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The Body One has and the Body One is: Understanding the Transsexual's Need to be Seen

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The transsexual individual confronts the analyst with a disturbing otherness. How this otherness is understood, that is, how the analyst 'looks' at the patient through her distinctive theoretical lens impacts, in turn, on the patient's experience and what transpires between them. In this paper the author outlines a developmental model rooted in attachment and object relations theory to provide one alternative way of 'looking' at some of these patients' experiences in the clinical setting. It is suggested that in some cases of transsexuality the primary object(s) did not mirror and contain an early experience of incongruity between the given body and the subjective experience of gender: it remains unmentalized and disrupts self-coherence leading to the pursuit of surgery that is anticipated to 'guarantee' relief from the incongruity. Through an account of work with a male to female (MtF) transsexual who underwent surgery during her five years of psychotherapy, the author explores how a focus on the transsexual's experience of 'being seen', that is, of being taken in (or not) visually and mentally by the object in their state of incongruity, affords another window through which to approach the transsexual's experience in the transference-countertransference dynamics.

Working with transsexual[1] individuals typically confronts the analyst with powerful countertransference responses to what can feel like a disorienting 'visible' otherness and which often indeed presents as such. In turn how we 'look' at the transsexual impacts on their experience. Our theory about transsexuality will lead us to see particular dynamics in the transference while obscuring other features. Given the likely heterogeneity of pathways to transsexuality we are best served by a range of perspectives because some theories may be more or less useful in understanding the distinctive particularities of transsexuality in each of our patients. Importantly, we need to understand the function of a transsexual fantasy in the psychic economy of each individual.

The aim of this paper is to contribute to the ongoing debate about how we can understand transsexuality. I contextualize the struggle *some* transsexuals convey within a necessarily speculative developmental framework rooted in object relations and attachment theories. This developmental account is a hypothetical formulation focusing in on a particular dynamic feature of the transsexual experience, namely that of 'being seen', of being

[1] I am not addressing here the question of transgenderism, which is a much broader term encompassing individuals who transgress gender norms but are not necessarily seeking surgery. Neither am I addressing transvestism, which refers to sexual arousal associated with cross-dressing.

taken in (or not) visually and mentally by the other in a state of incongruity. It is not intended as an all-encompassing explanation of transsexuality: as with any theory, by honing in on one dimension of experience, it neglects features that other theories will highlight. I present it here thus as one alternative way of looking at some of these patients' experiences relative to, say, how an analyst approaching transsexuality through the theoretical filter of 'perversion' might approach these patients' predicaments[2] (e.g. **Argentieri, 2009**; Limentani, 1979; **Socarides, 1970**).

My hypothesis is illustrated through a five-year, once-weekly psychoanalytic psychotherapy with a MtF transsexual who underwent sex reassignment surgery (SRS) during this time. The frequency of my work with Ms A inevitably limited the depth of exploration that would be possible within an analysis, but even so it provides some illustration of dynamic processes that could be profitably further explored and deepened within a more intensive clinical setting.

The Embodied Self and the Experience of Being Seen

In a study of eight transsexual individuals at various stages of transitioning, which comprised semi-structured clinical interviews, two themes emerged as central to the transsexual's experience **(Lemma, in press)**.[3] The first theme to emerge from the interviews concerned what participants variously called a "gap," "disjoin" or "incongruity" between the given body and the body they identified as their "true" physical home. Moreover, this experience, which I shall refer to from now on as one of *incongruity,* was precisely what several of the participants reported as being difficult to communicate to key attachment figures during childhood and adolescence. The second theme concerned the experience of being seen, of the self as a visual object. The core of the experience of the transsexual is indeed located in the visual order. They inhabit an internal *and* external scopic economy as their incongruous appearance invariably draws the gaze of the other towards the self.

Winnicott grasped the challenge imposed by our embodied nature when he reminded us that it is easy "…to take for granted the lodgment of the psyche in the body and to forget that this again is an achievement" (**1988**, p. 122). This 'lodgment' - **Winnicott (1970)** elsewhere referred to it through the somewhat poetic image of the 'psyche in-dwelling in the soma' - brings home the rootedness of mental structures in early sensory and affective experience **(Freud, 1923)**. It also speaks directly to the experiences recounted in the interviews I conducted in which the search for a receptive physical 'dwelling' for the self resonated throughout. And yet the other 'dwelling' that was also strikingly absent for many was that of a receptive mind that

[2] I am drawing here on Tuckett's reminder that: "A good theory makes distinctions that are practically useful" (**2011**, p. 1372).

[3] Notwithstanding the conscious nature of this data the themes that emerged from the interviews mapped onto my clinical experience with this group of patients - and specifically with a particular feature of the transference and countertransference dynamics that I have encountered. As such they provide some triangulation of data from the couch with data 'off the couch' and they have thus informed the ideas I present in this paper.

could house the experience of ambiguity, confusion and uncertainty felt to be lodged in the body.

The plight of the transsexual exposes in possibly the most extreme manner the developmental challenge we all have to negotiate and to which we all find compromise solutions, namely how to transform the body one *has* into the body one *is,* or, to use a **Winnicottian (1970)** term, how to 'personalize' it. For the transsexual this core developmental challenge is further complicated by an experience of embodiment which, for biological and/or psychological reasons, is felt to be intolerably confusing and painful.

Transsexual individuals often describe their experience in such terms as, for example, 'feeling in pieces' or 'I feel like a jigsaw you can't complete' or 'a stranger to myself', underlining a disturbing discontinuity in the experience of the self, which leads them to search for their 'true' body - one that is anticipated to relieve them of this intolerable experience. In the study the extent of the investment in SRS, and hence the extent to which the participants were focused on the materiality of the body, distinguished them. This seemed to be strongest in those who reported misattuned responses from attachment figures (e.g. hostile) to their subjective experience of incongruity between the body and their gender of identification.

The participants' conscious reports of other people's misattunement to their predicament is one that I have also encountered, albeit in its greater complexity and unconscious elaborations, through my analytic work with these patients. It manifests in the transference as an invitation - and indeed at times as an urgent, forceful pressure - to 'be seen' and taken into the mind of the analyst in the body's state of incongruity. I would like to suggest that one way of conceptualizing the experience of *some* transsexuals might thus be in terms of exposure to a repeated failure of contingent mirroring and mentalizing of the child's felt incongruence at the level of the body regardless of its aetiology.[4] In these instances transsexuality may be thought about as a disruption in identity coherence.

If one's bodily experience can be represented in the mind of the other this will make a difference to the development of a coherent sense of self rooted in the body. By contrast a child who experiences his body as incongruous with his internal experience, and is repeatedly not related to by the primary object as a separate and intentional being with contingent marked mirroring, is at risk of developing an 'alien self'. This is a self-state based on the misattuned mental state in the parent **(Fonagy *et al.*, 2002)**. Through a process of introjection it becomes part of the core self structure yet remains alien to the child's authentic state. The breakdown in an early mirroring process of an experience of incongruity felt to be located in the body may help us to understand how the child is then exposed to an intolerable internal experience of feeling dissociated from the given body, which feels

[4] Approaching sexuality from the standpoint of attachment and mentalization Fonagy (**2006**, **2008**) underlines that: "A key facet of psychosexuality is a sense of incongruence with the infant's actual experience [that] disrupts the actual coherence of the self" (Fonagy, **2006**, p. 17). At the core of this view lies the difficulty the mother has in mirroring the infant's sexuality - an adaptive failure that structures psychosexuality, indelibly inscribing in the mind the need for an other who makes it possible to experience our sexuality through their elaboration of it.

'unreal' and remains unintegrated into a coherent experience of the self. This may then lead to the search for the 'right' body that is anticipated to guarantee relief from the pain of incongruity.

The Case of Ms A

Through the case of Ms A, with whom I worked once weekly, face-to-face, for five years, I want to illustrate the experience of incongruity and the failure of mirroring as reported by the patient in her early relationship and as it played out in the transference. I selectively focus on the importance of the visual relationship between the analyst and the transsexual patient to illustrate how the patient's physical presentation may be used to forcefully impress on the analyst the experience of something that is felt to be fundamentally 'alien' and incongruous at the level of the bodily self and how the analyst, in turn, needs to represent this experience in her mind so as to mirror it back to the patient before further explorations are possible such as work on unconscious conflicts.

Ms A was a MtF transsexual in her late 20s who was referred for help as part of her decision to seek SRS. At the time she was feeling depressed and suffered with panic attacks associated with being in outside spaces. By the time I met her she had been living as a woman for over two years. Her physical presentation was the first thing that hit me. I use the word 'hit' advisedly to denote a powerful visual

dynamic that is present in this work. Interestingly, in the service of passing, and hence accompanied by the need to 'edit' the given body, many transsexuals often adopt a caricatured/stereotyped 'feminine' or 'masculine' look that tends to result in an outward appearance that does the opposite of what it is consciously intended to do[5]: it actively *draws attention to* an incongruity between the biologically assigned gender and the gender of identification. The 'excess' it betrays struck me forcefully with Ms A, as it has done in other cases, as if a possible (unconscious) function of this incongruous visual presentation[6] was precisely to draw my gaze towards the self's condition of incongruity, to take it in and digest it for her.

An only child, Ms A's early life was a miserable experience punctuated by frequent and at times violent rows between her parents, both of whom appeared to have been emotionally unavailable. Her mother had severe problems with alcohol. Her father was described as a distant, irascible man who died in her late adolescence. Neither parent was felt to have been physically affectionate.

She recalled dressing up in her mother's clothes from about the age of 4. She said she could identify the moment when it became clear to her that she was a 'girl' around the age of 5. Her cross-dressing remained a largely secret activity in which she often indulged when her mother was asleep after her frequent alcoholic binges. This activity was comforting but she denied any sexual arousal associated with it. I gained the impression that at times the

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[5] I am referring here specifically to the choice of clothes and the way makeup is used.

[6] I say this because not all transsexuals present in this more exaggerated manner.

cross-dressing had functioned as an attempt to create on her skin the loving touch of a fantasized mother, which replaced the actual mother who would not touch her.[7]

Ms A told me that her mother did see her cross-dressing a few times and she recalled that the mother seemingly ignored this. However, she also related one instance when her mother saw her, aged 6, wearing her clothes, told her she looked 'ridiculous' and laughed. Ms A recalled feeling very ashamed of her body.

Whatever her actual mother may or may not have done, the mother was felt internally by Ms A either to have not responded at all to her perception of an incongruence between her expectation of what Ms A should look like and Ms A's experience of her own body or to have actively ridiculed her when faced with this incongruence. This left Ms A not only filled with shame, but also with an unmetabolized experience of a profound incongruity at the level of her bodily self.

As I listened to these accounts I obviously had no access to external information that would allow me to corroborate them so my focus was on what they conveyed about Ms A.'s internal world. I was struck by the painful misattunement reported by Ms A in her exchanges with her mother which resonated countertransferentially with the way in which I felt unusually conscious of how I looked at her and of the words I used, as if not taking her in with my gaze or understanding her would be catastrophic.

Ms A recalled always feeling at odds in her given body. She had felt estranged from it, as if it "belonged to someone else". She did not "hate" her male body but neither did she feel at home in it. At school she had been drawn to friendships with girls and disliked playing with boys. As she grew older she felt that she was going to "explode" under the pressure of the reality she had to conceal from all: she felt she was a woman in a man's body. At 18, shortly after the father's death, she left home. She remained thereafter in sporadic contact with her mother.

Ms A was ill at ease in her body which tragically looked as if it belonged to someone else because her visual presentation jarred: she wore very short skirts that exposed her very athletic and unmistakable 'masculine' physique. Her breasts, enhanced by hormone treatment and other aids, were very much 'on display' but looked incongruous with the rest of her body. There was nothing sexual in her presentation. Rather, her body felt shut down, turned away from anything alive, like a ghost dressed up with nowhere to go. I understood this to be, at least in part, a consequence of a lack of early bodily cathexis by either parent leaving Ms A without recourse to an experience of a desiring gaze or touch directed towards her that could provide a bridge for the organization of her own pleasure in her body and the elaboration of her sexual desire.

As these sessions were face-to-face I sensed that a great deal was communicated and enacted between us through our respective gazes. For my part I had to take note of how I would look at her: I found her incongruous physicality hard to take in. At times I found myself exposed to something more

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[7] Ferenczi indeed noted how bodily self-stimulation could be understood as a substitute "on one's own body for the lost object" (**1938**, pp. 23-4).

forceful in the way she presented herself to me and looked at me, as if I was being made to look at the damage imprinted on a body that felt alien to her and that I, in turn, experienced as very 'other' to me. In truth I struggled to take her in visually and not infrequently I found myself wishing she were lying on the couch and not sitting opposite me. It was important to take note of this powerful countertransference reaction because it helped me to gain some understanding of that which could not yet be put into words between us.

Very quickly Ms A developed an intense transference towards me. She became preoccupied with the sessions and what was in my mind about her. She found the gaps between sessions very difficult but, as she was being seen in a publically funded service, she could not have more than once-weekly psychotherapy. In the early years I sensed her hunger, quite literally, for space in my mind. I took this up in the

transference on many occasions. Her response to transference interpretations during this stage was interesting and was itself a manifestation of this 'hunger': I felt that she settled into the intimacy and immediacy of a transference interpretation instead of being able to make use of it - the so-called 'here-and-now' became a comfortable, gratifying home that seemingly reassured her that we were very close only to then feel brutally ejected when the session ended.

Ms A often prefaced what she said with "I guess I'm not explaining this clearly" or "You won't understand this because I'm putting it so badly". Either way it seemed as though she felt she was communicating the incommunicable and I, in turn, would not understand her. Not infrequently I had the strong impression that we both 'talked' but never actually met. There was something rather sterile in our exchanges. It was only when I took her in visually, or when I became aware of her looking at me, that something more immediate, if disturbing, transpired. But it took time before we could 'look' together at the experience of looking and being looked at.

In the first year the transference was a rather idealized one during which time I often experienced her as wanting to fuse with me and effectively become me. This fantasy of becoming me was concretely actualized when she arrived for one of her sessions dressed in a manner that was evidently trying to copy one of my 'outfits'. Even her long hair had been styled like mine.[8] Over time we explored her imitation and appropriation of me in this very concrete manner. This led her to recount the long stretches of time when she was left alone in the house as a child with her inebriated mother, dressing up in her clothes, wearing her high heels, as if trying to conjure up an experience of closeness with her mother through imitating her - and quite literally stepping into her shoes.

However, there was another dimension to my experience of her imitating me that took us in a fruitful direction. The sight of Ms A wearing a copy of my outfit had a curiously disturbing impact on me. I found myself looking

[8] The psychological mechanism deployed here is what **Resnik (2001)** refers to as 'psychical transvestism': through projective identification the self acquires another person's bodily shape and character, dresses in someone else's clothing, and imitates their gestures and looks. It is a form of imitation that precedes identification and takes place primarily through vision **(Gaddini, 1969)**. Such imitations are phantasies of being or becoming the object through modification of one's own body.

at her, recognizing the vestiges of my outfit, but it now looked ill-fitting. I anxiously thought: "I don't look like *that*!" as if I needed to distance myself from what she was exposing. I also felt ridiculed through her impersonation of me - an experience perhaps not dissimilar to how she had felt when her mother laughed at the sight of her cross-dressing. In other words I reacted as if I was being misrepresented in some way, and shown a distorted and denigrated image of myself that I was struggling to take in because it felt alien: that was not how I saw myself or wanted to be seen.

As I reflected on this exchange I thought that Ms A had somehow turned the tables around and exposed me to an experience of not being accurately mirrored by her in my bodily state. It was not possible there and then to take this up because I needed time to really understand this. It also required repeated experiences of different kinds of misattunements in our relationship before we could find a language together for her experience of not feeling accurately mirrored by others and for feeling shamed.

This perspective was eventually helpful in also shedding light on her panic attacks and agoraphobia. Ms A subjectively experienced public spaces as a "hall of mirrors," as she put it. When outside her home she described feeling haunted by the prospect of catching sight of her reflection in shop windows or being looked at by other people. In those mirrors, she explained: "I look all wrong". At such times she described feeling dizzy, desperate to flee back to the safety of her dark flat. It was as if when in the grip of her panic attacks she entered a nightmarish experience of being forced to look at a body that did not hang together.[9] Outside spaces were seemingly equated with distorting reflective surfaces, perhaps not dissimilar to the inebriated eyes of her mother, or the absent eyes of her father, in which she could not find her self.

It became very important in our work to focus on her deep-seated expectation that her objects could not bear to look at her as she was and take in her experience of a 'bad fit' at the core of who she was - one that was visibly apparent in her bodily presentation. This understanding of the 'what' of her experience, as opposed to the 'why', is where much of our work resided to begin with.

In the two years leading up to surgery, during which time she was under the care of a specialist unit for transsexuals, we spent a long time thinking together about it through the transference experience. Ms A related to SRS as 'the' solution with a conviction that reinvigorated itself every time she experienced me as unavailable to her. In these moments we came to understand how the fantasy of the 'true' female body she would one day accede to became her way of reconciling herself to her separation from me, perhaps just as she had done as a young child when she repeatedly lost her mother to alcohol. At such times, in her mind, she comforted herself with the fantasy of giving birth to herself and inhabiting a body that was whole, self-sufficient

[9] I considered whether Ms A. might be suffering from Body Dysmorphic Disorder (BDD). This may well represent another group of individuals who present as transsexuals but are in fact better understood as suffering from BDD. However, it is important to note an important phenomenological distinction between the two, namely that in BDD the body part that needs excision is typically regarded as 'ugly', but this is not often so in transsexuals who tend to view the genitalia as incongruous with their gender identity or as 'not belonging' to them, but not necessarily as 'ugly' or flawed. Ms A did not see her given body as 'ugly'.

and a direct replica of an idealized maternal body and mind she felt deprived of - except in this fantasy the body became a 'copy without

originals' **(Baudrillard, 1988)** as the mother was effectively obliterated.

In this state of mind the given body became a ghost of a body that ceased to have any reality or origins: her penis was experienced then as an alien 'thing' that had nothing to do with her and needed to be cut off. By contrast her 'new' breasts became the reassurance that she needed no-one. The anticipated surgery ceased to function as potentially opening up the possibility of a better life more congruent with her subjective experience of herself, but became instead the means through which she enacted a profound grievance towards her mother.

The grievance she harboured was also aimed at a parental couple felt to have been wrapped up in violent fights that secured a physical closeness she felt deprived of. Interestingly, their fights were accompanied in her mind by a fantasy (but possibly also a reality) of an excited sexual reconciliation, which healed the fracture between them, leaving her alone with an experience of something in pieces inside that neither father nor mother had seemed able to help her with. This was painfully alive in the transference, especially during holiday breaks, when she imagined me having a good time with my family and dropping her from my mind.

Over the five years of our work together Ms A became more receptive to our explorations of her wish to effectively 'become me/mother' so that she could avoid the painful experience of separation, which felt to her like a traumatic expulsion from the mind of the other. However, this did not impact on her strong feeling that she was more at home in a woman's body and, I should add, it was never my therapeutic aim to change this. I considered my role to be that of helping her make sense of her experience.

After just over two years of therapy, Ms A underwent SRS. As the date approached she fluctuated between anxiety and mania. She anticipated how the surgery would finally lay to rest her experience of feeling at odds within herself and in her body. She imagined she could finally allow herself to have a sexual relationship because the body she would reveal to a partner would be the body she really was.

Post-surgery she experienced several physical complications, which led her to feel depressed and desperate that her body would never feel right. Once again, I became very aware of the visual relationship between us. I felt she needed me to take in with my eyes and mind this reconstructed body that she felt was still in pieces. It was as though she needed a witness to this process - one who was willing to look and not shame her. The castration she had effectively subjected herself to was hard for me to imagine and I felt she sensed this in me but, as she looked intensely at my face, I also felt the urgency with which she needed me to take in this reality.

Ms A was angry with the surgeon for doing a bad job: "I still look and feel wrong," she would say with some reproach. She was painfully aware that, even though she no longer had a penis and had a reconstructed vagina, she still looked more masculine than she wished. This proved to be a very painful time but it was essential for Ms A to face the decimation of the fantasy that SRS would take away the pain so concretely located in her body.

A dream she reported around this time involved *buying a large antique mirror, which she carefully hung above her mantelpiece. During the night it fell and shattered into pieces.* We came to understand this dream as a communication to me about how she looked into my eyes for a mirror that would reflect her back whole and reassure her that surgery had done the trick, but each time she looked she felt she could only see herself still in pieces. I was intrigued by the 'antique' nature of the mirror. I took up with her how this might express a wish for me to reflect back her 'old' body too, to keep it in mind that is, when she struggled to do so because her body and its history were still a part of her. Ms A became tearful and said that she could not bear to look at any old photos. She then composed herself and in a very detached manner said that she was toying with the idea of shredding them. I said that she was letting me know how hard it was to remain connected with her 'old' body and that she now wanted to literally tear to shreds my interpretation, which had perhaps felt like me forcefully exposing her to the reality of her old body and the pain that she carried inside her and which she had hoped the surgery would 'cut out'. I also thought, but did not interpret this at this time because I did not think she was in any state to take this in, that she recognized the violence she had inflicted on her body - that she had literally 'shredded' it through SRS - but that to acknowledge this now left her feeling in pieces again.

Recognizing the 'original' body is important psychically. The transsexual feels that s/he is not inhabiting the 'true' body and responds to this experience by developing a parallel body image. In turn this needs to be actualized because it is invested with the power to bring greater cohesion and relief. But this 'new' edited body is *always* a reconstructed body with a history. This is the area that requires considerable and painful psychic work. We can add breasts where there were once none, we can take away a penis where there was once one, but it is impossible to obtain the original genitalia of the opposite sex, that is the acquired genital, and hence the 'new' body is always in the wake of a body that once was. What can be achieved through SRS is a closer alignment between the outward appearance with inner experience. This undoubtedly brings relief to some transsexuals - I have no doubt of that - and makes a difference to their quality of life, but history and hence loss cannot be bypassed without psychic consequences (Quinodoz, **1998**, **2002**). How this treacherous internal course is negotiated makes a significant difference to post-operative adjustment. Pursuing surgery may be the only way to live, but the state of mind one has in relation to the surgery and what it can deliver is crucial to the quality of relationships the individual can then establish through the newly reconstructed body.[10]

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[10] The transsexual's relationship to sexual difference also represents an important dimension of their experience. It is beyond the scope of this paper to develop this theme. However, it deserves some mention because the reality of sexual difference and the meaning this acquires in the patient's experience will be an ever-present preoccupation for both patient and analyst in this kind of work. Being sexuated means biologically differentiated not at the level of the genitals *per se,* which can be grafted on or removed at will, but in terms of the biological function of the 'original' genital. We are 'sexed around reproduction' **(Mitchell, 2004)** - this is a fact. The painful reality for the transsexual who undergoes SRS is that they become biologically castrated. The traumatic realization that one cannot give birth or contribute to the biological creation of a child has to be managed internally and requires a process of mourning.

In the wake of the disappointment about the surgery it was important to think together about her experience that I had what she wanted and that I had kept it all for myself. At first I took this up in terms of me being the woman she wished to be, but I realized eventually that this was not right: my sex and my gender were red herrings. What Ms A envied most was her perception that I inhabited a desired body and that could desire. Indeed she spoke about her perception of me as "alive" and at ease in myself. These sessions heralded a slow and gradual shift in her state of mind towards what we could regard as more depressive functioning.

This development was apparent some months later when in an important and spontaneous gesture she brought photos of herself as a boy to show me how uncomfortable she had looked in this "old" body. I thought that, as well as trying to reassure herself that she had done the right thing by pursuing surgery, she was also beginning to *look* at a ghostly part of her, as captured in these images of her body from childhood, which was still within her despite the SRS. This helped us understand that part of her adaptation to her post-surgery body could only succeed if *she* was able to look and take in the male body she once inhabited and what it was consciously and unconsciously associated with in her mind.

A year post SRS Ms A began a sexual relationship, the first in over 10 years, with a man who appeared troubled but who was loving towards her. There was respect for the otherness of the other. She was able to tell him her story and felt accepted by him. She slowly started to come to life and relate to her body as a potential source of pleasure. Inevitably perhaps given her early history, she remained sensitive to slights from others and could easily feel shamed, but she could also understand this better in herself. Her panic attacks significantly subsided and she obtained work. It seemed as if her body not only in the context of her new relationship, but also more generally in her experience of herself in the open spaces of life that she had once so feared, was one of greater potentiality. Significantly, she started to wear clothes that were better fitting to her actual physique thereby diminishing the earlier visual incongruity I remarked upon. I began to discern feminine contours in her appearance alongside her more masculine features that somehow looked more of a piece than at odds with each other. When we ended our work Ms A remained clear that SRS had been the right thing for her and that therapy had helped her to "come to terms" with who she was.

Reflections on the Case of Ms A and Beyond

As I reflect on the experience of working with Ms A and what helped her, I consider that what may have made some difference to her adjustment was the experience of 'being seen' as she was and to experience her incongruous body and fragmented self represented in my mind. This helped her slowly to feel more coherent within herself and, as this stabilized, she was able to become more emotionally connected with the losses associated with the decision to pursue SRS even though she did not regret it. However, it was important too for her to be in a relationship with an analyst who not only

mirrored back this experience and contained it, but who could also hold in mind the hatred she felt towards her objects and her attacks on the object via the body.

Analytic work with transsexual patients raises a number of questions. I will selectively and briefly focus on two areas, namely considerations about aetiology and the impact of face-to-face work with these patients.

Pathways to Transsexuality

In some cases of transsexuality, as I hope I have illustrated through my work with Ms A, we can discern in the patient's history, and in what is elaborated in the transference, developmental experiences that might account for how a cross-gender identification evolves and its defensive functions. In this paper I have selectively focused on early mirroring of body states as crucial in the development of a coherent sense of self.

The primary object's capacity to mirror the child's experience has long been recognized within psychoanalysis as a vital factor in determining the quality of internalized object relationships. **Winnicott (1956)** proposed that, when the baby looks at the mother, what he sees in the mother's expression is his own self-state. Here the mother's mirroring function is seen as essential for the establishment of the baby's self-representation. From a different angle **Bion (1967)** effectively elaborates on the function of mirroring by emphasizing the developmental importance of an actual mother capable of absorbing (i.e. containing) *and* retransmitting the infant's psychological experience in a metabolized form thus supporting the gradual internalization of a thinking function.

Winnicott's and Bion's theories underline respectively the importance of mirroring and transformation of the child's experience as mediated by the primary object's capacity to accurately reflect the child's internal experience[11] whilst indicating clearly that s/he has a different experience (i.e. the mirroring is 'marked'). This process facilitates the 'mentalization' of experience **(Fonagy and Target, 2000)**. This line of thinking represents a point of convergence between psychoanalysis and contemporary elaborations of attachment theory and mentalization, notwithstanding their different epistemic assumptions **(Fonagy, 1999)**.

In Ms A's case her parents failed not only to mirror back her experience of incongruity at the core of her subjective bodily experience and gender identity but in a more general sense they also failed to mirror her emotional life. However, in the transference it was her bodily experience and appearance that I felt she needed me to look at with urgency and to represent in my mind, which is why I have focused on it in this paper. In proposing a failure of mirroring as central to understanding Ms A's transsexuality I have in mind the impact of repeated experiences of feeling "not right in my body," which remain unprocessed and hence become concretized in the body.

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[11] I want to stress here that this includes mirroring of the somatic reactivity and excitability stimulated by early physical exchanges between mother and baby.

Projective identifications into the child's body by the parent(s) or the parent's inability to mirror a child's experience of their body state may contribute to developmental distortions that can manifest clinically as disturbances in sexual development and gender identification. If we are to understand these clinical presentations we need to take into account not only the projective processes that underlie the way the body and gender as perceived and experienced by the parent is mirrored back to child, but also how the introjection of these experiences involves varying degrees of distortion and idiosyncratic elaboration. Ms A had unconsciously identified with a ridiculing, distorting object and this became apparent in the transference when she arrived wearing a facsimile of my outfit.

A focus on mirroring emphasizes the developmental importance of real-life relationships. However, such a relational focus is not psychoanalytic unless we also consider the role of unconscious phantasy and conflict in the development of the mind. Nowhere is this more important than in relation to an understanding of sexuality and gender identifications. Sexuality is not simply an instinct and behaviour as **Bowlby (1969)** acknowledged; it also organizes intrapsychic experience and phantasy. In other words, early attachment relations provide the interpersonal context within which the experience of embodiment, and hence of our sexuality, unfolds (**Diamond and Blatt, 2007**; **Schilder, 1950**; **Weinstein, 2007**) and infantile sexuality is in turn shaped by these interactions (i.e. external experience with others is relived as autoerotic activity). In our work with transsexual patients we need to understand not only the patient's experience of *sexuality in infancy* but also their idiosyncratic *infantile sexuality,* the residues of which are to be found in the unconscious **(Scarfone, 2002)**. In a once-weekly psychotherapy it was not possible to delve deeply into this latter level of experience.

Additionally, it is also important to incorporate into our analytic formulations the systemic cultural forces that frame the experience and expression of sexuality and gender (**Benjamin, 1998**; **Dimen, 1991**; Goldner, **1991**, **2011**; **Harris, 1991**; **2011**; **Suchet, 2011**) so as to challenge more simplistic equations of biological sex, gender and sexual desire (Butler, **1998**, **2003**; **Foucault, 1976**). Approaching transsexuality thus requires a wide-angled lens so as to formulate the interpersonal, intrapsychic and systemic processes that give rise to a highly idiosyncratic experience of the child's gendered embodiment.

In Ms A's case it is impossible to know with any certainty whether her early feeling that she was a woman in a man's body is best explained with reference to biological and/or psychological factors. In her particular case a psychogenic account of her difficulties is compelling given the early history of emotional deprivation and especially the way the 'absence' of her mother, and the hatred for her father who had abandoned her to this fate, appeared to have been managed through a feminine identification that supported a fantasy of symbiotic fusion with the mother (Ovesey and Person, 1973) and obliterated the father.

In other cases it proves harder to identify a deficit or trauma in early childhood. In such instances we need to remain open to the possibility that

there may be biological factors that influence the cross-gender identification.[12] This is not to say that such factors, even when present, operate independently of either psychology or social forces.

The Body in the Consulting Room

My work with Ms A was carried out face-to-face, which represents a departure from a more classical clinical setting. Whilst this way of working imposes a range of restrictions and demands on both patient and analyst, it may also afford important insights because it engages us in considering the reciprocal visual impact of patient and analyst on one another (e.g. **Peringer, 2006**; Steiner, **2004**, **2006**; **Wright, 1991**) in a sustained manner and not only at the beginning and end of sessions.

With Ms A I was struck by the impact of her visual presentation on me and especially of how her detailed descriptions of SRS affected me as I processed them in my mind *whilst she looked at me.* Not infrequently as Ms A inched closer to the day of her surgery, I felt as if I was being forcefully made to look, there and then, at a body part that needed to be edited out as if she really needed me to conjure up this disturbing image in my mind, to really 'look' at it, whilst I was still looking at her so that she could quite literally look at my face. I thought she needed to see not only that I could understand how trapped she felt in her male body but also to help her to see that what she was doing was indeed deeply disturbing. In other words, whilst mirroring of her subjective experience was important, it was also vital that she could see that I also had my own perspective on this which was different from hers - a perspective that eventually, albeit only after the SRS, helped her to connect with the loss that ravaged her life.

With some patients the enactments that play out around the gazing relationship provide important inroads into understanding the use made of the body in the transference and their experience of the gazing relationship. In my experience, for some of these patients, the use of the couch may be unhelpful primarily because it bypasses the visual field and the conflicts that are encapsulated through the sustained meeting of the two gazes.

Work with these individuals requires a particular attunement to the body self and to the bodily countertransference so that it becomes possible to construct "a language to enable corporeity to speak" (Lombardi, **2009**, p. 370). It is, of course, vital not to shame the patient by exposing prematurely, through the verbal medium, what the body silently yet forcefully expresses.

Conclusions

Although transsexuality is often conceptualized as if it were a unitary 'condition' afflicting a homogeneous group of individuals, it would be more correct to refer to transsexuali*ties* to capture the heterogeneity of pathways to,

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[12] As with analytic hypotheses, there is *some* evidence for biological ones (**Garcia-Falgueras and Swaab, 2008**; **Zhou, Hoffman and Swaab, 1995**) but this is by no means a consistent finding or the findings are themselves limited in a number of respects (for critiques, see **Chung, De Vries and Swaab, 2002**; **Hulshoff *et al.*, 2006**; **Nieder and Richter-Appelt, 2009**).

and of the functions of, a transsexual identity and the body modifications it can entail. In light of this heterogeneity the analyst may need to approach transsexual experience through a range of theories that tune into different dynamics, which will be more or less salient for understanding a given patient.

In this paper I have suggested that transsexual experience may be in some cases approached not simply as a matter of gender and sexuality but as a disruption in identity coherence. I have focused in particular on the transsexual's experience of incongruity suggesting that an unmentalized incongruity experienced at the level of the body-self may contribute, in some instances of transsexuality, to the search for the 'right' body that will relieve the incongruity through the certainty it imparts that the image in the mirror (literally and metaphorically) will match the subjective experience of the body. The search is fundamentally for the receptive mind of the other through a modified body anticipated to 'guarantee' relief from the incongruity.

A focus on the relevance of an intersubjective mirroring process in relation to body states, and as one of the foundations for the development of identity, provides another lens through which it may be possible to approach the transsexual's experience in the transference-countertransference matrix. However, I would like to suggest that marked and contingent mirroring of the self's bodily experience is most likely, for us all, a vitally important feature of the development of a coherent sense of self firmly rooted in the body.

Translations of Summary

Der Körper, den man hat, und der Körper, der man ist: Zum Verständnis des Bedürfnisses des Transsexuellen, gesehen zu werden. Die Autorin dieses Beitrags vertritt die These, dass die Konzentration auf das subjektive Erleben von Verkörperung und "Gesehen-Werden" ergänzend zu der in der Literatur ausführlich behandelten Perspektive von Gender und Sexualität einen weiteren Zugang zum Erleben transsexueller Menschen erschließt. Sie erläutert, dass Transsexuelle aus biologischen und/oder psychischen Gründen schon früh eine tiefe, verstörende Inkongruenz auf der Ebene des Körperselbst erleben. Diese Inkongruenzerfahrung wird in manchen Fällen von den Bezugspersonen nicht kontingent gespiegelt; infolgedessen bleibt sie unmentalisiert und beeinträchtigt die Kohärenz des Selbst. In dem Versuch, eine Selbstkohärenz herzustellen, suchen diese Individuen nach dem "richtigen" Körper, der die subjektiv erlebte Inkongruenz aufhebt. Der modifizierte Körper soll die Gewissheit vermitteln, dass das Bild im "Spiegel" der subjektiven Körperwahrnehmung entsprechen wird. Die Suche gilt letztlich der rezeptiven Psyche des/der Anderen durch einen modifizierten Körper, der die Beseitigung der Inkongruenz zu "garantieren" scheint. Illustriert wird diese Dynamik durch die klinische Arbeit mit einer Mannzu-Frau-Transsexuellen, die sich während ihrer fünfjährigen Psychotherapie operieren ließ. Die Autorin vertritt die Ansicht, dass die post-operative Anpassung auf der Fähigkeit der Patientin/des Patienten beruht, zu dem "alten," neben dem "neuen" rekonstruierten Körper bestehenden Gespenst des Körpers Verbindung aufzunehmen und sich mit ihm auseinanderzusetzen.

El cuerpo que uno tiene y el cuerpo que uno es. Hacia una comprensión de la necesidad del transexual de que lo vean. En este trabajo, la autora sugiere que centrarse en la experiencia subjetiva de la encarnación y de 'ser visto' brinda otra lente a través de la cual explorar la experiencia transexual, diferente de la perspectiva de género y de la sexualidad que ha sido tan bien desarrollada en la literatura. La autora propone que, por razones biológicas y/o psicológicas, los individuos transexuales experimentan desde temprano una profunda y perturbadora incongruencia en el nivel del *self* corporal. Para algunos de ellos, la experiencia de incongruencia no es reflejada contingentemente por sus cuidadores, sino que permanece sin mentalizar y afecta la auto-coherencia. En un esfuerzo por recuperar esta última, estos individuos buscan el cuerpo 'justo' que alivie la incongruencia que sienten. El cuerpo modificado lo logra impartiendo la certeza de que la imagen en el 'espejo' se corresponderá con la experiencia subjetiva del cuerpo. La búsqueda es, fundamentalmente, la de una mente receptiva en el otro a través de un cuerpo transformado que, según las expectativas, 'garantizará' el alivio de la percepción de discordancia. Esta

dinámica se ilustra con el relato del trabajo clínico con un transexual de masculino a femenino (MaF) que se sometió a la cirugía durante sus cinco años de psicoterapia. La autora sugiere que cuando estos pacientes deciden operarse, su adaptación postoperatoria depende de su capacidad para acercarse, en su mente, al 'viejo' fantasma de su cuerpo junto al 'nuevo' cuerpo reconstruido.

Le corps que l'on a et le corps que l'on est: comprendre le besoin d'être vu du transsexuel. L'auteur de cet article propose d'aborder l'expérience du transsexuel à partir du vécu subjectif de la corporéité et du besoin d'«être vu," ce point de vue venant compléter la perspective du genre et de la sexualité amplement développée dans la littérature. L'auteur suggère l'idée que, pour des raisons biologiques et/ou psychologiques, les individus transsexuels éprouvent précocement une incongruité profonde et bouleversante au niveau de leur soi corporel. Chez certains transsexuels, l'éprouvé de cette incongruité n'est pas tributaire du miroir que renvoie ceux qui lui prodiguent des soins: elle demeure non mentalisée et bouleverse leur sentiment de cohésion de soi. Dans une tentative de restaurer cette cohésion de soi, ces individus sont à la recherche d'un corps «juste» qui puisse remédier à leur sentiment d'incongruité. Ce corps modifié

remédie au sentiment d'incongruité en apportant la garantie que le corps dans le «miroir» correspondra à l'expérience corporelle subjective. Cette quête vise essentiellement la reconnaissance du regard d'autrui à travers un corps dont la modification est perçue à l'avance comme la «garantie» d'un remède à l'incongruité. Cette dynamique est illustrée par la présentation clinique d'un patient transsexuel ayant subi une opération chirurgicale - dans le sens homme-femme, au cours d'une psychothérapie poursuivie pendant cinq ans. L'auteur suggère l'idée que dans le cas d'une intervention chirurgicale, l'ajustement post-opératoire dépend de la capacité psychique du patient d'approcher «l'ancien» fantôme de son corps en même temps que son «nouveau» corps reconstruit.

Il corpo che abbiamo e il corpo che siamo. Come comprendere il bisogno del transessuale di essere visto. In questo articolo l'autore propone che il mettere a fuoco l'esperienza soggettiva di prendere corpo e di 'essere visti' permette una lente alternativa per avvicinarsi all'esperienza del transessuale, oltre a fornire la prospettiva sul sesso e la sessualità sviluppatasi nella letteratura intorno a questo campo. L'autore propone che, per ragioni biologiche o psicologiche, gli individui transessuali provano fin dall'infanzia un'incongruenza profonda e disturbante al livello dell'io corporeo. Per alcuni transessuali l'esperienza dell'incongruenza non viene riflettuta in maniera occasionale da chi li segue: rimane non mentalizzata e spezza la coesione dell'io. In un tentativo di ristabilire il senso di coesione dell'io, questi individui cercano il corpo 'giusto' per liberarsi da questo senso di incongruenza. Il modo in cui la modificazione del corpo riesce a liberarli dall'incongruenza avviene mediante la certezza ottenuta che l'immagine nello 'specchio' riflette l'esperienza soggettiva del corpo. L'oggetto della ricerca è fondamentalmente la mente ricettiva dell'altro, attraverso una modificazione del corpo che crea l'aspettativa di una 'garanzia' di liberazione dall'incongruenza. Queste dinamiche sono illustrate da un resoconto di un lavoro clinico con un transessuale maschio, divenuto femmina (MtF), che si e'sottoposta a interventi chirurgici durante cinque anni di psicoterapia. L'autore propone che, quando vengono richiesti ed eseguiti interventi chirurgici, l'adattamento che segue alle operazioni dipende dalla capacità del paziente ad avvicinarsi mentalmente al 'vecchio fantasma' del corpo contemporaneamente al 'nuovo' corpo ricostruito.

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