Transgender and Gender Diverse Identities in Psychoanalysis: A Critical Overview from Past to Current Perspectives

Fabrizio Mezza[1], Selene Mezzalira[2], Vincenzo Bochicchio[3] & Cristiano Scandurra[1]

Abstract

In recent decades, research on gender incongruence has shifted from a pathologizing perspective to a more complex approach, research on gender incongruence has shifted from a pathologizing perspective to a more complex approach that recognizes the diversity of gender identities and experiences. This paradigm shift, exemplified by the removal of Gender Incongruence from psychiatric disorders in ICD-11, has impacted psychoanalytic theory and clinical practice, which have traditionally been rooted in etiopathological and reparative perspectives. Psychoanalysis now focuses on understanding transgender and gender diverse experiences, emphasizing individuals' subjectivity and addressing the challenges this people face in their developmental trajectories, including gender dysphoria and environmental responses to their gender incongruence, by adopting an "affirmative approach" to gender experience. This manuscript first traces the transformation of the scientific approach to transgenderism in contemporary medical-psychiatric discourse, highlighting the shift from pathologization to recognition of the normative nature of gender diversity that has been driven by political, social, and cultural movements. In a second section, the manuscript examines the evolution of psychoanalytic thinking about transgenderism, beginning with classical perspectives and ending with recent contributions, recognizing that much in the field is still evolving.

Keywords: *transgender; gender diversity; psychoanalysis; affirmation; depathologization*

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1 University of Naples Federico II, Naples, Italy
2 University of Basilicata, Potenza, Italy
3 University of Calabria, Arcavate di Rende, Italy

Corresponding author: cristiano.scandurra@unina.it

Introduction

Over the past few decades, there has been a significant shift in how the scientific community and society as a whole perceive and approach gender diversity and, more generally, the concept of gender. From the pathologizing perspective that dominated the twentieth century, there has been a gradual evolution towards a more complex approach, which recognizes the extensive heterogeneity in individuals' gender identities and experiences. Alongside the conventional binary framework, which includes only male and female categories, there is a growing perspective that views gender as a spectrum encompassing various possibilities, acknowledging the non-pathological nature of these variations (Bass et al., 2018; Dray et al., 2020).

The removal of *Gender Incongruence* (GI) from psychiatric disorders in the latest edition of the *International Classification of Diseases* (ICD-11) marks a pivotal advancement in this direction. GI refers to a condition in which individuals' inner sense of their own gender does not align with the sex they were assigned at birth. This term encompasses both individuals who identify as the opposite gender, namely binary transgender people (i.e., individuals self-identifying as women if assigned male at birth: AMAB; or as men if assigned female at birth: AFAB), and individuals who do not identify with the societal binary construct of gender, namely nonbinary people (i.e., individuals whose gender identity does not fit into the gender binarism and who do not exclusively identify as male or female) (American Psychological Association, 2015; Davis & Davis, 2020). In the current scientific literature, the term "transgender and gender diverse" (TGD) is predominantly employed to encompass all individuals whose gender identities and expressions diverge from traditional gender norms.

The paradigm shift in the understanding of gender diversity has deeply influenced contemporary psychoanalysis, faced with the need to rethink and expand the language, meanings, and concepts traditionally used in the theory and clinical practice of transgenderism, which have long been informed by a pathologizing and reparative orientation.

As traditional views linking gender to sexual anatomy have been challenged and the binary understanding of gender have been questioned, psychoanalysis has developed renewed interest in this topic, increasingly recognizing this phenomenon as a possible subjective experience of gender, rather than just a symptom tied to pathogenic origins.

By distancing itself from searching for etiological factors and moving away from reparative approaches, psychoanalysis has shed light on new insights, reflections, and questions about gender diversity, which arise within an analytic setting that is now free from predetermined judgments and genuinely focused on encouraging individuals to explore and authentically express their true self (Giovanardi et al., 2019; Lemma, 2021; Lingiardi & Carone, 2019).

The current manuscript aims to outline the historical development of psychoanalytic perspectives regarding TGD identities. It begins with Robert Stoller's pioneering work (1968), which laid the foundation for subsequent contributions within an etiopathogenetic framework, designed to elucidate the root causes of a condition which has been long considered pathological The first psychoanalytic theories used the term "transsexual" to refer to this population, as it was the only term

available at that time (e.g., Chiland, 1997; Oppenheimer, 1980, 1992; Ovesey & Person, 1973; Person & Ovesey, 1974; Stoller, 1968). In this manuscript, we decided to still use the term "transsexual" only when referring to the first psychoanalysts.

It then extends to contemporary viewpoints, characterized by a notable shift towards placing the individual subjectivity at the core of analysis. These perspectives, which are still developing, investigate the developmental trajectories and personal experiences of TGD individuals through a more open and unbiased lens (Ehrensaft, 2016; Fraser, 2009; Lemma, 2013; Saketopoulou, 2014).

In preparing this paper, certain influential theories, such as those from the Lacanian perspective (e.g., Gherovici, 2017), have necessarily been omitted due to space constraints and the specific scope we have chosen. It is important to clarify that it is not our intention to provide an exhaustive overview of all psychoanalytic approaches to transgenderism. Rather, our goal is to use selected theoretical and clinical contributions to illuminate the development and transformation of the psychoanalytic field, both in terms of theoretical constructs and clinical practice in the field.

In order to trace this path, it is deemed appropriate to start from an investigation of the process of pathologization and subsequent de-pathologization of TGD individuals within the context of the contemporary medical and psychiatric discourse.

The Process of Pathologization and De-pathologization of Gender Diversity

Gender diversity within the medical-psychiatric discourse

Gender diversity has been historically documented across cultures, with its meaning and interpretation being shaped by the prevailing cultural norms and religious beliefs. Studies have revealed that in specific societies and historical periods, gender identities can transcend the male-female binarism, posing a challenge to the assumed universality of such a classification (Bisogno & Ronzon, 2007). Examples include the "Hijras" in India, the "Kathoyes" in Thailand, "two-spirits" among the Native Americans, and the so-called "Femminielli" in the Neapolitan culture (Zito & Valerio, 2013).

Gender diversity has been a rich source of inspiration for diverse cultural beliefs, myths, and artistic expressions. It has captured the attention of researchers across multiple disciplines, including socio-political, anthropological, artistic realms, and, notably, also within medical-psychiatric and psychological fields, which became predominant from the late 19th century onwards (Vitelli & Valerio, 2012).

Transgenderism, in particular, is the experience of gender diversity that has received the most remarkable attention by biomedical sciences (Santoni, 2009). Vague references to transgenderism are present in the works of some nineteenth-century psychiatrists such as Rudolf Arndt, Wilhelm Griesinger, and Jean-Étienne Dominique Esquirol (Vitelli, 2014).

Karl Heinrich Ulrichs, a German jurist and writer, is considered as an early pioneer in the scientific study of this topic. In the mid-19th century, Ulrichs published a series of five

booklets (1864-1865) proposing the concept of a "third sex," encompassing individuals attracted to the same sex due to a variation in embryonic development, leading to psychic hermaphroditism (Kennedy, 2002).

However, the emergence of transgenderism in the medical-scientific context is notably attributed to Carl Friedrich Otto Westphal, a Berlin neurologist and psychiatrist. In 1870, Westphal introduced transgenderism in the field through his publication in *Archiv für Psychiatrie*, detailing the case of a young woman who displayed consistent traits since childhood, such as a preference for male clothing and toys, and later developed a sexual attraction to women as an adult. Westphal coined the term "konträre Sexualempfindung", translated as "inverted sexual sensitivity", to describe these cases (Davidson, 2001; Westphal, 1870).

The process of medicalization of transgenderism, as well as non-heterosexual orientations, began later, with the systematic work of Richard von Krafft-Ebing, professor of psychiatry at the University of Vienna. His work, *Psycopathia Sexualis* (1886), starting from biographical evidence, is proposed as the first attempt at a taxonomic classification of aberrant forms of sexuality, according to the assumption that any deviation from the heterosexual relationship for procreative purposes is an indication of a profound psychophysical disorder. Two of the biographies reported in this work concern cases of transgender women, a condition that Krafft-Ebing defined "paranoid sexual metamorphosis". Krafft-Ebing's theoretical position brought transgenderism to the medical attention, placing it, together with homosexuality, in the category of mental pathologies (Davidson, 2001; Foucault, 1976).

The proliferation of scientific works that began in this era opened up new perspectives on sexuality, which transitioned from being confined within the realm of religious and moralistic perspectives to becoming a subject of scientific and medical inquiry (Foucault, 1976).

In the twentieth century, the perspective that viewed gender diversity as a pathology emerged as the hegemonic paradigm. This viewpoint garnered widespread acceptance within the medical-scientific community in the 1960s with the inclusion of the diagnosis of "Transvestism" in the most renowned diagnostic manuals globally: the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association and the ICD by the World Health Organization.

As noted by Vitelli and Giusti (2012), if it is true that the inclusion of transgender experiences within medical-scientific knowledge helped to clear the field of ethical-religious prejudices, as a rebound it brought down the shadow of the stigma and prejudice associated with mental illness. In fact, the psychiatric diagnosis specified a class of people who were perceived as deviant with respect to the cultural definitions of gender and sexual normality, distinguishing themselves from the majority population by specific characteristics.

However, not all theorists from the last century shared this pathologizing perspective, as evidenced by the work of Iwan Bloch (1906), in which evidence is presented in favor of the almost complete independence between sexual inclinations and the phenomena of psychic degeneration.

From Hirschfeld to Stoller: The emergence of the concept of "gender identity"

During the positivist era, theories displayed a rigid and binary view of gender, leading to confusion and mixing of different aspects of sexual identity like "biological sex", "gender", "gender expression", and "sexual orientation" (Shively & De Cecco, 1977), which were not yet clearly differentiated. As a result, non-heterosexual, transgender, cross-dresser, and intersex individuals were often lumped together, disregarding their diverse experiences and identity expressions.

One of the first conceptual demarcations between sexual orientation and gender identity is posed, albeit not using these terms, by Magnus Hirschfeld, a pioneering figure in sexology and early 20th-century gay activism. He introduced the concept of "transvestism" to denote the desire of some individuals to dress, live, and be recognized as a member of a gender different from the one assigned at birth. He distinguished this phenomenon from sexual preference for one's own gender.

Hirschfeld identified the existence of an "altering-sexual part" in individuals. When highly developed, this part causes suffering in individuals from an early age, resulting in a significant contrast between their physical body and inner self. This can be seen as one of the earliest scientific references to gender dysphoria, the distress that can arise in people experiencing a strong mismatch between their assigned gender at birth and their perceived gender identity (Russo & Valerio, 2019).

In *Die Transvestiten* (1910), Hirschfeld further introduced the concept of "sexual intermediaries" encompassing all those who fall within a spectrum between a "feminine heterosexual woman" and a "virile heterosexual man". He also questioned traditional notions of gender and sexuality proposing that an individual's sexual identity comprises four dimensions that can develop independently: sexual organs, other physical characteristics, sexual drive, and emotional characteristics. Such conceptualization highlights the infinite possibilities of sexual identity beyond binary categorizations (Hirschfeld, 1910; 1923).

He further argued that the term "transvestite" focuses solely on the external appearance of gender (i.e., the clothing) neglecting the emotional aspect and, therefore, cannot be considered an all-encompassing word. With these considerations, he introduced the term "geschlechts übergänge", which will be translated into English as "transsexual" in the first English version of *Die Transvestiten*, published in 1991. This term aims to encompass the emotional aspects alongside the external presentation, providing a more comprehensive understanding of the phenomenon.

Hirschfeld's empirical studies pavedthe way for the recognition of the variety of human sexuality. In 1919, he founded the *Institute of Sexual Science* in Berlin, where early sex reassignment surgeries were performed. Unfortunately, the Institute was destroyed by the Nazis in 1933, and its research was publicly burned.

However, the term "transsexualism" is commonly attributed to David O. Cauldwell (1949), who introduced it in the *Sexology Magazine* while discussing the case of a girl experiencing a strong desire to become a man. He referred to this condition as "psychopathia transexualis", a clever reference to Krafft-Ebing's earlier work. Despite making a significant contribution to the popularization of transsexualism, Cauldwell expressed negative views about sex reassignment surgery, deeming it a criminal act to alter functional organs. Moreover, he discouraged the normalization

of transsexual individuals, considering them mentally unhealthy (Cauldwell, 1949).

However, it was only after a few years that the concept of transsexualism solidified its position in scientific history, with the work of Harry Benjamin, a German sexologist and endocrinologist. In *Transvestitism and Transsexualism*, Benjamin (1953) recognized the essential difference between these two experiences. Indeed, transsexual individuals sought more than just clothing changes; they desired surgical intervention to align their bodies with their gender identity. This marked the emergence of transsexualism as a distinct phenomenon with medical legitimacy.

Influenced by Christine Jorgensen's case, the first widely known recipient of sex reassignment surgery, Benjamin (1966) further developed the idea of medical-surgical transitions as a therapeutic option for individuals who strongly identify with the opposite sex to the point that their sexual organs cause profound discomfort. For these individuals, surgical interventions offered a means to address the distressing incongruence between their gender identity and their physical body, providing a way to align their body with their deeply felt sense of self.

Benjamin's work significantly contributed to the establishment of medical protocols and treatments that continue to be the foundation of the health care for TGD individuals to this day. The establishment of the *Harry Benjamin International Gender Dysphoria Association* in 1979, now known as the *World Professional Association for Transgender Health* (WPATH), formalized the role of the medical-hospital institution in caring for TGD individuals. This association has defined standards of care, eligibility criteria, and therapeutic procedures for gender-affirming treatments, including hormonal therapies and surgeries to modify primary and/or secondary sexual characteristics according to a person's felt gender. The WPATH continues to study and update criteria for assessing suitability for treatments based on ongoing research in the medical and psychiatric fields.

Another crucial advancement occurred in the 1960s, attributed to the contributions of the American psychoanalyst Robert Stoller. In *Sex and Gender: The Development of Masculinity and Femininity*, Stoller (1968) introduced a groundbreaking distinction between "sex" and "gender". "Sex" pertains to biological aspects representing the physical attributes of being male or female. On the other hand, "gender" encompasses the psychological and cultural dimensions constructed based on these sex distinctions. Within the concept of gender, Stoller identified two interconnected components: "gender identity", representing an individual's perception of belonging to a particular sex, and "gender role", referring to the ways in which individuals navigate society and interact with others based on their gender identity. These two facets, akin to the two sides of a coin, respectively delineate the private and public aspects of the phenomenon.

Stoller's conceptual framework became integral to the psychoanalytic lexicon and has endured as a fundamental basis for subsequent multidisciplinary studies on the subject, shaping the discourse in the field until today (Vitelli, 2001).

Paths towards depathologization and affirmative care

The social movements of the 1960s and 1970s played a significant role in expanding

the discourse on sexuality beyond the boundaries of medical and psychological fields. This period witnessed the emergence of *Gender studies*, a multidisciplinary domain firmly grounded in the feminist thought, which offered a broader perspective on sexuality and gender emphasizing their historical, political, and socio-cultural dimensions rather than solely focusing on biological aspects (Bertone, 2009; Chiari, 2009).

Moreover, from that moment, the lesbian, gay, bisexual, and transgender (LGBT) communities started having a strong influence in reshaping the conception of sexual identity. Their ideas and advocacy contributed to the dissemination of new concepts and terminology that challenged gender binarism and heteronormative structures in the relationships between sexes.

However, a decisive contribution to a more inclusive and diverse understanding of gender and sexuality came from *Queer studies*, which emerged in the early 1990s in the U.S. academic and cultural landscape. Queer perspectives reject the notion of identity as a fixed and singular entity, emphasizing its continuous process of redefinition. They challenge the idea of reducing sexual and emotional experiences and meanings to unequivocal and rigid definitions, and any attempt to impose artificial categories on human beings is considered inappropriate. By deconstructing gender binarism and heteronormativity, these studies shed light on the existence of marginalized and transversal identities and experiences that transcend the established binary dichotomies. These identities, such as non-binary identities, are indicative of the multifaceted and intricate nature of gender experiences that extend beyond conventional norms. This challenges the prevailing assumption that alignment and coherence between biological sex, gender identity, gender expression, and sexual orientation are invariably necessary and inherently functional (Pustianaz, 2004; Scandurra et al., 2019).

This paradigm shift involved a gradual detachment from the model of GI as a pathological condition rooted in the notion of deviation from normality and ushered in a novel perspective recognizing the processes that shape TGD identities as equally healthy. This transition shifts attention to the social processes leading to the stigmatization of TGD individuals and its implications for their well-being (Bockting & Coleman, 2007). This trend has evolved particularly in the last decade, which has seen the multiplication of empirical evidence on the experiences of the TGD population in various life contexts, in which the gender binarism and the heteronormative model, still strongly rooted, expose these people to the challenges associated with minority stress (Meyer, 1995, 2003, 2007; Scandurra et al., 2016, 2017, 2019).

A crucial move toward the depathologization of GI within the field of psychiatry took place in 2013 with the release of the DSM-5 (APA, 2013). This revision involved the complete removal of *Gender Identity Disorder* as a diagnosis. Instead, a new diagnosis known as *Gender Dysphoria* was introduced. This shift in diagnostic terminology emphasized the distress stemming from GI as the primary concern for treatment, as opposed to the pathologization of gender identity itself. Hormonal treatment and surgery are indicated as effective in alleviating the primary symptom of dysphoria. The decision to retain a gender-specific diagnosis in the DSM was the result of heated debate and hinged on several important considerations, most notably ensuring access to care. Indeed, insurance companies

and health care systems often rely on formal diagnosis codes to govern coverage and reimbursement, so a formal diagnosis is essential to secure needed medical and psychological treatments (Drescher, 2014).

Importantly, the term "transsexual", originating from psychiatric discourse and inherently pathologizing, is gradually falling into disuse in contemporary discourses. Instead, broader designations such as "transgender", "trans", or "gender diverse" are preferred. These terms transcend the etymological emphasis on anatomical, physical, and biological attributes, thus encompassing individuals who identify as transgender despite not pursuing hormonal or surgical interventions for body modification to align with the opposite sex. In fact, changing one's own gender does not only concern the modification of sex and therefore the material body, but can concern the expression of gender as it is perceived in the individuals' identity experience.

In recent years, heightened visibility of TGD individuals and recognition of the myriad variations in gender identity have prompted the scientific community to embrace a more complex and dynamic conceptualization of gender. In conjunction with the traditional binary model, an evolving perspective of gender as a spectrum of potentialities is emerging, acknowledging the substantial diversity among individuals concerning gender identity, which assumes a unique and peculiar configuration in each individual (Bass et al., 2018; Dray et al., 2020).

With the publication of the eleventh edition of the ICD, the realm of gender and its nonconformity to societal norms definitively shifted away from the domain of psychiatry, transitioning from the category of mental disorders to that of conditions related to sexual health, under the name GI (WHO, 2022). ICD-11 has thus faced the difficult task of balancing the need to avoid undue stigmatization of TGD individuals by maintaining a psychiatric diagnosis with the essential requirement of diagnostic categories that allow access to specialized health services they may need (Furlong & Janca, 2022). At the same time, the affirmative approach has gained significant traction among mental health professionals by establishing itself as the predominant framework in clinical work with TGD individuals and is supported by current standards of care and guidelines for TGD individuals (American Psychological Association, 2015; Coleman et al., 2022). Based on a nonpathological view of gender diversity, the affirmative approach provides a safe, nonjudgmental, and respectful clinical context in which people of all ages can be helped to explore their unique gender identity and achieve positive emotional well-being. It is critical for clinicians to adjust or reconfigure their understanding of gender by perceiving gender diversity as healthy and normative, rather than assuming a predetermined path (Hidalgo et al., 2013). In contrast, corrective or reparative approaches aimed at altering or "correcting" a person's gender identity to match their sex assigned at birth have been widely discredited and labeled unethical by professional health organizations because of their potential harm to TGD individuals (Ashley, 2020). In the evolving landscape of transgender health care for children and adolescents, an alternative clinical approach known as the "Watchful Waiting" model has emerged in recent decades, coinciding with a notable increase in TGD youth seeking gender-affirming care (Kyriakou et al., 2020; Shumer, 2015). This approach, also known as the Dutch protocol, emphasizes a cautious and patient approach to

children with gender identity issues. It advocates for not intervening during a child's prepubescent years and allowing them to explore their gender identity without actively promoting a social transition until puberty. This approach is based on the idea that children should experience the early stages of physical puberty in order to better understand their authentic gender identity. If a child's gender identity persists into adolescence, interventions such as social transitions, puberty blockers, hormone therapy, and gender-affirming surgeries may be considered (Turban & Ehrensaft, 2018).

Past Psychoanalytic Perspectives on Gender Diversity

The work of Robert J. Stoller

In addition to delineating the distinction between sex and gender, Robert J. Stoller, an American psychiatrist and psychoanalyst associated with the Gender Identity Clinic at the University of California, is credited with bringing transgenderism to the attention of psychoanalysts.

Central to Stoller's framework is the concept of "core gender identity," which encompasses a primal, preverbal sense of belonging to either the male or the female gender. This formative nucleus is believed to take shape irreversibly during the formative period from birth to three years of age. Stoller identifies three pivotal factors influencing this nucleus: (1) biological and hormonal components; (2) anatomo-physiological attributes of external genitalia, crucial for initial sex designation by medical professionals and parents, and as a place of fundamental somatic sensations essential to primitive body-ego formation; and (3) an intricate interplay of relational elements encompassing unconscious attitudes and behaviors, primarily demonstrated by the mother and subsequently by the father. While the maturation of gender identity continues through subsequent phases such as the phallic stage and oedipal events, Stoller posits that this foundational, non-conflictual phase plays a decisive role in shaping an enduring core, unalterable over the course of an individual's lifetime.

In the majority of individuals, sex, gender identity, and gender role are congruent, yet there are instances where they diverge. Such is the case with what he called "transsexualism", which presents a disparity between anatomical data and subjective experience. Stoller, focusing on male transsexualism, supports an alternate hypothesis contrary to Freud's claims. Indeed, he proposed that the original psychic state is the "protofemininity", not bisexuality, shared by both sexes and linked to early embryonic developmental stage. This phase involves a symbiotic mother-child relationship, where foundational identification processes occur. While girls, when emerging from this symbiotic fusion, maintain gender identification with the mother, boys redirect these identifications towards the figure of the father. In this view, for later transsexual males, excessive mother-child closeness and an absent father figure may crystallize the protofeminine state (Vitelli, 2001). The mother occupies a central role in inhibiting the transition from symbiotic fusion, since she seeks solace from her own void, stemming from her relationship with her mother. The father's passive presence further contributes to this process.

Stoller viewed transsexualism as an irreversibly fixed female gender identity in

males, originating from a specific pathological family dynamic that obstructs the development of a male identity. Stoller's diagnostic framework excluded a psychotic nature, as transsexual individuals can realistically assess their anatomy, differently from psychotic patients.

While Stoller advocated medical-surgical interventions for highly "feminine" men, he expressed reservations about the proliferation of gender affirmative procedures. He noted challenges in managing transsexual patients, who may exhibit traits like irresponsibility, dishonesty, and difficulty forming lasting emotional bonds. Furthermore, Stoller introduced the differentiation between "primary transsexualism," emerging from the aforementioned family context and evident in the first three years of life, and "secondary transsexualism," encompassing diverse individuals with varying degrees of the desire to be a woman, sometimes related to conditions like transvestism or homosexuality (Stoller, 1985).

Stoller remained influential among researchers and experts investigating gender identity. Nevertheless, the pathologizing approach of his theory, which associates transsexualism with dysfunctional family dynamics, marked psychoanalysis in subsequent decades.

"Transsexual Syndrome" and separation anxiety: The contribution of Ovesey and Person

Informed by Margaret Mahler's theories (1968, 1972), the American scholars Lionel Ovesey and Ethel Spector Person proposed an alternative hypothesis about the origins of what they defined "the transsexual syndrome" in males, situated within the separation-individuation process. According to the authors, transsexualism arises as a defensive response to an intense form of separation anxiety that the child confronts very early on, prior to the distinction between self and object, leading to a fantasy of symbiotic fusion with the mother (Ovesey & Person, 1973). Notably, while they termed it "separation anxiety", it appeared to be more accurately an anxiety of self-fragmentation, akin to Winnicott's (1962) notion of "falling apart." This strategy avoids separation threat but results in an "ambiguity of the core of gender identity" and, consequently, a blurred sense of masculinity (Ovesey & Person, 1973).

Lasting about 36 months, the separation-individuation process contains distinct sub-phases, yielding varied transsexual outcomes, each linked to distinct mechanisms of managing separation anxiety. Ovesey and Person distinguished primary transsexualism, in which there is no "ambiguity" towards one's own gender identity, and secondary transsexualism, embracing homosexuality or transvestism, which use less primitive separation anxiety mechanisms (Person & Ovesey, 1974).

Regarding treatment, the authors advocated psychotherapy as the initial approach. Surgical intervention may be considered if psychotherapy proves ineffective, although it should not be recommended. They underscored the importance of thorough assessment for surgery candidates, ensuring genuine motivation, absence of psychosis, and the ability to overcome social, economic, and physical challenges (Person & Ovesey, 1974).

Transsexualism as narcissistic pathology: The French perspective

French psychoanalysts have long been intrigued by transsexualism, and many of them associated it with narcissistic fragility.

Agnés Oppenheimer, a Kohutian psychoanalyst, critiques Stoller's theories, viewing them as fostering an inaccurate understanding of the trans experience. The distinction between sex and gender proposed by the American psychoanalyst was in fact interpreted by Oppenheimer as a "reflection theory", based on the false beliefs of transsexual patients (Oppenheimer, 1980). Instead, she viewed transsexualism as a narcissistic disorder rooted in a specific facet of self, "sexuation" (Oppenheimer, 1992). In particular, Oppenheimer challenged the idea that unaddressed femininity leads to transsexualism. She emphasized family dynamics, where the mother's disregard for the son's masculinity and the father's lack of recognition drive compensation through fixation on femininity occurring as an *après coup*. Indeed, the child seeks solace with the maternal figure to fulfill the longing for idealization. This follows disengagement from the father, preventing conscious resentment due to his lack of adequate recognition. The driving force behind the desire for transformation lies in the hatred of masculinity and the penis. This aversion stems from the urge to dismantle the father's masculinity and genitalia. However, this destructive impulse targets a self-representative aspect, namely the penis, satisfying sadistic tendencies and aiding in overcoming the object loss. Oppenheimer saw parallels between this process and melancholia, referring to it as a "melancholic process focused on sex." The transformation into a woman replaces low male self-esteem, healing narcissistic wounds through identity confirmation. Oppenheimer argued that transsexualism mirrors the stages of psychosis (Freud, 1924): a withdrawal from sex's reality and the creation of a neo-reality, that is female body and gender. The distinct symptom observed in transsexual patients, evident in their active pursuit and realization of gender transition, can be analogized to a prolonged "acting out" behavior. This persistent behavior, in the process of shaping a new identity, replaces the function of delirium (Oppenheimer, 1992). To achieve a state of well-being, security and self-esteem, Oppenheimer suggested that the individual must undergo a process of rebirth, which serves to negate their original conception, disavowing parental roles in response to feeling denied child status.

However, the work of the French-Swiss psychoanalyst Danielle Quinodoz (2002) suggested the complexity of achieving lasting well-being, security, and self-esteem through medical interventions. Quinodoz's study involves a trans individual named Simona who, after undergoing gender-affirming surgery, seeks psychoanalytic treatment due to lingering discomfort. This request occurs when Simona, in a historical period of her life in which she can engage with her internal world, confronts unresolved questions despite her transition. The therapeutic process delves into a search for a deeper sense of self beyond physical transformation. Quinodoz's reflections on the case lead to inquiries about the genesis of identity itself. She ponders the existence of a pre-sexual and pre-gender identity, a non-sexed self that resonates with one's fundamental humanity (Bolognini, 1998).

Colette Chiland, a prominent French psychoanalyst with extensive experience in treating trans patients, offers a distinct perspective. Chiland echoes criticisms of Stoller's gender identity concept, proposing the term "sexual identity" or "identité sexuée" instead. The adjective "sexed" encompasses both the division into sexes ("sexué") and the sexual aspects ("sexuel") of human beings

(Chiland, 1997). Chiland asserts that sexual identity is not inherent but emerges through interactions with parents, evolving as a psychosocial construction shaped by their real and phantasmal presence (Chiland, 1997). The initiation of a "transsexual trajectory", according to Chiland, originates from parental dynamics. If parents fail to positively validate the child's body experience and subtly disqualify it, the child may internalize the belief that belonging to the opposite sex is necessary for love and acceptance. Inadequate parental mirroring of gender identity results in a devaluation of the child's gender and a lack of foundation for consolidating sexual identity. In response, individuals may change their sex to reject a troubled narrative and seek validation. This denial is not about the body's reality, but the inability to change it. Claiming surgically altered bodies as the "true body" is a form of psychotic denial, reflecting a quest for transformation and self-esteem (Chiland, 1997). Despite acknowledging the presence of narcissistic elements, Chiland (2009) suggests that transsexualism is shaped by various factors without clear-cut causes. She emphasizes the need to differentiate a range of distinct clinical patterns within transsexualism rather than simplifying them into a linear continuum.

The multifactorial model by Di Ceglie

The search for underlying causes of transgenderism has progressively grown intricate over time. Some psychoanalytic theories on child development have sought to elucidate the multiple dimensions contributing to the emergence of GI. One notable endeavor was made by Domenico Di Ceglie, who founded the Gender Identity Development Clinic at St. George's Hospital in London in 1989 before its subsequent relocation to the Tavistock and Portman NHS Foundation Trust.

In his work "A stranger in my body", Di Ceglie (1998) introduces the concept of *Atypical Gender Identity Organization* (AGIO), a psychological pattern within the inner world of children and adolescents resembling Gender Identity Disorder as outlined in DSM-IV during developmental stages (APA, 2000). AGIO's phenomenology encompasses unconventional variations in aspects like clothing, toy choices, peer interactions, behaviors, voice tone, and anatomical dysphoria, which involves rejecting the physical body (Di Ceglie, 1998).

In Di Ceglie's definition of AGIO, the term "organization" refers to a system of rigid defenses aimed at mitigating or evading anxiety, ensuring a sense of psychic survival in the face of psychological catastrophe and chaos, and facilitating the integration of atypical experiences with a biological basis. Based on research and clinical observations, Di Ceglie argues for a multifactorial and interactive causality in AGIO formation. However, traumatic early-life events often play a significant role, triggering dissociative responses where children may adopt novel self-perceptions. In particular, within a dissociative continuum, a boy may reach the conviction of "being the mother", or a girl of "being the father", and by extension, of "being a woman", or a girl of "being a man" seeing himself as the mother or a girl as the father, as a protective measure. This self-perception acts as an omnipotent defense against external threats, altering inner reality to lessen the impact of trauma and establishing a dominance of psychological processes over physical ones concerning gender. These dissociative mental states significantly impact the child's developing neural systems during their critical phase.

The catastrophic psychic experience underpinning AGIO development notably stems from the separation from the primary attachment figure, a suffering made intolerable by the child's temperament. To cope with the psychological turmoil caused by threats or repeated instances of separation, the child might use projective identification by assuming a gratifying maternal image. This results in the child identifying as the mother, fostering a sense of safety. While securing psychic survival, this strategy leads to disregarding external realities, such as one's biological sex (e.g., the child's male body).

Atypical organizations emerging early in a child's life are inclined to exhibit greater rigidity in their structure compared to those forming later. According to the Kleinian model, Di Ceglie suggests that AGIO development dominated by the paranoid-schizoid position is likely to result in highly structured configurations, characterized by a solid identity and reduced susceptibility to change. Conversely, if AGIO is shaped within the depressive position, it is more likely to exhibit fluid traits and undergo evolutionary shifts (Di Ceglie, 1998).

From this model, the author presents therapeutic strategies for individuals with AGIO. The central goal is to assist young individuals in recognizing and accepting their gender-related experiences without judgment, guiding them through the exploration of their identity development and fostering their ability to make independent life decisions. Yet, Di Ceglie (2019) emphasizes that every decision in this path carries inherent risks, compromises, and emotional burdens, impacting both individuals themselves and the professionals engaged in this complex undertaking.

A multifactorial hypothesis regarding childhood GI is further elaborated by the American psychoanalyst Susan Coates (2006). She suggests that the presence of cross-gender interests and behaviors in children can indicate transient phases or signal significant distress that may lead to lasting disturbances. Coates highlights the role of separation anxiety in contributing to such disturbances. She identifies both non-specific factors like maternal depression and paternal withdrawal, intensifying the child's distress, and specific factors including the mother's and sometimes the father's selective focus on cross-gender behavior. These specific factors can lead to fantasies of belonging to the opposite gender as a coping mechanism to manage anxiety. When intersecting with a child's temperament, these factors may lead to gender dysphoria.

From "Classic" Positions to Contemporary Perspectives

The preceding sections highlight the psychoanalysis' historical interest in TGD people, from its early emergence within the scientific landscape. However, the examined theories were predominately formulated based on clinical observations of AMAB individuals seeking gender medical interventions, which represents a specific subset of a potentially larger and more diverse population, which at the time remained largely concealed (Fortunato et al., 2020).

These "classical" interpretations (Giovanardi et al., 2019) have been criticized over the past decade, as they have been considered an expression of a limited and reductionist approach to transgenderism within psychoanalysis. Such theories portray TGD identities and experiences through a pathologizing lens, depicting gender diversity as a unified syndrome

marked by a distinct phenomenology, including deterministic connections to traumatic experiences, parental influences, and other factors. Various manifestations of gender diversity are interpreted as efforts to address self-construction deficits or evade mourning, lack, and separation (Di Gregorio, 2019; Saketopoulou, 2014).

In *Unthinkable Anxieties* (2017), Griffin Hansbury, a transgender psychoanalyst, attributes pathologizing interpretations of classical theories not to inherent characteristics of TGD patients, but rather to clinicians' anxieties, which arise from confronting gender realities that challenge their theoretical and personal beliefs. Hence, the pathologizing perspectives would originate from countertransference, wherein clinicians grapple with profound uncertainties and unnamed fears in response to these challenges.

Agvi Saketopoulou (2014, 2020), an American relational psychoanalyst, argues that the inclination to pathologize non-normative gender identities and experience stems from the deeply ingrained psychoanalytic assumption that sexual anatomy determines gender reality (Kubie, 1974). The "regulatory anxiety" (Corbett, 2009), which drives the urge to correct the patients' gender according to the equation "gender = sex", hinders the analyst's empathetic connection with patients, resulting in the neglect of their affirmative gender needs. Conversely, the ideal therapeutic outcome for TGD individuals is assumed to be accepting their assigned birth sex and relinquishing the desire for physical alterations through medical intervention, which are perceived as conflicting with the psychoanalytic emphasis on insight over action (Argentieri, 2009; Chiland, 2009; Kubie, 1974).

Nevertheless, Saketopoulou (2014) highlights that empirical research has consistently demonstrated the ineffectiveness of interventions aiming to align an individual's gender experience with their physical body (de Vries & Cohen-Kettenis, 2012; Suchet, 2011). Referred to as "reparative therapies", these approaches, despite still being practiced in different parts of the world, have been officially deemed unethical, ineffective, and detrimental by major national and international mental health organizations (APA, 2015).

In recent years, there has been a resurgence of interest within the psychoanalytic community regarding TGD identities and experiences. This renewed attention stems from an awareness of the considerable diversity present within this population and an acknowledgment of the intricate and evolving nature that characterizes the subjective experience of gender (de Vries et al., 2013). Psychoanalysis has started to distance itself from the pathologizing viewpoints of the past and to move away from seeking out causal explanations. Indeed, as Saketopoulou (2014) points out, both research and clinical practice have been unable to yield substantial evidence in favor of any of the proposed explanatory theories intended to elucidate transgenderism (de Vries & Cohen-Kettenis 2013; Smith et al. 2005). Additionally, the pursuit of causal foundations tends to view the trans experience as a singular entity, disregarding its inherent diversity arising from multifaceted developmental trajectories and complex compromise formations (Saketopoulou, 2014)

This increased openness within psychoanalysis can be traced back to the adoption of novel perspectives on gender, which have been integrated into the contemporary discourse through a fruitful interdisciplinary dialogue with Gender Studies since the 1970s.

This dialogue has prompted psychoanalysis to challenge the supremacy of the body in shaping gender dynamics (Saketopoulou, 2014). With contributions from authors such as Jessica Benjamin (1995), Muriel Dimen (1986), and Adrienne Harris (1991, 2008) psychoanalysis has embraced a constructivist interpretation of gender, shifting away from anatomy as an immutable "destiny" (Freud, 1924). This transition involves questioning binary frameworks and acknowledging the fluid, contradictory aspects of gender and its societal representations. Gender development encompasses multiple trajectories, not a singular path, and gender identity emerges through a complex process involving interdependent biopsychosocial factors across multiple levels (Graglia, 2019; Levi & Curti, 2020), rather than being strictly biologically predetermined (Corbett, 1993).

By embracing this complex and systemic perspective on gender (Harris, 2003), psychoanalysis becomes capable of acknowledging the presence of a broad spectrum of gender identity configurations. This shift entails moving away from outdated linear and dichotomous notions of gender and embracing a novel, more expansive and pluralistic perspective that is gaining ground within Western societies (Graglia, 2019).

This profound change in psychoanalysis has enabled the emergence of novel treatments for individuals with diverse gender identities. The "affirmative approach" towards gender experience has been developed, guided by some principles (Crapanzano, 2022; Ehrensaft, 2018): (1) gender variations are not disorders; (2) innumerable gender trajectories exist; (3) all gender paths are positive; (4) no path is privileged over another; (5) cultural contexts shape gender presentations; (6) gender involves biology, development, socialization, culture, and context; (7) sex is a fluid and non-binary construct; and (8) psychological issues stem from societal responses, not individual pathology. In this model, treatment does not aim to "fix" gender, but to provide a safe space for self-expression and resilience-building to address social issues. The goals include reducing minority stress and fostering supportive networks for TGD individuals. The notion of gender health entails authentic gender living, free from constraints, through acceptance and support (Ehrensaft, 2017).

The most influential recent contributions

In recent years, the psychoanalytic exploration of TGD populations has increasingly focused on the individuals' subjectivity, examining their psychic vicissitudes and developmental trajectories within various relational contexts. This approach has enabled analysts to concentrate on the distinctive aspects linked to the TGD experience, which, while not inherently pathological, often involves grappling with significant challenges, in addition to often painful experiences of gender dysphoria. Such challenges encompass significant struggles in establishing a coherent identity, particularly within familial and sociocultural environments where the binary gender framework remains deeply entrenched (Scandurra et al., 2019). The psychoanalytic literature on this subject is thus expanding significantly, offering new perspectives for comprehending the phenomenon and proposing more effective clinical strategies.

Avgi Saketopoulou

A notable contribution comes from aforementioned Avgi Saketopoulou (2014), who highlighted the risk faced by TGD individuals of encountering a "massive gender trauma" during their development. This trauma stems from the intersection of two pivotal psychological events: (1) being misgendered by caregivers, who incorrectly identify the individual with the gender assigned at birth and (2) experiencing body dysphoria due to incongruence between the body and the perceived gender. These distressing experiences can arise as early as the age of two or three, potentially exposing the child to subsequent psychiatric difficulties. The latter should be viewed as consequences rather than causes of this traumatic experience. To cope with feelings of dissonance between their identity and body, children might employ powerful defense mechanisms, including the unconscious fantasy that their assigned birth sex is untrue. This enables them to maintain their gender identity without confronting the physical reality of their body. Such dynamics can manifest consciously in the commonly recurring notion among transgender narratives of being "born in the wrong body."

Consequently, Saketopoulou cautions psychoanalysts against inadvertently reinforcing patients' unconscious fantasies and encouraging the complete rejection of their physical bodies. Rather, a crucial therapeutic objective involves facilitating the mentalization of distressing somatic sensations, helping patients to acknowledge and address the emotional turmoil related to their birth bodies. This approach does not negate the pursuit of hormonal and surgical intervention. Acknowledging one's own birth body and engaging in a process of mourning for its incongruence with the felt gender might serve as a foundation for a psychologically healthy medical transition. In cases involving TGD children, Saketopoulou also underscores the importance of working with parents to ensure they can thoughtfully understand and address their child's gender incongruence.

Alessandra Lemma

Another significant recent contribution comes from psychoanalyst Alessandra Lemma (2013), a member of the British Psychoanalytic Society. Drawing from object relations theory and attachment theory, Lemma emphasizes the pivotal role of mirroring by primary caregivers. She identifies "not being seen" as a dynamic characterizing the early experiences of many TGD individuals. The child's experience of bodily incongruence often goes unrecognized by caregivers, who are unable to process, accommodate, or mentalize the incongruity, confusion, and uncertainty felt by their children. This has a significant impact on the "psyche in-dwelling in the body" (Winnicott, 1970), that is the integration of psyche with the soma, hindering the development of a coherent embodiment. This process underlies the challenge these individuals face in transforming the body they have into the body they are (Lemma, 2013).

Particularly, children are at risk of developing an "alien self" by internalizing a parental mental state incongruent with their own. This may explain the intolerable sensation of dissociation from one's own physical body, which is perceived as unreal and remains detached from a unified sense of Self. In certain cases, this dynamic underlies a desperate search for the "right" body to mitigate the sense of mismatch, offering the TGD individual the assurance that the mirrored image

aligns with their subjective bodily experience. As Lemma (2013) contends, this quest fundamentally represents a search for the other's receptive mind. This phenomenon is also evident in analysis, particularly when the analyst detects, within the realm of countertransference, the patient's yearning to be acknowledged and embraced in the analyst's mind while experiencing this state of incongruence[1].

Lemma observes how the quality of mirroring experiences influences the TGD individuals' expectations and intentions regarding medical interventions. Those who have received a certain validation of their incongruence in primary relationships often exhibit less urgency for medical interventions, compared to those who have encountered recurrent mirroring failures. The latter group tends to manifest greater inflexibility in their intentions and harbors unrealistic expectations of transformation.

Lin Fraser

In her article "Depth psychotherapy with transgender people," the American psychoanalyst Lin Fraser (2009) outlines her clinical approach to work with TGD individuals, drawing inspiration from the Jungian perspective. Fraser contends that while the issues addressed in therapy with TGD patients are similar to those with cisgender patients, the former face unique challenges. These challenges stem from the distorted mirroring of their TGD identities by the external environment, resulting in the emergence of a gender False Self alongside a more authentic Self, which remains unseen and concealed.

During adolescence, the misalignment between the physical body and the internal gender experience complicates the process of body integration. Developing secondary sexual characteristics can evoke a sense of betrayal from the body. Aversion towards it can be accompanied by dissociative phenomena and may lead to the development of a persistent experience of a disembodied Self.

During the coming out process, TGD individuals experience relief alongside fear due to perceived rejection and social stigma, which hinders the pursuit of authenticity. Initiating medical treatments may lead to somatic changes that align with their gender, yet also evoke feelings of alienation. The actual transformation might not match the envisioned internal image, potentially inducing resignation towards the aspiration of embodying cisgender norms. Confronting and accepting this reality becomes a lifelong endeavor for TGD individuals (Fraser, 2009).

Constructing one's identity and navigating the "individuation process"[2] are particularly challenging for TGD individuals. A

[1] The author discusses the case of a patient, Ms. A., a transgender woman who underwent gender-affirming surgery during her five-year psychoanalytic treatment. What immediately strikes the analyst is the body excessively exhibited by the patient through clothing and makeup choices which remark the disparity between her assigned male body and her experienced female gender. This emphasis on bodily incongruence seems to convey a desire for the analyst to recognize and internalize the struggle. Lemma discerns an unspoken request from the patient to hold the image of this incongruence within her mind, signifying a yearning for visibility and acknowledgment of her bodily incongruence.

[2] In the Jungian theory, the "process of individuation" pertains to constructing individuality from a shared nature. This involves realizing latent potential within the unconscious, a realm that encompasses not only repressed aspects but also prospective possibilities. Jung perceives this process as the manifestation of the life purpose and meaning. The process of individual transformation comprises "differentiation" and "integration." From a social perspective, individuation entails

Jungian psychotherapy can aid and facilitate this process, assisting the individual in realizing their authentic self and fostering healthy relationships with themselves and others. Vital to this endeavor is addressing the influence of gender binarism, a system that negatively impacts authentic self-expression. The analyst must mirror the patient's gender identity – whether fully or partially developed – so the patient feels acknowledged and comprehended (Kohut, 1971), enabling them to genuinely engage with their gender as therapy progresses.

Diane Ehrensaft

The American psychoanalyst Diane Ehrensaft (2016), director of the Child and Adolescent Gender Center in San Francisco, has adapted Winnicott's (1965) theories to comprehend the identities of her young TGD patients, resulting in three core concepts: (1) *True Gender Self*, emerging at birth and influenced by mind, body, and brain, embodies the child's foundational identity and gender expression; this dynamic convergence, resembling a network of chromosomes, hormones, brain, and societal factors, evolves throughout life due to interactions with the external world; (2) *Gender False Self*, the outward presentation shaped by societal expectations and internalization of gender norms; (3) *Gender Creativity*, referring to the process through which children weave their genuine gender identity by integrating internal (body, brain, mind) and external factors (socialization, culture, family). This negotiation between the child and their environment, particularly family, influences the process (Ehrensaft, 2012).

When the True Gender Self is suppressed by defense mechanisms employed by the False Self, symptoms often emerge, leading even to suicide attempts. This tragic phenomenon arises from both internal factors, such as the inability to express own authentic gender identity, and external factors, encompassing rejection, harassment, and transphobic violence experienced in their environment. Parental support and acceptance serve as crucial protective factors against psychiatric symptoms, disorders, and risky behaviors like suicide attempts (Turban & Ehrensaft, 2018).

Ehrensaft (2012) translated these theoretical concepts into the clinical practice of TGD youth, named "true gender self child therapy". This approach fosters a transitional space for children to freely and safely explore their gender, with therapists attentively listening without redirecting their gender identity, and thus aiding in the consolidation of their true self. It embraces an in-between space of gender ambiguity, while also considering potential differential diagnoses and social constraints. Children are also provided with strategies to identify dangerous situations and avoid internalizing negative self-images stemming from hostile surroundings. Therapists collaborate with families and communities,

distinguishing oneself from uncritical conformity to collective norms, then critically integrating prevailing cultural norms and models, replacing inadequate ones that guided prior growth. On an intrapsychic level, individuation involves distinguishing the Ego from unconscious psychic elements. Subsequently, there's an integration of repressed aspects which can enhance Ego development. The analyst's role is to assist patients in resuming their natural developmental trajectory toward establishing a differentiated identity when life events have impeded or distorted this process. These events might have curbed its fluidity or even arrested its progression (Jung, 1921).

including school, adapting their approach according to the level of acceptance within these contexts.

In this vein, Oren Gozlan (2018) emphasizes how analysis might facilitate finding authenticity in a transitional space, enabling the patient to address their enigmatic condition through empathetic acceptance. Transitioning is a process of rebirth, creating new meanings to align the body with the authentic self psychically invested. The analyst can help the patient to manage defenses, mourning, and processing deep perceptions, working on partial objects that are not integrated into the unity of the self, transforming them through processes of resignification, in constant tension between inside and outside.

Conclusions

As shown in this paper, the trajectory of psychoanalytic perspectives on TGD identities has been marked by a transition from foundational theories anchored in etiopathogenetic frameworks to contemporary understandings that foreground individual subjectivity. Early psychoanalytic perspectives pathologized TGD experiences by attributing gender diversity to traumatic events, parental influences, and other deterministic factors. These interpretations, which have been critically reevaluated, are now widely understood to stem from clinicians' anxieties about being confronted with gender identities that challenge their personal and theoretical views. Interdisciplinary dialog with Gender Studies led to a shift away from rigid, body-centered views toward fluid, constructivist interpretations of gender and caused psychoanalysis to rethink traditional concepts based on binary gender constructions. Accordingly, modern psychoanalytic perspectives take a nuanced and multifactorial approach to transgenderism, shifting the focus to address both the negative environmental reactions to gender dysphoria or nonconformity and the personal anxieties that many of the TGD population face regarding their anatomical sex characteristics. In a seminal moment in 2019, Lee Jaffe, then president of the American Psychoanalytic Association, acknowledged the historical role of psychoanalysis in stigmatizing nonnormative gender identities (Tronconi, 2020). His statement provided a clear path forward for psychoanalysis and emphasized the need for deep exploration, understanding, and adaptation to contemporary research (Giovanardi et al., 2019).

There is an obvious need for ongoing research and proactive engagement in the psychoanalytic community to better understand and respond to the evolving knowledge landscape around gender identity, with an openness to learn, adapt, and challenge existing paradigms and integrate the insights of TGD analysts (Saketopoulou, 2020). Exploring this territory through clinical practice guided by an affirming approach holds immense potential to develop new perspectives on gender identity in all its complexity while providing relevant and effective care for TGD individuals. By valuing the personal narratives of TGD individuals and respecting their right to self-determination, clinicians can more effectively address diverse gender identities and gain deeper insight into patients' experiences, which in turn allows for the formulation of more effective clinical strategies. Denial of a patient's gender identity is not only a repetition of historical biases, but may also compromise therapeutic outcomes. In contrast, a supportive clinical environment that encourages self-expression and builds resilience in the face of social stigma empowers individuals to

confront and manage their fears, conflicts, and aspirations. This approach promotes self-recognition, self-discovery, and thus the mental and emotional well-being of TGD individuals across the full range of their experiences.

References

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*(9), 832-864. https://doi.org/10.1037/a0039906

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders. Fourth edition text revision* (DSM-IV-TR). American Psychiatric Press.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (DSM-5). American Psychiatric Press.

Argentieri, S. (2009). Transvestism, transsexualism, transgender: Identification and imitation. In G. Ambrosio (Ed.), *Transvestitism, transsexualism in the psychoanalytic dimension*. Karnak.

Ashley, F. (2020). Homophobia, conversion therapy, and care models for trans youth: Defending the gender-affirmative approach. *Journal of LGBT Youth*, *17*(4), 361-383.

Bass, M., Gonzalez, L. J., Colip, L., Sharon, N., & Conklin, J. (2018). Rethinking gender: The nonbinary approach. *American Journal of Health-System Pharmacy*, *75*(22), 1821-1823.https://doi.org/10.2146/ajhp180236

Benjamin, H. (1953). Transvestism and Transsexualism. *International Journal of Sexology*, *7*, 12-14.

Benjamin, H. (1966). *The transsexual phenomenon*. Julian Press.

Benjamin, J. (1995). *Like subjects, love objects: Essays on recognition and sexual difference*. Yale University Press.

Bertone, C. (2009). *Le omosessualità*. Carocci.

Bisogno, F., & Ronzon, F. (2007). *Altri generi. Inversioni e variazioni di genere tra culture*. Il dito e la luna.

Bloch, I. (1909). *The sexual life of our time in its relations to modern civilization*. Rebman.

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming-out process. In R. Ettner, S. Monstrey, & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185-208). Haworth.

Bolognini, S. (1998). Psicoanalisi e sessualità. *Rivista di Psicoanalisi*, *XLIV*(1), 189-199.

Cauldwell, D. O. (1949). Psychopathia transsexualis. *Sexology Magazine*, *16*, 274-280.

Chiari, C. (2009). Orientamento sessuale e sviluppo psicosessuale. In C. Chiari & L. Borghi (Eds.), *Psicologia dell'omosessualità: Identità, relazioni familiari e sociali* (pp. 31-46). Carocci.

Chiland, C. (1997). *Change de Sexe*. Odile Jacob.

Chiland, C. (2009). Some thoughts on transsexualism, transvestitism, transgender, and identification. In G. Ambrosio (Ed.), *Transvestitism, transsexualism in the psychoanalytic dimension*. Karnak.

Coates S. (2006). *Childhood gender identity disorder: etiology, assessment, and treatment*. Analytics Press.

Corbett, K. (2009). Boyhood femininity, gender identity disorder, masculine presuppositions, and the anxiety of regulation. *Psychoanalytic Dialogues*, *19*, 353-370.https://doi.org/10.1080/10481880903088484

Crapanzano, A. (2022). *Il modello affermativo dell'identità di genere per persone transgender e di genere non-conforme incontra la psicoanalisi*. Retrived September 4, 2023 from https://www.spiweb.it/la-ricerca/ricerca/ricerca-empirica/il-modello-affermativo-dellidentita-di-genere-per-persone-transgender-e-di-genere-non-conforme-incontra-la-psicoanalisi-m-antoncecchi/

Davidson, A. I. (2001). *The emergence of sexuality: Historical epistemology and the formation of concepts*. Harvard University Press.

Davies, R. D., & Davies, M. E. (2020). The (slow) depathologizing of gender incongruence. *TheJournal of Nervous and Mental Disease*, *208*(2), 152–154. https://doi.org/10.1097/nmd.0000000000001119

de Vries, A. L. C., & Cohen-Kettenis, P. T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, *59*(3), 301-320.https://doi.org/10.1080/00918369.2012.653300

de Vries, A. L. C., Kreukels, B. P. C., Steensma, T. D., & McGuire, J. K. (2013). Gender identity development: A biopsychosocial perspective. *Focuson Sexuality Research*, 53–80. https://doi.org/10.1007/978-1-4614-7441-8_3

Di Ceglie, D. (1998). Reflections on the nature of the atypical gender identity organization. In D. Di Ceglie & D. Freedman (Eds.), *A stranger in my own body: Atypical gender identity development and mental health* (pp. 9-25). Karnac Books.

Di Ceglie, D. (2019). L'uso di metafore per comprendere lo sviluppo dell'identità di genere atipica e il suo impatto psicosociale. *Adolescenza e Psicoanalisi*, *XIV*(1), 19-50.

Di Gregorio, L. (2019). *Oltre il corpo*. FrancoAngeli.

Dimen, M. (1986). *Surviving sexual contradictions*. New York, NY:Macmillan.

Dray, K. K., Smith, V. R. E., Kostecki, T. P., Sabat, I. E., & Thomson, C. R. (2020). Moving beyond the gender binary: Examining workplace perceptions of nonbinary and transgender employees. *Gender, Work & Organization*, *27*(6), 1181-1191. https://doi.org/10.1111/gwao.12455

Drescher, J. (2014). Controversies in gender diagnoses. *LGBT health*, *1*(1), 10-14. https://doi.org/10.1089/lgbt.2013.1500

Ehrensaft, D. (2012). From gender identity disorder to gender identity creativity: True gender selfchild therapy. *Journal of Homosexuality*, *59*(3), 337–356. https://doi.org/10.1080/00918369.2012.653303

Ehrensaft, D. (2016). *The gender creative child: Pathways to nurturing and supporting children who live outside gender boxes*. The Experiment.

Ehrensaft, D. (2017). Gender nonconforming youth: Current perspectives. *Adolescent Health, Medicine and Therapeutics*, *8*, 57–67. https://doi.org/10.2147/ahmt.s110859

Ehrensaft, D. (2018). What's your gender? In C.Bonovitz and A. Harlem (Eds.), *Developmental perspectives in child psychoanalysis and psychotherapy* (pp. 241-262). Routledge.

Fortunato, A., Giovanardi, G., & D'Angelo, V. (2020). Breve storia di una diagnosi controversa. *Ricerca Psicoanalitica*, *31*(2), 277-294. https://doi.org/10.4081/rp.2020.259

Foucault, M. (1976). *Storia della sessualità: La volontà di sapere*. Paris: Éditions Gallimard.

Fraser, L. (2009). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy, 24*(2), 126–142. https://doi.org/10.1080/14681990903003878

Freud, S. (1924). Il tramonto del complesso edipico. In *Opere* (Vol. X, pp. 27-33). Boringhieri.

Furlong, Y., & Janca, A. (2022). Gender (r) evolution and contemporary psychiatry. *BJPsych Open, 8*(3), e80. https://doi.org/10.1192/bjo.2022.46

Gherovici, P. (2017). *Transgender psychoanalysis: A Lacanian perspective on sexual difference*. Taylor & Francis.

Giovanardi, G., Fiorini Bincoletto, A., & Fortunato, A. (2019). Un più vasto orizzonte: psicoanalisi e identità di genere, storia di un rapporto controverso, da Freud ai contemporanei. *Psicobiettivo, 3*, 133-152.

Gozlan, O. (2018). From continuity to contiguity: A response to the fraught temporality of gender. *The Psychoanalytic Review, 105*(1), 1–29. https://doi.org/10.1521/prev.2018.105.1.1

Graglia, M. (2019). *Le differenze di sesso, genere e orientamento. Buone pratiche per l'inclusione*. Carocci.

Hansbury, G. (2017). Unthinkable anxieties: Reading transphobic countertransferences in a century of psychoanalytic writing. *Transgender Studies Quarterly*, *4*(3-4), 384-404. https://doi.org/10.1215/23289252-4189883

Harris, A. (1991). Gender as contradiction. *Psychoanalytic Dialogues*, *1*(2), 197-224.https://doi.org/10.1080/10481889109538893

Harris, A. (2003). Identità di genere: un concetto "in restauro". *Ricerca Psicoanalitica*, *14*(1), 7-28

Harris, A. (2008). *Gender as soft assembly*. Routledge.

Hidalgo M.A., Ehrensaft D, Tishelman A.C., Clark L.F., Garofalo R., Rosenthal S.M., Spack N.P. & Olson J. (2013). The Gender Affirmative Model: What we know and what we aim to learn. *Human Development, 56* (5), 285-290. https://doi.org/10.1159/000355235

Hirschfeld M. (1910). *Die transvestiten. Eine Untersuchung über den erotischen Verkleidungstrieb mit umfangreichem casuistischen und historichen Material, I-II*. Alfred Pulvermacher & Co, Berlin.

Hirschfeld, M. (1923). Die intersexuelle Konstitution. *Jahrbuch für sexuelle Zwischenstufen, 23*, 3-27.

Jung, C. (1921). Tipi psicologici. In *Opere* (Vol. VI). Boringhieri.

Kennedy, H. (2002). *Karl Heinrich Ulrichs, pioneer of the modern gay movement*. Peremptory Publications.

Kohut, H. (1971). *The analysis of the self*. International Universities Press.

Krafft-Ebing von R. (1886). *Psychopathia sexualis*. Trad. It. Milano, IT: Carlo Manfredi Editore, 1966.

Kubie, L. S. (1974). The drive to become both sexes. *The Psychoanalytic Quarterly*, *80*(2), 369-439.

Kyriakou, A., Nicolaides, N. C., & Skordis, N. (2020). Current approach to the clinical care of adolescents with gender dysphoria. *Acta Bio Medica*, *91*(1), 165.

Lemma, A. (2013). The body one has and the body one is: Understanding the transsexual's need to be seen. *The International Journal of Psychoanalysis*, *94*(2), 277–292. https://doi.org/10.1111/j.1745-8315.2012.00663.x

Lemma, A. (2021). *Transgender identities: A contemporary introduction*. Routledge.

Levi, F. M., & Curti, A. G. (2020). Identità di genere e orientamento sessuale in epoca ipermoderna: Soggettivarsi tra delega e affermazione di sé. *Ricerca Psicoanalitica*, *31*(2), 241-257.

Lingiardi, V., & Carone, N. (2019). Challenging Oedipus in changing families: Gender identifications and access to origins in same-sex parent families created through third-party reproduction. *The International Journal of Psychoanalysis*, *100*(2), 229–246. https://doi.org/10.1080/00207578.2019.1589381

Mahler, M. S. (1968). *On human symbiosis and the vicissitudes of individuation, Vol. 1, Infantile psychosis*. International Universities Press.

Mahler, M. S. (1972). On the first three subphases of the separation-individuation process. *International Journal of Psychoanalysis, 53*, 333-336.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, *36*(1), 38. https://doi.org/10.2307/2137286

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H. (2007). Prejudice and discrimination as social stressors. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on Lesbian, gay, bisexual, and transgender populations* (pp. 242-267). Springer.

Oppenheimer, A. (1980). *Le choix du sexe: à propos des théories de R. J. Stoller*. Parigi: PUF.

Oppenheimer, A. (1992). Il desiderio di cambiare sesso: una sfida per la psicoanalisi?. In P. Valerio, M. Bottone, R. Galiani, & R. Vitelli (Eds.), *Il transessualismo. Saggi Psicoanalitici*. Franco Angeli.

Ovesey, L., & Person, E. S. (1973). Gender identity and sexual psychopathology in men: A psychodynamic analysis of homosexuality, transsexualism, and transvestism. *Journalof the American Academy of Psychoanalysis*, *1*(1), 53-72.

Person, E. S., & Ovesey, L. (1974). La sindrome transessuale nel maschio: Il transessualismo primario; La sindrome transessuale nel maschio: Il transessualismo secondario. In P. Valerio, M. Bottone, R. Galiani & R. Vitelli (Eds.), *Il transessualismo. Saggi Psicoanalitici* (pp. 117-157). Franco Angeli.

Pustianaz, M. (2004). Studi Queer. In R. Coglitore & F. Mazzara (Eds.), *Dizionario degli Studi Culturali* (pp. 441-448). Meltemi Editore.

Quinodoz, D. (2002). Termination of a fe/male transsexual patient's analysis: an example of general validity. *The International Journal of Psycho-Analysis*, *83*(4), 783–798. https://doi.org/10.1516/7ulg-83lg-pc08-dntx

Saketopoulou, A. (2014). Mourning the body as bedrock. *Journal of the American Psychoanalytic Association*, *62*(5), 773–806. https://doi.org/10.1177/0003065114553102

Saketopoulou, A. (2020). Thinking psychoanalytically, thinking better: Reflections on transgender. *The International Journal of Psychoanalysis*, *101*(5), 1019-1030. https://doi.org/10.1080/00207578.2020.1810884

Santoni, B. (2009). La questione trans. In F. Batini & B. Santoni (Eds.), *L'identità sessuale a scuola: Educare alla diversità e prevenire l'omofobia* (pp. 79-144). Liguori.

Scandurra, C., Amodeo, A. L., Bochicchio, V., Valerio, P., & Frost, D. M. (2016). Psychometric characteristics of the Transgender Identity Survey in an Italian sample: A measure to assess positive and negative feelings towards transgender identity. *International Journal of Transgenderism*, *18*(1), 53–65. https://doi.org/10.1080/15532739.2016.1241975

Scandurra, C., Mezza, F., Bochicchio, V., Valerio, P., & Amodeo, A. L. (2017). La salute degli anziani LGBT dalla prospettiva del minority stress: Rassegna della letteratura e raccomandazioni di ricerca. *Psicologia della Salute, 2,* 70-96. https://doi.org/10.3280/PDS2017-002004

Scandurra, C., Mezza, F., Valerio, P., & Vitelli, R. (2019). Approcci affermativi e rilevanza del minority stress nel counseling psicologico con persone LGBT: Una revisione della letteratura internazionale. *Psicoterapia e Scienze Umane, 53,* 67-92. https://doi.org/10.3280/PU2019-001004

Shively, M. G., & De Cecco, J. P. (1977). Components of sexual identity. *Journal of Homosexuality*, *3*(1), 41–48. https://doi.org/10.1300/j082v03n01_04

Shumer, D. E., & Spack, N. P. (2015). Transgender medicine—long-term outcomes from 'the Dutch model'. *Nature Reviews Urology*, *12*(1), 12-13.

Smith, Y. L. S., van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine*, *35*(1), 89–99. https://doi.org/10.1017/s0033291704002776

Stoller, R. J. (1968). *Sex and gender: The development of masculinity and femininity*. Science House.

Stoller, R. J. (1985). *Presentations of gender*. New Haven and London: Yale University Press.

Suchet, M. (2011). Crossing over. *Psychoanalytic Dialogues, 21*(2), 172-191.https://doi.org/10.1080/10481885.2011.562842

Tronconi, A. (2020). Aspetti della transessualità: Dalla consultazione alla costruzione della relazione analitica. *Psicoterapia e Scienze Umane, 54*(3), 425-446. https://doi.org/10.3280/PU2020-003007

Turban, J. L., & Ehrensaft, D. (2018). Research review: gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, *59*(12), 1228-1243. https://doi.org/10.1111/jcpp.12833

Vitelli, R. (2001). “Presentazione”. In P. Valerio, M. Bottone, R. Galiani, & R. Vitelli (Eds.), *Il transessualismo: Saggi psicoanalitici* (pp. 29-45). Franco Angeli.

Vitelli, R. (2014). “Gender Dysphoria in adults and adolescents as a mental disorder... But, what is a mental disorder? A phenomenological/existential analysis of a puzzling condition”. In B. L. Miller (Ed.), *Genderidentity: Disorders, developmental perspectives and social implications* (pp. 55-90). Nova Science Publishers.

Vitelli, R., & Giusti, Z. (2012). Per un’archeologia del soggetto transessuale: un’introduzione a Die Transvestiten di Magnus Hirschfeld e a PsychopathiaTransexualis di David Cauldwell. In R. Vitelli & P. Valerio (Eds.), *Sesso e genere: uno sguardo tra storia e nuove prospettive* (pp. 7-26). Liguori Editore.

Vitelli, R., & Valerio, P. (2012). *Sesso e genere: Uno sguardo tra storia e nuove prospettive*. Liguori Editore.

Westphal, C. (1870). Die conträre Sexualempfindung. *Archiv für Psychiatrie und Nervenkrankheiten*, *2*, 73-108.

Winnicott, D. W. (1970). On the basis for self in body. In C. Winnicott, R. Shepherd, & M. Davis (Eds.), *Psycho-analytic explorations* (pp. 261-283). Harvard University Press.

Winnicott, D. W. (1962). Ego integration in child development. In *The Maturational Process and the Facilitating Environment* (pp. 56-63). International Universities Press, Inc.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. International Universities Press.

World Health Organization. (2022). ICD-11: International classification of diseases (11th revision). Retrieved September 4, 2023 from https://icd.who.int/

Zito, E., & Valerio, P. (2013). *Genere: Femminielli. Esplorazioni antropologiche e psicologiche*. Dante & Descartes.