite self-focused and absorbed. If they move too quickly, it can be like a “bull in a china shop”, which can lead to damage, or like a too early birth that, once started, can't be held in the womb, but then suffers from prematurity.

Relational and trust issues are central. With some people, the therapist needs to be quite interactive, not just reflective, because the self has been so protected. One useful image is helping like a midwife with a difficult birth. From the Jungian perspective, an attitude of extroverted feeling can be helpful. Many male-to-female clients appear to be introverted thinking types and respond well to someone carrying their weaker function.

To alleviate body dysphoria, the therapist can provide information, support and referral for feminizing or masculinizing hormone therapy or surgery (Meyer et al., 2001). The effects of hormones can be unexpectedly dramatic, albeit desired. Sharing knowledge of how others have negotiated the transition path can predict and facilitate the way for the newly transitioning person. The therapist can also model an appropriate gender role presentation.

A decision to transition not only has a major impact on the transgender person, but also on their loved ones. Sometimes, depending upon the client's need, the therapist may include loved ones and even members of the work environment in the therapy. Loved ones also go through a transition in terms of their identity and place in the world. Loved ones and certainly members of the work environment should only be included in therapy with fully informed consent and potential risks discussed. For many clients, the safety of the one-to-one relationship in the therapist's office should not be violated and appropriate referrals can be made to other specialists. To facilitate transition in the workplace, consultation with employers and trainings for co-workers may be appropriate.

Not everyone transitions. Some learn to live more comfortably in the role consistent with their sex assigned at birth while understanding and accepting that their transgender feelings are a part of who they are. Most, however, transition partially or fully. No matter the location of the client on the transgender spectrum, the therapist's task is still always to see, but also to contain and to

hold. The office is both a holding environment and place of safety. For those who transition, it serves as a container that protects the person from moving too quickly or, in some cases, of putting oneself in danger. For example, one client who temporarily lived in a fundamentalist Muslim society felt compelled to cross-dress and go outdoors knowing that if caught, she could be jailed or even beheaded. She was in constant contact with the therapist via the Internet (as well as seeing a local psychiatrist) and the virtual office provided enough of a holding environment to contain her need for being seen until she could return to the USA and transition safely.

In a more general sense, the therapist needs to hold both or all the possibilities of where the person could land on the gender spectrum or, in some cases, even never really land anywhere but instead maintain fluidity. Some do not fully transition but find a place on the gender spectrum that feels most comfortable, while others recognize that their gender is fluid and open to change over time, never to stabilize. Again others settle on a bi-gendered life, alternating personas and gender roles, potentially widening formerly rigid archetypal patterns as they experience more options and spend more time out in the world developing a self or selves.

The therapist will be faced with exploring options that don't fit a binary system of gender with a mix and match of body and gender expressions. This spectrum of gender diversity will challenge established theories assuming a unitary gendered self and stability of sex, gender and sexual orientation over time. Some people will live transition fully, others will live in a state of partial transition. Some will change their sexual object choice, others won't. Transgender women may opt to keep their penis; transgender men may choose to have genital reconstructive surgery while at the same time keeping their vaginal opening but give that opening a different name. Some will identify as transgender, others won't. Some will prefer cross-gender pronouns with no bodily changes. In short, the range of permutations is quite varied. Many people, as they explore their preferred gender role, do tend to transition more and more fully, but not all. Much depends on, aside from an internal self-representation, their social context, age and community.

Even though the therapist might be seeing that which might be new, the therapeutic approach is really not much different from other depth work. The therapist maintains the same stance of compassionate neutrality that would be used in any good therapy, paying attention to counter transference and all parts of the individuation process. The contents of the unconscious as illuminated by dreams can be very helpful to assist the person in sorting out the various permutations for gender identity and expression because they often have few external images to follow.

Another important role of the therapist is that of mentoring. Many clients experience relational naïveté in general and especially in their new gender role. For both the therapist and the client, feeling-in-connection is paramount. Relational issues and developing more empathy become increasingly important during the process of building a self. Transgender individuals then have the opportunity to consciously construct a self. They have the opportunity to live authentically without the constant feeling of wrongness and can thus become less self-conscious and more relational. Once they have discarded the inappropriate shell, many become more externally outer oriented because, for the first time, they perceive no barriers. Many report feeling more connected and less self-focused as they practice and build a new gendered self that is seen and mirrored in the world. This process often includes confronting issues that emerged in childhood as a result of faulty mirroring. The goal

is to integrate the selves that developed in parallel, resolving the associated complications along the way.

### **Post-transition and beyond**

After transition, individuation continues as transgender individuals consolidate their sense of self. They continue to develop a sense of bodily integrity, with a growing realization that the early fantasy of changing sex cannot really come true. This includes grief associated with the longing for a “real” penis or vagina and the associated sexual implications. Issues of love and work in the new gender role emerge. Many continue to ask: “Where do I fit? Who will love me? Should I tell/not tell about my past?” A change in sexual orientation is often a surprise. Many find partners, which can sometimes be another transgender person. Some learn to accept celibacy and solitude.

Issues of meaning become more important during this phase. In Jungian terms, it is a time of expanding the self and potentiating undeveloped archetypal patterns in the new gender role. The theme remains authenticity versus feelings of fraudulence. If fully transitioning, some ask: “Am I going from one closet into another?” Traditionally, a “successful” transition involved passing in the “opposite” gender role rendering transgender identity invisible. This outcome is desired by many, yet also presents a denial of one’s transgender history and experience (see also Bockting, 2008; Bockting & Coleman, 2007). How can a person be authentic if they can’t tell the truth? Individuals weigh authenticity versus avoidance of social stigma. The concern is: “If you truly know me, you’ll reject me or at the very least you’ll treat me differently, differently than you would if you thought I was ‘genetic’, so I’ll lose the dream of being the woman or man I always wanted to be. But if I’m not truthful, I’m still a fraud.” This quandary often becomes an ongoing dilemma throughout the lifespan and is managed in different ways. Some emphasize passing, staying in “stealth” mode. Others “tell the truth” but never really experience their lives the way they would like to, unless they truly embrace their transgender or third gender status. Most tell the truth to a few close friends, but not the larger world.

Post-transition can also be a time of longing, disappointment and grief over lost opportunities. Many wish they had transitioned earlier. Some male-to-female transgender individuals mourn the loss of youth in the appropriate gender role, of being a pretty maiden. For female-to-male transgender individuals, aging can also be difficult. Many look quite young and don’t look like men. Some want to remain boy-like because of negative socialization associated with manhood. Many have found community among feminist identified lesbians and are uncomfortable with heteronormative notions of masculinity. Others worry that they look younger than they are and won’t be treated like a mature adult. Some female-to-males experience a continued sense of invisibility because they pass so well. Both transgender women and men experience grief over relationships that were lost as they transitioned as some friends, co-workers and especially family members could not accept the transition.

For many, however, this period is indeed a time of relief and satisfaction, finally feeling “right” with themselves, whether the outer world can fully accept them or not. As one 6-year post-operative male-to-female client said:

**Not a day goes by that I don’t realize that I’m different.  
You always know that you’re not genetic, “the holy grail”.**

But:

That's what I've been given,  
and I have to deal with it,  
the fact that I'm not 100% female.

**But there's no doubt in my mind,**

that I did the right thing,  
and it's getting easier.

More people accept that I got here via a different mode than they did,  
but I AM here.

Therapy continues to address questions of meaning while continuing to work on issues not addressed in earlier phases of the work. As integration progresses, the spiraling and returning to the same issues that occur in any therapy process continue. Outside of the office, the quandaries posed by discrimination and misunderstanding can lead the therapist to advocacy and sometimes activism. Many therapists become educators to help change the culture to better accept and hopefully someday celebrate gender variance.

For the transgender person, the lifelong task becomes coming to terms with and accepting reality as they continue on the path of individuation. This includes learning to experience pride in a job well done, finding meaning in their unique path (e.g. the wisdom of knowing [in a sense] life in both gender roles; awareness of a spectrum of gender) and celebrating their unique perspective and journey.

### Notes

Homosexuality was removed from DSM as a mental disorder in 1973.

The International Guidelines of the Harry Benjamin International Gender Dysphoria Association for the care and treatment of gender dysphoria. Therapists are responsible for assessment and referral of qualified individuals to physicians for hormones and surgery.

Classification, assessment and management of gender identity disorders in the adult male: A manual for counselors, University of San Francisco, 1991.

Herb Wiesenfeld PhD from 1977–1980; Crittenden Brookes M.D./PhD from 1980–1985 and Jean Shinoda Bolen M.D. 1985-present.

Bay Area Gender Associates (BAGA), an ongoing peer consultation group of licensed mental health professionals with a specialty in transgender conditions that has been meeting for the last 15 years.

The Transgender Phenomenon/Psychodynamic Viewpoint, Plenary Talk at HBIGDA Conference, Gent, Belgium, September 2003.

### Notes on contributor

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### References

- Ainsworth, M.D., Blehar, M.C., & Waters, E. (1978). *Patterns of attachment*. Hillsdale, NJ: Lawrence Erlbaum.
- Ainsworth, M.D. (1979). Infant-mother attachment. *American Psychologist*, 34(10), 932–937.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Bak, R.C. (1968). The phallic woman: The ubiquitous fantasy in perversion. *The Psychoanalytic Study of the Child*, 2, 15–36. New York: International Universities Press.



- Bockting, W. (2008). Psychotherapy and the real life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211–224.
- Bockting, W., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey, & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185–208). New York: The Haworth Press.
- Bockting, W., & Goldberg, J. (Eds.). (2006). Guidelines for transgender care. *International Journal of Transgenderism, 9*(3/4), 1–231.
- Bolen, J.S. (1984). *Goddesses in everywoman*. New York: Harper and Row.
- Bowlby, J. (1969). *Attachment and loss. Vol. I: Attachment*. New York: Basic Books.
- Bowlby, J. (1973). *Attachment and loss. Vol. II: Separation, anxiety & anger*. New York: Basic Books.
- Chodorow, N. (1978). *The reproduction of mothering: Psychoanalysis and the sociology of gender*. Berkeley, CA: University of California Press.
- Chodorow, N.J. (1994). *Femininities, masculinities sexualities, Freud and beyond*. Lexington: University Press of Kentucky.
- Di Ceglie, D. (1998). *Stranger in my own body: Atypical gender identity and mental health*. London: Karnac Books.
- Erickson, E. (1968). *Identity, youth and crisis*. New York: Norton.
- Fenichel, O. (1930). The psychology of transvestism. In *Collected papers* (Vol. I, pp. 167–180). New York: W.W. Norton.
- Fraser, L. (1991). Classification, assessment and management of gender identity disorders in the adult male: A manual for counselors. (Unpublished doctoral dissertation, University of San Francisco).
- Freud, S. (1905/1962). *Three essays on the theory of sexuality*. New York Basic Books.
- Freud, S. (1940/1964). *Splitting of the ego in the process of defense* (Standard ed.). London: Hogarth Press.
- Freud, S. (1933/1964). *Femininity* (Standard ed.). London: Hogarth Press.
- Goldman, D. (1993a). *In search of the real: The origins and originality of DW Winnicott*. Northvale, NJ: Jason Aronson.
- Goldman, D. (Ed.). (1993b). *In one's bones: The clinical genius of Winnicott*. Northvale, N.J.: Jason Aronson.
- Green, J. (2004). *Becoming a visible man*. Nashville, TN: Vanderbilt University Press.
- Greenacre, P. (1969). The fetish and the transitional object. *The Psychoanalytic Study of the Child, 24*, 144–164.
- Greenson, R.R. (1966). A transvestite boy and a hypothesis. *International Journal of Psychoanalysis, 47*, 396–403.
- Greenson, R.R. (1968). Dis-identifying from mother. *International Journal of Psychoanalysis, 49*, 370–374.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Kohut, H. (1982). Introspection, empathy and the semi-circle of mental health. *International Journal of Psychoanalysis, 63*, 395–407.
- Kramer, L. (2002). *European thought and culture in the twentieth century: Lecture 23 on European postmodernism*. Chantilly, VA: The Teaching Company.
- Lacan, J. (1949, July). *Le stade du miroir*. Paper presented at XVI Congress International de Psychanalyse, Zurich.
- Lev, A. (2004). *Transgender emergence*. New York: Haworth Clinical Practice Press.
- Meyer, W., Bockting, W., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., et al. (2001). The standards of care for gender identity disorders (6th ed.). *International Journal of Transgenderism, 5*(1). Retrieved May 30, 2009, from [www.symposium.com/ijt/soc-2001/index.htm](http://www.symposium.com/ijt/soc-2001/index.htm).
- Meyerowitz, J. (2002). *How sex changed*. Cambridge, MA: Harvard University Press.
- Money, J., & Ehrhardt, A. (1972). *Man and woman, boy and girl: The differentiation and dimorphism of gender identity from conception to maturity*. Baltimore: Johns Hopkins Press.
- Ovesey, L., & Person, E. (1973). Gender identity and sexual psychopathology in men: A psychodynamic analysis of homosexuality, transsexualism and transvestism. *Journal of American Academy of Psychoanalysis, 1*(1), 53–72.

- Ovesey, L., & Person, E. (1976). Transvestism: A disorder of the sense of self. *International Journal of Psychoanalytic Psychotherapy*, 5, 221–235.
- Person, E., & Ovesey, L. (1974a). The transsexual syndrome in males: Primary transsexualism. *American Journal of Psychotherapy*, 28, 4–20.
- Person, E., & Ovesey, L. (1974b). The transsexual syndrome in males: Secondary transsexualism. *American Journal of Psychotherapy*, 28, 174–193.
- Pollack, W.S. (1995). No man is an island: Toward a new psychoanalytic psychology of men. In R. Levant & W. Pollack (Eds.), *A new psychology of men* (pp. 33–67). New York: Basic Books.
- Roughgarden, J. (2004). *Evolution's rainbow*. Berkeley, CA: University of California Press.
- Stein, M. (1998). *Jung's map of the soul*. Chicago, IL: Open Court.
- Stoller, R.J. (1970). The transsexual boy: Mother's feminized phallus. *British Journal of Medical Psychology*, 43, 117–128.
- Stoller, R.J. (1972). Transsexualism and transvestism. *Psychiatric Annals*, 1, 6–72.
- Stoller, R.J. (1973). The male transsexual as experiment. *International Journal of Psychoanalysis*, 54, 215–226.
- Stoller, R.J. (1973a). *Splitting: A case of female masculinity*. New York: Quadrangle.
- Stoller, R.J. (1975a). *Sex and gender* (Vol. 2). London: Hogarth.
- Stoller, R.J. (1975b). *Perversion: The erotic form of hatred*. New York: Pantheon.
- Watson, M. (2002). Lectures 13, 14, 15 on Attachment Theory. *Theories of human development, Part I*. Chantilly, VA: The Teaching Company.
- Watson, M. (2002). Lectures 8, 9, 10, 11 on Erickson. *Theories of human development, Part I*. Chantilly, VA: The Teaching Company.
- Westen, D. (1998). Lecture 5, Is anyone really normal? Perspectives on abnormal psychology. *Contemporary psychodynamic thinking*. Springfield, VA: The Teaching Company.
- Wheelwright, J. (1982). *Si George & the dandelion: 40 years of practice as a Jungian analyst*. San Francisco: CG Jung Institute of San Francisco.
- Winnicott, D.W. (1958). Collected papers. *Through paediatrics to psychoanalysis*. London: Tavistock Publications; New York: Basic Books.
- Winnicott, D.W. (1965). *The maturational process and the facilitating environment*. New York: International Universities Press.
- Winnicott, D.W. (1971a). Mirror-role of mother and family in child development. In D.W. Winnicott (Ed.), *Playing and reality*. London: Routledge.
- Winnicott, D.W. (1971b). On the split-off male and female elements to be found in men and women. In D.W. Winnicott (Ed.), *Playing and reality*. London: Routledge.
- Winnicott, D.W. (2005). *Playing and reality* (2nd Edition). Routledge Classics. London & New York: Routledge. Originally published in 1971, Tavistock Publications.
- Zucker, K., & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.