Chapter 2

Minding the gap

Intersections among gender, race and class in work with gender-variant children

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I have barely stepped onto the inpatient unit to pick up DeShawn for our first therapy session when I see him running towards me. His sprint is interrupted by his body forcefully slamming into mine. He reaches up, grabs as much of my hair as he possibly can, and pulls it violently with all the strength his 9-year-old body can muster. I instantly tear up from the pain. Courtesy of this traumatic moment, time stops. I hear him scream, 'I swear, I'll pull all your hair out.' Reflexively I crouch down to his height to lessen the pain. I can neither think nor speak, an opportune moment for him to grab more of my hair. This draws me even closer and now our noses nearly touch. As he yells in my face, I can almost taste the smell of his breath. I feel the heat radiating from his body. Droplets of his sweat and saliva land on my skin as he is thrashing about. Somehow I recover (some of) my ability to think. 'I know you want your own long hair; I know you are angry and scared,' I say. My interpretation releases neither DeShawn from his rage nor my hair from his grip; he's still yanking, I'm still hurting, we are still painfully entangled. I call for help. As staff gets him to let go, a thick bunch of my hair is clasped in his small fists. He walks away threatening, 'Don't you ever come near me again; I'll pull it every fucking time.'

DeShawn is 10 and black American[1] and grew up in a poor family where no one had finished school. He and I worked together in various capacities for three years. I am 34, a white immigrant who grew up in Greece when it was still a monoracial culture, and come from a mixed-class background.

My work with DeShawn informs the thesis of this paper: that in clinical work with transgender (and otherwise queer)[2] patients, considerations of race and class are not only important facets of the work: they *are* the work. Contemporary theory has deconstructed essentialist conceptions of race and gender challenging the idea that female/male and black/white

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are neatly separated categories (Altman, 2000; Bornstein, 1995; Butler, 1990; Corbett, 1996, 2009; Dimen, 1991, 2007; Dimen & Goldner, 2005; Fausto-Sterling, 2000; Feinberg, 1996; Gillman, 1993; Goldner, 1991, 2003; Halberstam, 1998; Harris, 2005; Kovel, 2000; Straker, 2004; Stryker & Whittle, 2006; Suchet, 2004a, 2007). This has cracked open a Pandora's box of meanings that have been as decentering as they have been exciting. However, a clinical theory of trans experience requires that we address the emotional dimensions of gender fluidity in more nuanced ways than our current thinking permits. Existing theorizing tends to be problematic because it assumes either that gender atypicality is inherently pathological (Chiland, 2000; Coates, 1990; Green, 2000) or neglects the fact that gender in *both* its normative and non-normative iterations can become an expression of psychic pain.

The latter is a particularly thorny issue for psychoanalysts because of the blood that stains our clinical hands throughout a long history of pathologizing homosexuality and other variant identities (Blechner, 2009; Mitchell, 1981). In working with trans, the simmering fear of repeating the offense dampens the degree to which we are willing to reflect on whether/how we can distinguish gender variance from the emotional distress that traffics in gender. Further complicating these distinctions is that stigmatization and marginalization of trans experience comes with its own psychiatric costs that include depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Huegel, 2003; Turban & Ehrensaft, 2018), substance abuse (Burgess, 1999), anxiety disorders (Durwood, McLaughlin, & Olson et al., 2015a; Landolt, Bartholomew, Saffrey, Oram, & Perman, 2004; Olson et al., 2015b; Wallien, van Goozen, & Cohen-Kettenis, 2007), and suicidality (Olson 2016; Steensma et al., 2014; Spack, 2005) and that are often erroneously attributed to the trans experience itself.

While some trans individuals' gender embodiment does not require recourse to medical intervention, others feel that some or substantial bodily alteration is necessary to align inner experience with outward presentation. Installed in a gatekeeping role, clinicians are asked to determine which trans subjects are eligible and emotionally ready for medical/surgical procedures. Despite the fact that rates of hormonal detransitioning and post-operative genital reconstruction surgery regret are low (respectively: Turban & Keuroghlian, 2018, Turban, Carswell & Keuroghlian, 2018; and Carroll, 1999; Kuiper & Cohen-Kettenis, 1998; Rachlin, 2002; Hembree et al., 2017), and that the two existing published reports of anecdotal

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cases of hormonal detransitioning both indicate that the individuals feel they benefitted from having been allowed to explore their gender through hormones (Turban & Keuroghlian, 2018; Turban, Carswell & Keuroghlian, 2018) the possibility captures our worst fears, fueling the mistaken impression of trans experience as a footprint of pathology. This impression draws on gender atypicality as a uniform category rather than as a set of lived experiences that are often expressions of variability and that can, in some cases, like all registers of human experience, be annexed by emotional pain. We lack and are in need of clinical theory that minds the gap between the pathologizing of transgender identities and political trans activism that fails to inquire about gender's psychic meanings.

I have come to think of DeShawn as a casualty of this particular gap, a casualty of our yet limited understanding of *both* the complexities *and* the complications of gender, of the fact that there is not one but many gender fluidities. This has significant implications in work with gender-variant children; though surgical decisions are postponed until adulthood with genderfluid kids, not being able to navigate the space 'between phobia and advocacy' (Corbett, 2008, p. 849) can be as problematic. Hormone-blocking protocols that have been applied and researched in Europe (Hembree, et al., 2017; Smith, van Goozen, & Cohen-Kettenis, 2001) are now also available in the United States, making medical interventions with transgender children a viable option. Alternatively, erring on the side of caution by advising parents to defer or altogether discourage transitioning is also accompanied by serious emotional repercussions on psychic development, ranging from a retreat into a false self and its dissociative aides (Lev, 2004) to suicidality (Cooper, 1999; Spack, 2005).

To straddle the proverbial fence and straddle it well, we need to inhabit a both/and position. We must consider *both* gender's reduction to rigid, binary male/female formations as pathological (Dimen, 2007; Goldner, 1991; Harris, 2005) *and* recognize that gender can, at times, be an expression of distress. But how are we to know when gender acts as proxy for psychopathology? If Foucault (1977) has taught us anything about discursive power, it is to be suspicious of such questions and mindful as to who asks them. In this case, the problem lies with the questions themselves not only because in our postmodern times we are more aware of the regulatory power of psychiatry, but also because they mislead us into thinking that gender, typical and atypical, can be conceived as a singular category.

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Rather, we are better off approaching gender as a category of experience that can be appropriated by multiple psychic ends and that is permeable to varied identity categories (Harris, 2008). Of these, I believe that race and class as they clash onto and melt into each other, hold *a privileged position* vis-a-vis gender constitution. I rely on material from DeShawn's treatment to clinically illustrate how gender cannot be thought of monocausally, how race is woven into its fabric, and how both can be *appropriated by* and *folded into* mental illness. Drawing on theories of intersectionality from black feminist sociology (Collins, 2000, 2005), I hope to interrogate current psychoanalytical practices that conceptualize identity as the accretion of distinct constituents developing in parallel with and independently of one another, and to question the usefulness of notions of the self as constituted of clearly defined/clearly separated, layers of psychic meaning and experience (see also Brown, 2005).

DeShawn belongs to the small minority of transgender children who are also afflicted with severe psychopathology, a statistical epiphenomenon of how infrequently psychosis is encountered in childhood (an estimated 1:10,000, Remschmidt, 2001; Morgan, 2009). Genderfluid kids are impacted to varying degrees by social rejection in response to their gender unintelligibility. This is more pronounced for girlyboys than it is for masculine girls as caretakers are more receptive to the lacing of femaleness with masculinity, often perceived as a sign of precociousness, than male effeminacy which tends to be perceived as damaged masculinity (on how this shifts as girls enter adolescence, see Halberstam, 2004). I have, however, chosen to use my work with DeShawn as opposed to work with more psychically intact patients because it captures in especially poignant ways the interplay between gender and race[3] and because the complexities that arise in considering gender fluidity as it co-occurs with disability are largely neglected in the literature. Taking on these complexities requires as much of a focus on the cultural economies on race and class in the clinical milieu where I worked with DeShawn as it does on the individual work itself. Let me then begin by describing the setting where he was growing up and being treated.

Cultural and clinical setting

I met DeShawn on an inpatient unit that serves an inner-city child population of mostly black and Hispanic 5- to 10-year-olds that is often neglected

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in the analytical literature (Altman, 2009). Our patients usually come from homes ravaged by poverty, a lack of education and unemployment and often bear the marks of neglect, physical violence and sexual intrusions by parental figures who are themselves hemorrhaging from early deprivation and maltreatment. Children are developmentally unequipped to manage such levels of psychic pain and as a result trauma goes unmentalized (Fonagy & Target, 1996). These primitive internal states coalesce around affective holograms (Ferro, 2006), which have often left me in horror: a child hallucinating a blood-soaked Holy Mary, a naked patient rubbing her genitals against a door, a boy barking like the dog he is convinced he is, a 7-year-old scratching his face, leaving trails of blood-soiling clothes and psyche alike. The severity of these illnesses makes press reports questioning the existence of child psychiatric disorders and challenging psychotropic medication use seem ignorant and naïve. Stabilizing these patients requires months, even years, of their early lives spent in the hospital.

As a result, clinicians and unit staff become real parental figures as much as they are transferentially imbued with such roles. Staff spend several hours a day with each child waking them up, helping them get dressed, accompanying them to the school (located within the hospital), eating meals with them, tucking them in at night. These relationships are steeped in the nuances of early attachment; love, hatred, longing, envy, idealization, grief, disappointment. Bonds that develop among staff are similarly powerful, forming a community that coheres around clinical care and its traumata. Race and class mark a divide: clinicians are mostly white, nursing staff almost exclusively not and staff's class and racial backgrounds are more proximal to that of the patients'. These psychic fault lines lend themselves to identificatory and counter-identificatory processes that figure prominently in the patients' internal lives and create complicated dynamics that, as I discuss, permit some interventions and foreclose others.

However cursory, contact with this world of raw affects and the violent projective and introjective processes they engender is inherently traumatic. In the course of my work, I've found my ability to maintain the links between my thoughts to be constantly under attack (Bion, 1967) and have had to actively resist the mutiny of my own distancing defenses. To prevent such anxieties from stultifying this paper, I have chosen to avoid the standard authorial format of presenting separately material from different registers. Instead, I have braided together the strands of clinical material relevant to this paper with theory, history and research.

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DeShawn; first introductions

DeShawn was admitted to our unit when he was 7 with a diagnosis of schizoaffective disorder, multiple hospitalizations starting at age 4 and only partial responsiveness to antipsychotics. Biologically encumbered with serious mental illness on both sides of his family, he had tried to kill his adult sister, stabbed a peer, was threatening suicide and was severely thought disordered. DeShawn's hypersexual behaviors were equally disturbing. When manic he would implore male staff to 'fuck me', often screaming, 'I'm going to suck your dick'. Preying on younger, developmentally delayed male patients whose genitals he'd try to touch, he required constant supervision. Multiple trials of psychotropics proved him impossible to stabilize and when he did respond, medical complications required that his medications be discontinued. Efforts to help him transition to structured settings outside the hospital failed, requiring numerous readmissions.

Sprinkled in this weighty clinical record were also derisive references to his cross-gender identifications as 'sissy-like behaviors'. DeShawn had wanted to be a girl from as early as his mother, Ms. H, could remember.[4] On the unit, he walked and gestured in ways hailed as effeminate. Most of the nursing staff and clinicians felt disturbed by his presentation; their transphobic concerns were amplified by their genuine wish to protect him from being bullied and teased by his peers. In a society that adheres to rigid taxonomies of gender, a genderfluid presentation poses serious risks to physical safety (Walton, 2005). Even for parents who are accepting of their children's variance, bullying and physical abuse in school are serious concerns that need to be weighed carefully in making decisions about use of pronouns, dress and overall transitioning (Brill & Pepper, 2008). In the hope, thus, of encouraging masculine identifications and 'correcting' his gender, staff prevented DeShawn from frequenting the girls' areas and ensured that he was cared for by male aides.

Staff's viral approach to gender, as something DeShawn would hopefully 'catch' if sufficiently exposed to males, was proposed by Greenson (1966) and Stoller (1966, 1968). These psychoanalysts attributed boyhood femininity to difficulties dis-identifying from the mother and with 'excessive' maternal contact.[5] We know today that clinical interventions based on this rationale are notoriously unsuccessful in converting gender experience (Pickstone-Taylor, 2003). Aside from being misguided though,

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for DeShawn, paired with admonitions that he 'be a man', the feelings of shame and self-hatred they engendered got stacked onto preexisting layers of low self-esteem and negative self-perceptions that derived from his psychiatric illness and repeated hospitalizations. Like other effeminate boys who respond to such pressures by encasing their true selves in the protective shield of a false presentation (Menvielle, 1998; Rowland & Incrocci, 2008), DeShawn also struggled with how he was being perceived. Often humiliated and attacked by peers he would withdraw to his room to play by himself.

To make matters worse, staff otherwise accustomed to working with sexually intrusive patients recoiled from DeShawn's effeminacy and homoeroticism. Whereas they physically soothed other hyper-sexual children when they were upset, they hesitated to touch DeShawn, populating his inner life with rejecting objects and representations of himself as disgusting and abject. To ensure the desperately longed-for physical contact, DeShawn responded by dramatically escalating his aggression, unconsciously provoking intrusive physical interventions. In turn, these lent reality to his internal experience of feeling assaulted and left staff feeling emotionally drained.

Information about DeShawn's early history had been sparse or, to be more precise, the little that was known was fragmented. There was no known physical or sexual abuse, but I otherwise had little information about his earlier life. When Ms. H was 10, there had been a murder in the family, the circumstances of which were unclear. Ms. H had suffered a serious medical illness early in DeShawn's life from which she was now seemingly recovered. His father's whereabouts, and maybe his identity too, were unknown. Beyond a general sense of his early years being steeped in intergenerational trauma and emotional chaos, this information lent itself to conjecture but provided limited substantial help.

Ms. H would visit her son weekly but was too overwhelmed by her own life to participate in his treatment. More than anything, she'd comment on his effeminacy. Typical of parents of gender-variant boys (Pleak, 1999) she hoped that her son would develop into a gay man, casually commenting, 'He can be a faggot all he wants, but he ain't wearing any of *my* dresses.' While studies had previously suggested that atypically gendered children mostly grow up to be gay rather than transgender adults (Green, 1987; Zucker & Bradley, 1995), suggesting that effeminacy may mark

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one particular type of homosexual boyhood (see also Corbett, 2009). This raised questions about whether our field's clinical focus on fluidly gendered children may serve as an indirect way of psychiatrically targeting homosexuality (Burgess, 1999; Leli & Drescher, 2004; Menvielle, 1998). As Sedgwick (1991) noted bolstering this notion, the diagnosis of 'gender identity disorder' was introduced in the 1987 edition of the *Diagnostic Statistical Manual of Mental Disorders*, the first from which homosexuality was purged as a psychiatric category. We are today, however, in the position to better assess that these early studies suffered from serious methodological difficulties that put the finding (that most atypically gendered kids grow up to become gay adults) under considerable pressure (Olson, 2016; Turban, Carswell, & Keuroglian, 2018; Turban & Keuroghlian, 2018).

Gender variance in the clinical milieu

The question of how to understand DeShawn's effeminacy arose early in his hospitalization. Following a long tradition of dismissing trans experience as delusional and pathognomonic of schizophrenia (Caldwell & Keshavan, 1991; Laufer, 1991; Siomopoulos, 1974), clinicians' countertransferential anxieties about DeShawn's gender were expiated by attributing it to his psychosis. DeShawn was seen as a boy who wanted to be a girl because he was a *disturbed* boy.[6] His psychosis made him dismissible, discounting his right to a serious consideration of his gendered experience (McRuer, 2006; Siebers, 2009). Defensive mechanisms he mobilized to protect himself from the barrage of external pressures complicated the clinical picture and were misattributed to his effeminacy rather than to the impact of its suppression. Such conceptualizations persisted despite the fact that, even when psychotic symptoms yielded to psychotropic intervention, his cross-gender identifications remained unaffected.

The experiential gap between one's gender fluidity and the rigid cultural regulation of gendered behavior can be profoundly disorienting (Di Ceglie, 1998). A robustly constituted ego may be able to enlist the psychic derivatives of such discrepancies in a variety of successful ego adaptations (e.g. activism; see Muñoz, 1999). However, for an ego that is constitutionally porous to psychotic processes or that of a child's which is called upon to also tackle multiple developmental challenges, withstanding and creatively refashioning the pressures of gender normative expectations may be impossible. Under those circumstances, 'the person with a shameful

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differentness can break with what's called reality' (Goffman, 1963, p. 10) and psychosis may come to mark the only psychic space within which these misalignments can be tolerated. For such patients, encouraging the exploration of the meanings of gendered experience and offering the opportunity to metabolize affective reactions and unconscious fantasies becomes a matter of psychic life or death, psychosis and its containment.

Bringing to the clinical table both psychiatric vulnerability and a developing ego well below his chronological age, DeShawn's functioning was further compromised by the excess in the familial trauma of murder, his mother's medical illness, his father's absence and multiple disrupted attachments. In this context I felt that deeming his gender a manifestation of illness did more than just marginalize him: it *fenced him into his psychosis*. Out of concern that I'd be seeking to explore rather than 'fix' his gender and the fear that my feminine appearance would intensify his longings, DeShawn had by this time worked with almost every other clinician and trainee on the unit before being assigned to me despite my experience with genderfluid children. I had had a hard time watching clinicians agonize over whether he should be allowed to play with dolls, whether it was acceptable to let him talk about wanting to be a girl for fear that 'it would encourage his belief' or 'make him more hypersexual'. Therefore, when he'd seek me out on the unit long before I started treating him individually, I'd gladly engage with him around his interests in dolls and makeup. He had many questions – how did it feel to have my hair brush against my shoulders? How did I learn to walk in heels? How did I coordinate colors?

The bond that developed through these interactions was strong and intimate. When he became thought disordered and self-abusive upon being shamed for his effeminacy, he'd seek me out. Wrapping his arms around my waist, he'd press his head against my belly and cry inconsolably with an abandon children have not yet learned to suppress. My hair figured prominently in this process. Amidst his tears he'd beg, 'please, let me touch it', clasping strands of it between his hands. The vibrations of his small, sobbing body gently tugging on my hair would transcribe his emotional experience into a somatic one of my own. Sometimes he'd weep '*please please*' and before I could stop him he'd stuff my hair into his mouth with the urgency of a famished infant ravenously reaching for the nipple.

I understood these intense moments as primitive communications of tangled knots of affect that DeShawn was unable to process and, much less, verbalize. The regressive quality of his dependency spoke as much to

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the grief and longing that his lengthy separation from his family evoked, as it did to what I was now convinced must have been Ms. H's limited emotional availability from early on his life. I viewed the despair with which he'd throw himself on my lap soaking my clothes in his tears, as a reflection of how little emotional containment he'd had. I imagined Ms. H in his early years, overwhelmed by her own unmentalized trauma and the tremendous undertaking that attending to her ill son must have been, helplessly retreating from him when he'd need her, letting him soak in a pool of escalating affects he was unable to regulate. As such while staff's rejections were in themselves traumatic, they also transferentially activated these early experiences of neglect and emotional abandonment. My hair which evoked so much yearning, envy and pain not only represented his fantasy of an uncomplicated, 'natural' femininity which he was convinced I embodied, but also captured his need for an idealized mother who could withstand the hurricane of his primitive experience and help him modulate it, a mother who would want and be able to know him for who he was.

I wanted to do all that for DeShawn and, yet, his pain and anguish were often hard to bear. Sometimes I felt so spent I had to guiltily take breaks off the unit. Between his intensity and staff's strong reactions to him, my exhaustion swelled. For months I was visited by terrifying nightmares; this insufficiently processed emotional material, what Ferro (1999) calls 'balpha elements', was evidence of my inability to detoxify DeShawn's evacuated primitive mental states, unwelcome traces of my own anxieties about whether I'd be able to negotiate the complexities of his treatment. At the same time, I was concerned for the fate of his affects were they to remain unmetabolized, as I had come to see his physical aggression, predatory sexual behaviors, and thought disorder as undigested bits of experience that morphed into psychic objects that could not be processed and which needed to be urgently and forcefully evacuated (Bion, 1967). For them to be thinkable, for DeShawn to no longer need to violently expel them, they would need to be alphabetized and made tolerable (Ferro, 2005). But how could I detoxify them when I also felt hostage by them?

Lessons from the clinical front

The contrast between DeShawn's regressively desirous relationship to my hair and the barbarism with which he'd pulled it had left me feeling shocked, hurt and rejected. It was, thus, with some apprehension that a few

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minutes after he'd pulled my hair I took him off the unit, agreeing to his insistence that we not cancel our first session.

Walking to my office DeShawn asks to hold my hand, an attempt at reparation. Unlike prepubertal boys who retreat from the indignities of needing physical contact, DeShawn is starved for it. As we are walking down the corridor with his hand in mine, he tells me casually about his day. I'll later notice that he lets go of my hand around staff; right now I'm just relieved that a point of connection can be still be found. I miss this signifier of a social awareness that is saturated with meaning of which I am yet unaware.

When we arrive at my office, he ravenously rummages through bags of toys. In contrast to descriptions of gender-variant boys' play as 'compulsive, joyless' (Coates & Moore, 1998, p. 53), DeShawn's is anything but stilted. He intently sets aside several black dolls before he finds a white one with long, luscious, silky hair. He places her on top of a fan and giggles joyfully as he watches the transformation of a still, lifeless toy into a girl whose tresses are now playfully getting tangled in the wind. His pleasure is contagious, and it catches me in its draft as I watch him enjoy the freedom of playing with a doll. These moments are not only gendered, they are also racially marked. DeShawn is happy to play but not any doll will do. Over time he will often enact the same sequence, always consistent in his choice of the white doll.

Registers of meaning are multiple and multiply layered. I ask myself, is this driven by his relationship to me? Has DeShawn conflated my comfort with his gender fluidity with my white skin and staff's discomfort with their being black? I wonder if his insistence on the white doll may be a result of an identificatory process, a transferentially saturated choice made because DeShawn has come to feel that it is skin color that determines whether he'll be accepted. In other words, if he's going to be playing with dolls, does he feel it's easier to do so in white company?

Or, might it be that gender is being appropriated by racial self-hatred? I think of Kenneth Clark's research and his then-surprising-now-familiar finding that black schoolchildren preferred white to black dolls (see Klueger, 2004). 'Inherited across time', Cheng (2001) wrote, 'this wound endures not only in the individual psyche, but in the American national psyche as well' (p. x). And endure it does in DeShawn's play as it becomes the dominant theme in our work. Does that indicate a hatred of his black skin, one that metamorphoses into wanting to be a white girl? If Freud's

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dictum that anatomy is destiny is no longer true in a time where genitals can be surgically altered, can gender offer itself as an alternative to race?

Conversely, I also wonder, has DeShawn folded race *into* gender? I linger on the long history of black women struggling with the length and texture of their hair (Banks, 2000), of the bleaching agents used to lighten their complexions, of Madam Walker who built her empire on the proceeds of her hair-straightening pomades to become the first black female millionaire (Rooks, 1996). As a black boy growing up with this particular brand of racial discourse, could DeShawn be experiencing femininity as being *at odds with* his blackness? If ideals of femininity are hued in white, does gender subordinate race, encoding it differently for white than for black Americans? How does race do gender?

Under the weight of these questions, considering race and racial difference in work with non-white transgender patients carries different meanings than when working with white gender-variant children or with black normatively gendered youth. In the latter, considerations of race tend to exclude how racial affiliation complicates and is complicated by gender. DeShawn, however, was not yet ready to follow me into this labyrinth. When I'd try to bring up race, he'd outright ignore me and when I failed to take the hint, he'd offer supervision, instructing me to 'shut up'.[7] Though rebutted, my questions indicated to him my willingness to take on race; my technical choice was to wait and listen. The shift came, as it does in child work, in the form of play.

DeShawn picks off my toy shelf a big, stuffed teddy bear wearing a pink wig, that's been sitting on my shelf all along but which he has previously never touched. He tries the wig on. Looking at himself in the mirror he says proudly, 'I'm beautiful.' He seems genuinely pleased with himself and in this moment that he is admiring his reflection in the mirror he is no longer the insecurely effeminate gender-variant boy I've known; his girliness has now become something to delight over. A new image of him enters my mind – I visualize him as an adult. A vibrant, radiant performer he's onstage singing, 'I will survive', the audience beneath him cheering him on: drag queen extraordinaire! My reverie, the product of our intersubjective process (Ogden, 1998), captures a creative, resilient part of DeShawn. For the first time, I'm picturing him happy and outside institutional walls. This moment does not rest on splits and dichotomies, dissociation and repression. The importance of this moment does not hinge on whether DeShawn will indeed grow up to be a drag performer;

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this is not about how his atypical gender will carry him into adulthood. What matters is that hope, happiness, a community where DeShawn can be accepted, loved, even admired has been possible to imagine. 'You are *so* beautiful' I tell him, moved; he stares at himself in the mirror, smiling with pleasure.

Race has been so far too radioactive to handle in the immediacy of the transference. I hope that this moment which has afforded us a different angle into his experience can help bear the weight of a discussion around race. I hope that the projective barrier can hold the tension. I point to a black doll he's cast aside earlier in our session. 'What does she think of all this?' I ask. He shrugs. A pause. I wait. 'I'm sorry I pulled your hair that day,' he says. I'm caught off guard. He's apologized before but always mechanically, never with time to talk about it. I wonder, why now? Why after I ask about the black doll? 'I think about it too,' I tell him, careful to navigate the fragile space between acknowledging his aggression and shaming him for it. 'Do you know why you were so upset that day?' He nods. Another, long pause. Then, 'That was the day I got my haircut, you know?'

No. I had not known. DeShawn had fought hard to be allowed to grow his hair. His interest in it had gone through multiple iterations since his admission. Early ones involved a troll doll whose kinky hair he'd violently tear from its plastic head. His brutality was followed by reparative attempts, as compulsive as they were dismal, to glue it back on. The result was grotesque, and he soon abandoned this play. He had then shifted to constructing makeshift wigs. He'd staple paper in a circle and would then attach to its periphery long pieces of string. When worn over his head, the string mimicked strands of hair brushing against his shoulders. His elation had equaled only staff's upset. Only with its gendered meanings smothered by referring to it as a 'headband' was DeShawn allowed to wear it.

However, when he started playing with the 'hair', tucking it behind his ears in girlish mannerisms, staff and teachers had had it. Grabbed off his head, the wig would be taken from him and thrown out. Or somehow, somewhere between bedtime and the next morning it would mysteriously disappear. No one 'knew' what had happened to it. No sooner had a new one been constructed then it would again go missing. In an effort to restore some semblance of control, DeShawn started compulsively destroying his wigs, biting staff and becoming self-abusive. The unit was in disarray.

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I spoke to the clinical team, insisted on special trainings for both staff and clinicians. We discussed DeShawn's gender, and I approached those working directly with him to talk more about their frustrations. Slowly, some came to me with questions: 'Why can't he just be normal?' 'Is he gay?' 'Why not just stop this nonsense?' Slowly, these questions gave way to private confessions about underlying anxieties that his gender transgressions had stirred up; someone's brother who'd recently come out, a male cousin caught wearing a dress, an unmarried aunt living with a female 'friend'. Heartened though I was by this interest it had little impact on staff's tolerance of DeShawn's effeminacy. In the absence of being emotionally processed, it remained concrete information, barren knowledge (Bion's, 1962) and it could not be productively used.

It was then that DeShawn shifted everything by coming up with an ingenious solution. Casting 'wig' and 'headband' aside, he began referring to his stringed strands as 'dreadlocks'. In its linguistic drag the wig was freed from its feminine inscriptions and now became acceptable. For the first time it survived the night and he was allowed to wear it on the unit and in school. Staff now agreed to a request he had made often before and which had always been previously rejected: He was allowed to grow his hair and to have it braided. DeShawn's rage subsided, and things began to calm down. And while his psychosis did not resolve, he became less thought disordered, his communications began making more sense and his aggressive outbursts diminished in frequency and intensity.

Somehow, however, DeShawn never did grow out his hair. When I'd asked him about it, he'd dismissed my questions but at this moment he was ready to talk about it. 'How come you got the haircut?' I asked. DeShawn said plainly, 'Paul said that I gotta keep it real, I gotta be a man.' Paul had worked with DeShawn for years and felt strongly about the importance of 'protecting' my patient's masculinity. His explicit commitment to 'make a man out of him' had routinely overridden any concerns about feelings of rejection they engendered in DeShawn. 'You didn't want to disappoint him,' I said sadly. 'No!' DeShawn corrected me, '*I*' – he emphasized the *I* – '*I* gotta keep it real.'

In DeShawn's crisp response, I now heard something new. I had till now been thinking of his interest in the white dolls' and my hair as gender based, with race implicated only insofar as it was caught in femininity's white web. Condensed in Paul's statement, however, the sentence that DeShawn so clearly recalled was a gender imperative spoken in ebonics.

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The kind of 'man' that Paul implored my patient to be wasn't merely rigidly gendered – it was raced. What made DeShawn's dreadlock wig acceptable was not only that it had been purged of feminine markers but also that, perhaps more importantly, dreadlocks safeguarded DeShawn's blackness. It proved not merely that a black man with long hair can still be a man, but that *he can still be black*. What had been at stake here was not masculinity but racial identification, and it was because of that why discussions with staff had amounted to 'barren knowledge'.

DeShawn may have shrugged a dismissive 'I don't know' when I'd asked him about the linguistic shift from 'wig' to 'dreadlocks' but he had on some level been keenly aware of and responsive to the racial anxieties underlying staff's fears, racial anxieties that he likely also shared. I now saw how my previous attention to homophobia and transphobia and my consideration of his race as an independent identity strand to be kept in mind had blinded me to considering the intersections between and co-constitution of those different elements, that it had blinded me to *the racial demands on DeShawn's gender*. Caught up in a discourse which treats masculinity as white culture's most prized possession, I had missed that *for black boys racial identification trumps gender anytime*. 'The specter of the fag' Pascoe (2007) found in her research in American high schools 'is tightly raced' (p. 97). Where white teenage boys taunt one another for being 'a faggot', for black adolescents the offense is 'acting white'. Further, race and class mediate perception of gender transgressions. Consider, for instance, the fact that interest in one's hair, clothing and shoes is an indisputably masculine preoccupation among black adolescents but marks effeminacy in white teenagers (Perry, 2002).

If for the (largely white) clinicians, questions about DeShawn's gender revolved around its relation to his psychosis, for the non-white staff it could not be extricated from a racial matrix. Embedded in a historical discourse on attacks on black masculinity, ranging from actual castrations (see Dray, 2003) to the more symbolic emasculation of black men who were denied access to paternity rights and male entitlements by their white slave owners (Ferguson, 2005a; hooks, 2004), the notion of approaching DeShawn's gender atypicality as nonpathological was seen as akin to a form of black male emasculation. In this cultural milieu, my being white subjugated my views on his effeminacy to the trope of black male emasculation, intensifying

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the perception of a threat to his black identity and diluting the usefulness of my interventions on the unit level. My previous, casual observation that DeShawn would let go of my hand when we'd be around staff, now made more sense.

I started researching the historical origins of the investment in normative iterations of identity among black Americans. In discussing the economics of reproduction in colonial times, Collins (2005) describes how slaves were encouraged to have as many children as possible to enhance wealth and power for their owners. Affording 'breeder women' the protections of not being sold, this consolidated the survival value of heterosexuality (Cole & Guy-Sheftal, 2003). When the 1863 American Freedman's Inquiry Commission sought to situate newly emancipated slaves in the state system, it deemed unions outside matrimonial walls as emblematic of the 'uncivilized, degraded . . . ways of the slaves' (Ferguson, 2004, p. 86). For former slaves, therefore, American citizenship was made contingent on heterosexual marriage. Those who refused to comply were severely sanctioned.[8]

The erasure of homosexuality was thus to be counted among the costs for black Americans' inclusion in the white, dominant culture. Homosexual deviations jeopardized not only the social standing of transgressors but also endangered the status of the entire race. 'African Americans', Richardson wrote, 'have often looked to heterosexual marriage to afford us respectability' (Bailey, Kandaswamy, & Richardson, 2008, pp. 113–114). This whitewashed homosexuality gave birth to the notion that those who are gay cannot possibly be authentically black (West, 1993).[9] This assimilationist violence extended beyond the brutalities of cultural erasure to the violence perpetrated on the black men whose non-normativity threatened to forestall the race's upward mobility, melting race into class (Kennedy, 2008; see also Sycamore, 2004). Thus, although the notion that homosexuality compromises masculinity does not adhere to race, in black American culture homosexuality carries the additional burden of imperiling racial membership (Ferguson, 2005b). 'Homosexuality,' said Julien (1989/2007) in his famous *Looking for Langston*, 'is *a sin against the race*.' Things were now making more sense: Unlike white girly-boys I'd worked with, DeShawn was dealing not just with straight-up homo/transphobia but also with its racially queered equivalent, saturated in intergenerationally transmitted anxieties about preserving black identity.

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In thinking about the intersectional identities of minoritarian subjects at a time that the term *intersectionality* had not yet developed the traction that it has in our discourse today, the queer theorist Jose Muñoz wrote:

> I always marvel at the ways in which nonwhite children survive a white supremacist US culture that preys on them. I am equally in awe of the ways in which queer children navigate a homophobic public sphere that would rather they did not exist. The [psychic] survival of children who are both queer and racially identified [as nonwhite] is nothing short of staggering.
>
> (1999, p. 37)

Muñoz's language is blunt, lacerating: it is this precarity of psychic survival that we are confronted with as clinicians in working with patients like DeShawn, patients who navigate worlds that would rather they not exist. These worlds are not only the cultural worlds undergirded by white supremacy, classism and heteronormativity; they are also largely – and with only few exceptions, even to this day – the worlds offered to us as therapists by our theoretical frameworks and our clinical techniques. Our theories of therapeutic action and our models for understanding racialized gendered embodiment are refracted through the enduring difficulties of psychoanalysis to think of race with gender and with class; to think through history and its reverberating impact; to think about the psychic tangles of how these materialize in a single individual. This is especially urgent when it comes to working with children, further raising the stakes for the lived implications for our metapsychology.

On not concluding

I wish that I could go on from here to describe how this rigorous intellectual and clinical journey led to a major shift in technique that then changed my patient's life. I have always been envious, and perhaps because of that somewhat mistrustful, of clinical narratives where an analyst's new insight bends the therapeutic rainbow to that coveted pot of clinical gold, that aha moment that breeds radical experiential and behavioral change. To the contrary, there was nothing spectacular in how these thoughts influenced my work as they slowly worked their way into my treatment of DeShawn.

Having a way of linguistically representing and, thus, of being able to think of the continuities between race and gender, having found my way

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into the clinical iteration and lived experience of identity as intersectional, my receptivity to DeShawn's material began to gradually shift. I found myself entertaining questions that pertained less to his gendered and racial experience as based on static, distinct and monolithic systems but that, rather, allowed them to be intricately knotted together. But of this, I said very little if anything at all. Mostly, I became better able to nod encouragingly as he'd turn to me anxiously when his play would venture into what I now recognized as racio-gendered territory. Where I'd have previously jumped into his play to verbalize my sense of what he was struggling with, framing it as distinctively raced or gendered, I now stopped disrupting him from playing, playing out, and dwelling on their tangled meanings. DeShawn's play flourished and a wider variety of enacted scenarios began emerging, a newly found flexibility in his emotional range.

Sadly, I did not have the opportunity to continue to work with DeShawn much longer. Two months after these issues had started becoming clear to me, I left the hospital and I left DeShawn. I've managed my guilt by taking solace in the fact that what I learned through him stays with me, permeating my clinical thinking with my other patients. That one category of difference can be cloaked in another's garb, the mechanism by which one category can offer itself as a viable alternative to negotiating trauma and psychic pain originating in another, has been possible to see with increasing frequency in my work with gender and sexual variance. Is it too much to hope that work which bears the tensions of these complexities might help disrupt the kind of developmental trajectory that fuel well-founded concerns about how to work with non-normatively gendered patients? Is it possible to consider this kind of clinical work without collapsing all non-normative phenomena into potential catastrophes that need to be averted? How do we mind the gap?

Worrying is endemic to child work. But when we work with genderfluid children, worry increases exponentially. Contrary to clinical issues where we can, for the most part, map a topography of possible adaptations our patients can make to the external world, treating atypically gendered children at this point in time carries the additional burden of trying to imagine a world that does not yet exist. What does this future that we are asked to envision hold for fluidly gendered kids? What does the future hold specifically for someone like DeShawn who lacks the protections afforded those with the cultural capital of class (see also Munt, 2009)? Will he be happy as a cross-dresser, a transwoman, a gay man, a drag queen? Will he be

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living in a hospital, in a community, in jail, in the streets? Is he awaited by a life of happiness, rejection, creativity, hope, despair? Observing how his race, his class, and his gender loop together offers no answers. Rather, it queers the discourse, breeding further questions still. Was DeShawn a boy who wanted to be a girl, but felt that being black limited how feminine he could eventually succeed in being? Did feeling feminine locate him outside his racial identity because not being a typical boy compromised his blackness? Was he a black boy struggling with racial self-hatred who used gender to negotiate skin color? As asking these questions becomes possible for us, it may also become possible for DeShawn, and he may one day be able to make his own decisions.

Space limitations don't permit me to follow in this paper the labyrinthian trails of several other important aspects of DeShawn's psychic make-up that arose in the course of our work. What about the place of eroticism, the maternal erotic transference (Wrye & Welles, 1998) in his intense engagement with my white, female body? How about his attraction to males, of which I've only said little and which was exclusively interracial? Is there a link between the transgressions of homoeroticism and those of miscegenation (Cheng, 2001)? Would it (not) be stereotype to assume that the allure white men held for DeShawn reflects self-loathing, as the popular claim goes (Craig-Henderson, 2006) and others challenge (Fisher, 1996; Mercer & Julien, 1988; Reid-Pharr, 2001)? Would those possibilities as readily enter our minds if DeShawn had been white and desired cross-racially? Or would we then turn our attention to the black subject, now object, of desire as fetish (hooks, 2004; Poulson-Bryant, 2005)? Does the notion that a non-white subject has absorbed racial fantasy (LaFarriere, 2010) necessarily have to submit to the trope of stereotype (Cheng, 2001)?

How about the way in which my own subjectivity framed this work? What does it mean for me as a white person to be wondering about these issues? How does it relate to the fact that as a foreigner who was raised in Greece when it was still an exclusively white culture, my whiteness has different meanings than that of my white American colleagues (Crouch, 1995; Suchet, 2004b)? Does that (in)validate the questions I ask? The ones that elude me? How are my questions as a cis woman different from otherwise sexed others, and which important ones does my gender and the way I inhabit it preclude? How about my class privilege and the fact that, unlike DeShawn, whose aspiration is to work at McDonald's, I can enjoy the luxury of being able to reflect on our work and process its

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emotional impact and its psychic toll by writing about it? What about you? How does *your* gender, *your* racial identity, *your* class background sculpt your understanding of DeShawn? Who gets to ask what and how dismissible do our subject positions make us anyway?

The most apt commentary on these questions is, perhaps, that of 9-year-old Doshanda, DeShawn's hated rival and ardent attacker who would appear, whenever he wore his wig, as if out of nowhere to inflict psychic pain and physical injury. When I asked her what she found so upsetting about him, she was disarmingly direct and disturbingly clear: 'he makes my brain hurt,' she replied. Her statement made immediate, visceral sense. My brain had also hurt as I tried to disentangle the different discursive threads in working with DeShawn, and maybe yours has as well as you've been reading through this paper. Still, Doshanda's succinct response stays in my mind as the most comprehensive, most succinct explication of homophobia and transphobia I've heard.

When I announced that I was leaving the hospital, staff was worried: 'What's going to happen to DeShawn?' Deciding to leave the hospital had been especially hard because I specifically did not want to end my work with him. Plus, I dreaded having to tell him. When I did, he bit and kicked me; he pulled my hair, then begged me to stay. A few weeks later in the community meeting where I was saying good-bye, DeShawn was floridly psychotic: hallucinating, giggling, talking to himself. Hearing patients and staff express their sadness, I teared up. For DeShawn, it was too much. Wrapping his face in a curtain his speech became unintelligible before he was eventually able to tell me: 'it pisses me off that you're crying; just stop it!' I later found him in his room sobbing. He pleaded with me, for yet another time, not to leave him. When he calmed down, he asked me if I'd get him a tissue. 'How about we get one together?' I offered, not wanting to leave him alone. 'No,' he said, 'I don't want others to see me cry and think I'm a fruit.' There he was, my 10-year-old patient, a child assigned-male-at-birth who had by now been wearing a wig for several months, worrying that it would be his tears that would mark him as queer. That image in its poignancy and absurdity, in the depth of his shame and the extent of his need, captures the complexity of who I knew DeShawn to be. Six months later, together with his new therapist, he made some drawings that he asked her to send me. In bright red and gold glitter he wrote, 'I very miss you. I'm sorry I pulled your hair. Do you love me?'

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Notes

1 Racial identities mediated by ethnicity, immigration and the particular brands of imperialism that stain them do not carry uniform meanings. Rather, they are steeped in taxonomies of history and ideology that are contingent on cultural, geographical and chronological locale. Consequently, African, West Indian and American blacks all carry and experience their racial identities differently; this paper deals specifically with black American identities.
2 I use the term ‘queer’ here to encompass variant identities that resist culture’s normative regulation of gender and sexuality and that include genderfluid experience (masculine women, effeminate men, drag queens and kings, transmen and transwomen), and variant sexual orientations (gay, lesbian, bisexual and leather).
3 The focus of this essay is to theorize the links among gender, race and class and, as such, a discussion of other aspects of my work with DeShawn, and technique issues arising in work with this population are beyond its scope.
4 Despite his feminine identifications, DeShawn felt strongly about and insisted on the use of male pronouns.
5 This model of gender contagiousness is not an exclusive property of the 1960s and ’70s; see Nicolosi and Nicolosi (2002) who advise that effeminate boys shower with their fathers to help foster a “relaxed, anatomically based identity and dispel the erotization of male anatomy which may accompany concealment” (p. 82).
6 It is, of course, impossible to miss the sexist implications of such formulations.
7 I am here drawing on Bion’s (1994) idea of the patient as ‘our best colleague’. See also Ferro (1999) for discussions on using child patients’ verbal and nonverbal responses as supervisory input.
8 Other minorities have similarly suffered heteronormative impositions to gain American citizenship (Gopinath, 2005). See also Puar (2007) for a discussion of a related and very interesting discussion of how non-normativity has more recently and in the context of the War on Terror, been appropriated by projects of American citizenship.
9 Cohen (1999) uses the term *advanced marginalization* to describe how minority groups trying to establish their legitimacy within a majority culture erase their non-normative members. Examples abound: The gay movement, for instance, notoriously marginalized transgender individuals (Serano, 2007; Sycamore, 2008) and leather sexuality (Samois, 1981) in its efforts to secure homonormative rights for its members.

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