UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Psychotherapists' experiences of working with somatic phenomena in the therapeutic setting when treating clients with gender-related body dysphoria

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A research project submitted in partial fulfilment of the requirements for the degree of MA by Coursework and Research Report in the field of Clinical Psychology in the Faculty of Humanities at the University of the Witwatersrand, Johannesburg. 2022

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT
PSYCHOLOGY

Declaration:

A research project submitted in partial fulfilment of the requirements for the degree of MA by Coursework and Research Report in the field of Clinical Psychology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg, Republic of South Africa, 13th November 2023.

I declare that this research project is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university.

SIGNED:

David Coleman

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DATE:

13th November 2023

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Word Count:

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ABSTRACT

This study explored psychotherapists' experiences of somatic phenomena, in relation to their own bodies, when treating clients with significant gender-related body dysphoria within the treatment setting. It also examined their experiences and deeper understandings of somatic transference and countertransference within the analytic frame when working with this particular client profile. The various resistance mechanisms deployed by such clients were also explored as well as the ways in which psychotherapists may be resistant to working more closely with their own somatic countertransference. A qualitative approach to research was in order to generate meaning and understanding through rich material. An interpretivist paradigm was employed whose ontology examines the perceptions and experiences of therapists who have treated clients with significant gender-related body dysphoria. Therapists' experiences of somatic countertransference phenomena were varied and inconsistent. More than half of the therapists reported the experiencing of sensations including nausea, headaches, restriction of the chest and experiences of drowsiness. Some therapists could not recall any experiences of somatic countertransference and demonstrated a tendency to minimize, deny or disavow somatic phenomena.

Keywords: somatic countertransference, transference, transgender, gender-related body dysphoria

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OVERVIEW

A STORM IS BREWING

An increasing number of people are nowadays variously identifying as transgender, non-binary, or gender-fluid, and many are employing a host of newly crafted and creative terms to define their gendered identities. With an emerging societal embrace of gender diversity, conceptualizations of gender are radically shifting and there are more insistent demands for equal rights for gender diverse individuals. As demonstrated by recent sociological and public health research, there has been an abrupt surge of diverse gender identities, and the range of non-normative gender designations has proliferated.

Over 1.6 million adults (aged 18 and older) and youth (aged 13-17) presently identify as transgender in the United States according to research conducted by the Williams Institute, UCLA School of Law. Among American adults, 0.5% (approx. 1.3 million adults) identify as transgender. Among American youth, aged between 13 and 17, 1.4% (approx. 300,000 youth) identify as transgender (Herman et al., 2022).

New estimates, based on the Centers for Disease Control and Prevention (CDC) health surveys, underscore a stark generational shift in the growth of the transgender population of the United States, revealing that the number of young people identifying as transgender has nearly doubled in recent years. Each year since 2010, the Gender Identity Development Service (GIDS) in London has reported a 50% increase in the number of children presenting with gender issues so, empirically, it appears that this pervasive trend is global. This explosion in numbers, as well as the emergence of Rapid Onset Gender Dysphoria (ROGD) as a clinical subgroup of transgender youth, indicates a cultural phenomenon of enormous importance (Bell, 2021; Tanner, 2019).

Accordingly, psychoanalysis is now compelled to grapple with new concerns, as an increasing number of clients, especially children and young adolescents, arrive into the psychotherapeutic space with precise and pressing demands to be supported through their gender transition.

In the midst of such turbulent and frenetic times, is there a space for transformation within the discipline of psychoanalysis?

CHAPTER 1: INTRODUCTION

1.1 Research Title

Psychotherapists'[1] experiences of working with somatic phenomena in the therapeutic setting when treating clients with gender-related body dysphoria.

1.2 Research Rationale

The relationship between the psyche and soma has been extensively explored in psychoanalytic[2] research and as a result a body's subjectivity is considered to have a developmental history in its own right and is no longer regarded as simply a depository for unwanted contents of the mind (Freud, 1920; 1923; Harris, 1996; Klopstech, 2009; Lemma, 2010; 2016; 2018; 2020). Moreover, the shift within psychoanalysis from classical ego psychology towards a more relational or intersubjective perspective has brought the body inexorably into the foreground wherein both the client's body and the therapist's body are deemed to constitute the relational body intersubjectively intertwined. As a result, the traditional focus on the somewhat mechanistic and overly objective view of the characterological body has shifted to the bodily subjective experience in the somatic interaction within the therapy dyad (Booth et al., 2010; Kloptech, 2009; Lemma, 2018; Music, 2015; Stone, 2006).

There has been a growing sense of the significance and clinical utility of bodily phenomena, including the concept of somatic countertransference in verbal, nonbody-oriented psychotherapies, and its contribution to informing 'meaning' constructions which yield deeper empathetic understandings of clients. Additionally, the concept of an *embodied setting* has been refined, latterly, to include the analyst's own *internal setting* which exists internally as a structure in the mind of the analyst, the primary custodian of the analytic setting. Various accounts of the process of somatic countertransference have utilised the metaphor of the therapist as a pseudo "tuning fork" (Stone, 2006, p. 109) unconsciously vibrating to the frequency of the client's psychic material. Other authors

[1] For the purposes of this research the terms 'therapist', 'psychotherapist', 'analyst', 'psychoanalyst' and 'practitioner' will be used interchangeably; correspondingly, the terms 'client', 'patient' and 'analysand' will also be used interchangeably.

[2] Throughout this study the terms 'therapy, 'psychotherapy', 'psychology', and 'psychoanalysis' will be used interchangeably.

have reported an inverse sense of therapeutic *discomfort* surrounding emerging or inchoate bodily phenomena within the analytic frame, where interpretation occurs in limited or predictable ways, and therapeutic attentiveness to broad gestural expressions, other than facial, tends to be deemed primitive and regressive (Bady, 1984; Booth et al., 2010; Kloptech, 2009; Lemma, 2018; Paniagua & Hartmann, 2004; Stone, 2006).

The majority of prior studies into somatic countertransference have tended to focus on therapists' experiences of working exclusively with trauma victims. However, there has been an evident paucity of psychoanalytic research and literature concerning the phenomenon when working with clients presenting for treatment with marked symptoms pertaining to either gender dysphoria and/or body dysmorphia (Booth et al., 2010; Forester, 2007; Hunt et al., 2018; Quillman, 2013; Lemma, 2018). An exploratory study of a sample of Irish clinical psychologists, which used a body-centred countertransference scale to assess the frequency of body-centred countertransference, reported that 70% of respondents experienced muscle tension and sleepiness as the most common forms of body-centred countertransference with other forms including unexpected bodily shifts, tearfulness, yawning, headaches, genital pain, sexual arousal, nausea and numbness (Booth et al., 2010). A study by Egan and Carr (2008) found that 83% of their sample of trauma therapists had also experienced muscle tension in the previous six months.

Many authors, including Evzonas (2020, 2022), Glocer-Fiorini (2022) and Harris (2022), have explored somatic phenomena, within case material, when treating gender dysphoric clients; these are clients who experience a marked incongruence between their experienced or expressed gender and the gender which they were assigned at birth (Sadock et al., 2015). This literature has reported that psychotherapists routinely wrestle with deeply troubling feelings of hate and disgust towards their own bodies, can oftentimes develop fears relating to lost or severed limbs or have experiences wherein they become "situationally ill" (Connolly, 2013; Langer, 2016; Marcus & McNamara, 2012; Ross, 2000; Winograd, 2014). It has also been argued that such therapists are liable to obviate or obliterate the dangers of "countertransferential horror" owing to gender variance or gender unease by enforcing rigid gender norms within the analytic frame (Marcus & McNamara, 2012, p. 53). Beyond these studies, there is a conspicuous research gap within the field of psychology, pertaining specifically to therapeutic experiences of somatic countertransference when working therapeutically with body dysmorphic clients. Existing studies, examining transgender people's negative experiences of treatment, have variously cited therapeutic hostility, a distinct lack of

competency, the imposition by therapists of strict gender identities, and a pronounced emphasis on eliminating pathology as experiences most commonly disclosed (Hunt, 2014). Psychology literature has consistently posited that the body of the analyst will inevitably and ineluctably feature in clinical treatment, as an invariant, embodied aspect of the setting, whilst working with clients whose body is the primary medium for unconscious communication (Harris, 2011; Lemma, 2006; 2008; 2009; 2010; 2015; 2016; 2018; 2020; Marcus & McNamara, 2012; Saketopoulou, 2014). This paper aims to explore whether working with transgender bodies or with gender-variant clients arouses specific countertransference experiences for therapists and whether such reactions can be ascribed to either the subjective or the collective.

Within South Africa a qualitative study (2017) of *social-service* therapist-practitioners which explored experiences of their own lived bodies in the context of practice, indubitably acknowledged the phenomenon of embodied self-awareness and various experiences of bodily-felt sensations. Notwithstanding the therapist-practitioners referring to an intuitive knowing and a sense of the body-schema-in-relation, they disclosed a marked tendency to deny, suppress, or control their sensory cues or to rationalise them (Potgieter & Bloem, 2017). Accordingly, conducting such pertinent research can lead to deeper awareness and understanding of the various therapeutic implications, including recommended practices, when working with bodily phenomena in the analytic setting (Lemma, 2010; 2015; 2016; 2018; 2020).

Research has variously reported somatic feelings of intrusiveness and hostility when treating clients who unconsciously need to create a symbiotic object fusion with the analyst in order to maintain psychic equilibrium (Lemma, 2010; Orbach, 2005; Willemsen, 2014). Existing research has urged caution against therapists interpreting somatic phenomena defensively, by enacting interpretations as a means of concealment, arguing that therapeutic work may be acutely compromised in instances where psychosomatic phenomena becomes undermined or ignored (Athanasiadou & Halewood, 2011; Lemma, 2020). Moreover, Forester (2007), who specifically reflects upon the phenomena of ‘kinesthetic empathy’ or ‘mimesis’, two forms of empathic physiological response, has explained that a capacity for reflective awareness upon countertransferential experiences, without preemptively reacting, labeling, denying, or censoring them, can actually enhance therapy. Conversely, not attending to and processing somatic phenomena, whether through dissociation or neglect, can potentially derail therapy and lead to clinical ignorance and errors. Given that the existing literature signals strong countertransferential responses to patients, and indicates a potential

bifurcation in treatment outcomes relative to therapists' handling of somatic countertransferential experiences, this is a relevant and timely area for further exploration.

1.3 Research Aims

This primary aim of this exploratory research is to investigate therapists' experiences, within the analytic setting, of somatic phenomena in their own bodies, when working with trans-identified and/or gender nonconforming patients.

The secondary aim of the study is to examine therapists' understandings of those experiences of somatic transferential and countertransferential phenomena in the treatment setting. It will also examine therapists' experiences and understandings of defensive resistance in the therapeutic encounter.

1.4 Structure of the Research

The research report comprises five chapters. A summary of the chapters will be outlined below which will assist in providing an overview of the research considerations:

Chapter 1 explains the primary and secondary aims of the study and offers a specific rationale for undertaking the research. It will also identify some gaps which the research intends to fill.

Chapter 2 presents a review of the existing literature and theoretical overview. The literature review will critically evaluate existing research relating to the research topic. The theoretical overview section has been integrated with the literature review section in order to avoid unnecessary repetition.

Chapter 3 outlines the research questions and the particular research design employed. This chapter will examine the theoretical framework and explain how the sample was sourced and the data analysed.

Chapter 4 includes the research findings and presents a discussion of the various themes which emerged. The findings and ensuing discussion have been integrated for each of the distinct themes.

Chapter 5 concludes the research study. It will address the limitations of the research and specify some recommendations for future research.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL OVERVIEW

The discussion will commence with an exploration of the embodied experience from a developmental and clinical perspective. Theoretical understandings relating to the body in psychoanalysis will follow in a separate section. Literature pertaining to trans-subjectivities and their effects on countertransferential reactions will be examined. This will be followed with a review of the utility of countertransference in the clinical setting, including the various challenges. The general treatment of gender diversity within psychoanalysis will be critiqued and will be followed by an exploration of how gender diversity specifically manifests within the clinical setting. Finally, the role of the 'Other' in the development of gender identity will be discussed. In the interests of avoiding unnecessary repetition the literature review and theoretical framework sections have been integrated. Accordingly, concepts of the body, transference and countertransference, and gender, as conceptualised in psychoanalytic theory, have been explored from the standpoint of ego psychology, through object relations theory and to current intersubjective understandings.

2.1 Embodied Experiencing

The mind and body are inseparable and the notion that the mind cannot be conceived without a sense of embodiment has been espoused by many, most notably Freud (Freud, 1920; 1923). The ego was conceptualised by Freud as being "first and foremost a body-ego", the body representation being the most primitive form of self-representation and the starting point of mental functioning (Lemma, 2010, p. 10). He regarded the ego as a psychical map derived from a projection of the surface of the body and as a mental representation of the individual's perceived libidinised relationship to the body, a relationship predicated on the quality of the relationship to own one's body via the mother. In his conception of instinctual dynamics, or body-rooted phenomena, the instinct has its source in bodily sensation with the aim of eliminating tension at the somatic source. However, modern trends in psychoanalysis have been shifting attention away from the body and its drives, as object-relations theories have been growing in influence. In psychoanalytic theory, recastings of subjectivity have departed from Freud's

'Oedipal' structures and inborn 'drives', toward more ambiguous perspectives often termed 'pre-Oedipal' or 'pre-object relations' (Hinton, 2009).

Klein theorised, from an object-relations perspective, that the primary anxieties of the infant are originally rooted in the bodily-felt experiences including the trauma of birth (separation anxiety) and the subsequent frustration of bodily needs. Winnicott (1971) suggested that when impingements are enforced upon a child owing to inadequate maternal handling the potential aliveness of the infant's body is killed off wherein the infant fails to 'accept the body as part of the self and to feel that the self dwells in and throughout the body' (p.18); he further theorised that the true self of the infant emerges from the aliveness of bodily tissues and the functioning of physical processes such as cardiovascular activity and breathing (Athanasiadou & Halewood, 2011; Freud, 1923; Klein, 1928; Laufer & Laufer, 1984; Lemma, 2010; Orbach, 2004; Watts & Hook, 2017; Winnicott, 1960).

Contemporary psychological projective tests of body image such as the 'Draw-A-Person' test bear out these classical formulations by positing that how one perceives their body is significantly related to performance on perceptual and cognitive tests (Yalom, 1980). Moreover, contemporary neuroscientists such as Iacoboni have endorsed the view of *embodied cognition* and proposed that the body and its actions are integral to thinking and that ''…our mental processes are shaped by our bodies and by the types of perceptual and motor experiences that are the product of their movement through and interaction with the surrounding world" (La Barre, 2011, p. 180). They have advanced that an intention of mental derivation is not primarily responsible for activation of the neural circuitry of action and that neuroscientific research has proven its activation in advance of the conscious awareness of that intention. Essentially the body's expressed action patterns *determine* intention and emotion and are not the direct corollary of intention and emotion as widely depicted. Malmeleira and Santos (2019) assert that we are embodied minds and that the body cannot be relegated as simply an effector for cognition or an instrument for gathering information for the brain. They argue that the specific structural, functional, affective, relational, and symbolic features of our bodies play a crucial role in our cognitions, perceptions, emotions, behaviours, and human relations.

William James in 1884 proposed that emotions are dictated by and reliant on bodily sensations and that the body is a passive recipient of impressions from forces in its external environment. Similarly, Damasio (2012) argued that sensations, as opposed to feelings, "are first and foremost about the body, in that they offer us the cognition of our

visceral and musculoskeletal state" (p. 28). Phenomena of unconscious conflicts such as defense and resistance in addition to impulses are generally the antecedents of somatic manifestations or concomitants. In discussing the erogeneity of the body Fenichel (1996) has even suggested that it is conceivable that every body organ can express sexual excitement *and instinctual conflicts* (Athanasiadou & Halewood, 2011; Barbalet, 2001; Dunckley et al., 2005; Fenichel, 1996; Iacoboni, 2008; James, 1884; La Barre, 2011; Malmeleira & Santos, 2019; Rizzolati & Sinigalia, 2008).

Notwithstanding the abundance of research that affords insights into the connection between the client's body and mind the therapist's body has remained a neglected research topic. It has frequently been argued that Freud's almost exclusive focus on the individual's unconscious mental processes has unfairly marginalized the role of the body in psychotherapy despite it constituting our locus (Freud, 1920; 1923). Malmeleira et al. (2019) argue that a vibrant reconceptualization of the role of the body in the field of psychotherapy is required and contest the notion that embodiment ideas should just be delimited to the field of cognitive science. Despite the application of embodied approaches to psychotherapeutic treatment (such as the rise of specific body-oriented psychotherapies), traditional talk-oriented therapies such as psychoanalysis have been reformulating theoretical views and treatment techniques under the influence of embodied science.

Psychoanalytic practitioners pay close attention to patterns of relating that become accessible and unfold in a relational context and during the therapeutic discourse. How the client relates to their own physicality can serve as a rich source of information for the analyst and the client's bodily limitations or impairments may inform how the client engages with their environment and how others relate to the client (Athanasiadou et al., 2011; Stone, 2006). This narrative of the body as expressed through non-verbal interactions in the form of projective identifications or even the medium of bodily motion and/or bodily movement patterns is filtered through the subjectivity of the analyst which also includes both bodily and psychic components. Use of the nonverbal within the psychotherapeutic discipline, as demonstrated in various arenas including attachment theory, trauma theory, kinesics, body movement theory and neuroscience has sharply demarcated the limitations of language and reason. Instead, use of the non-verbal in the therapeutic setting has underscored the significance of a sustained exploration of the nonverbal realm when, for example, examining instances of dissociated, negative traumatic experiences, the transgenerational transmission of attachment experiences, infant observations, observations of adult alertness (when studying dementia or delirium),

psychomotor issues, autonomic responses, emotionality and verbal congruency (Brems, 2001; Fonagy & Target, 2007; La Barre, 2011; Lemma, 2016, 2018).

2.2 The Body in Psychotherapy

As discussed above the body representation is the most primitive form of self-representation. The body supports all other psychic functions and incarnates the self's identity through imposing itself as ineluctable evidence of its interconnectedness with others. Questions surrounding ownership of the body materialise throughout the development process as the child initially grapples with the psychic fact of a shared corporeality of caregiver and baby (Lemma, 2009, 2015, 2018; Watts et al., 2017). It has been claimed that some of the most minimal dimensions of selfhood are fundamentally shaped by the infant's embodied interactions with their earliest caregivers especially with respect to the feeling qualities associated with being an embodied subject. It has also been asserted that such interactions permit the developing organism to mentalize its homeostatic regulation (Fotopoulou & Tsakiris, 2017). When mental models of the infant's physiological states are constructed from such interactions it facilitates "embodied mentalization" through the progressive integration and organization of sensory and motor signals (Fotopoulou & Tsakiris, 2017, p. 5). Given the crucial fact of infant dependency there is a necessity for embodied, proximal interactions with mothers; these experiences of intercorporeality are responsible for shaping the mentalization process, a process which influences the constitution and primary organisation of the minimal self (Fotopoulou & Tsakiris, 2017).

The phenomenon of intersubjectivity refers to the experiences between infant and caregivers of sharing mental states through their affective communication (Athanasiadou & Halewood, 2011; Dosamantes, 1992). This has extended to psychoanalysis to refer to a two-person subject to subject relating – a sharing of both conscious and unconscious thoughts and feelings (Bohleber, 2013). However, as far as the channelling of communication is concerned the body also plays an important role, as the site where somatic affective communication originated in infancy. Accordingly, intersubjectivity continues to assume a somatic form in adulthood. The term "somatic countertransference" (or "embodied countertransference", "body/bodily/body-centered countertransference") is used to refer to bodily sensations of therapists towards their clients within the analytic setting (Bady, 1984;

Booth et al., 2010; Lemma, 2006). The interactions of psychological and somatic processes holds much clinical utility and has been a central theme in the annals of psychotherapy from the initial formulations of psychoanalysis to the more contemporary orientations including bioenergetics and dance movement therapy (Forester, 2007). Notwithstanding this nexus only the cognitive and emotional countertransference reactions of therapists to client material have been documented prolifically whilst research and literature pertaining to spontaneously aroused physical or somatic reactions within the therapist's body have been largely underreported (Klopstech, 2009; Ross, 2000).

Dosamantes (1992) asserts that an analyst must not merely confine their attention to attending to the manifest content evinced in clients' movement enactments and by only paying attention to the images and verbal associations emanating from clients' bodily movement experiences,. She also impresses the importance of continually prioritising and tracking her own emotional-bodily reactions to patients as well as sensing the type of object-relations that clients are constellating with her in the analytic setting and the latter's emotional developmental state in such moments. She explains this unconscious process as the way in which humans position and manage their bodies in space and configure their intersubjective space. She recommends that emphasis is placed on the varying tension levels and the rhythms of actions which are experienced during movements, including awareness of the interpersonal distances maintained and the boundaries individuals establish in relation to others (Dosamantes, 1992). The analyst's phenomenological experiences in the context of the intersubjective encounter can facilitate therapeutic change rather than inhibit or stymie the progress (Ammaniti & Ferrari, 2013; Athanasiadou & Halewood, 2011; Dosamantes, 1992; Stern, 2010).

In a study that focused on the responses of patients to a pregnant analyst, Paniagua et al. (2004) elucidated the common themes which emerged and intensely polluted the analysis; these included an incipient fear of fusion, an inimical sense of estrangement or mistrust, identity and sexuality concerns and/or issues of abandonment and sibling rivalry. Paniagua et al. (2004) make mention of Jessica Yakeley, a member of the British Psychoanalytic Society, who rated an analyst's pregnancy as a pivotal event which has a bearing on the analytic frame and upon the client, given that it emphasises fecundity and essentially amounts to a bald self-disclosure of the analyst's sexual and maternal interests. She disclosed how her own pregnancy had a causal role in altering the body image of two individual clients and outlined a

detailed evolution of the shifting, intensifying and oftentimes subterranean dynamics that can transpire within an analytic dyad. She reported that during her pregnancy, transference was heavily centered towards pre-oedipal, oedipal and adolescent anxieties, pertaining to memories of the mother as primary object; she ascribed this to the fact that the plasticity of the female body can be a source of deep anxiety for both men and women. Yakeley (as cited in Paniagua et al, 2004) elaborated on the phenomenon of negative hallucinatory experiences, which occur in such scenarios, wherein patients struggle to discern or acknowledge the fact of pregnancy out of a profound reluctance to concede the analyst's otherness. According to Paniagua et al. (2004) some patients were likely to either have dreams appertaining to motherhood, to demonstrate marked ebullitions during sessions or to abruptly terminate treatment.

In discussing the body in hypochondriasis, Paniagua et al. (2004) explore a particular pathology of chronic schematic disturbances which they ascribed to a primitive somatic mapping. According to the authors the afflicted clients' inveterate tendency to persistently fixate on specific somatic symptoms was a pathology which they associated to three primary elements – temporal regression owing to a weakened ego; formal regression as a result of a cathected organ; and a traumatic complex. The authors express doubts that these types of somatic cases are devoid of transferential manifestations and argue that rendering the analyst therapeutically impotent is part of clients' transference. It was noted that hypochondriacal symptomatology can render clients refractory to interpretations as the clients feel self-involved with their organs during sessions.

Soth (2006) argues that an 'intersubjective-relational' stance must be assumed in order to grasp the full extent to which unconscious processes and re-enactments present a problem for the therapist. Containment of the 'here-and-now' re-enactment of the client's original wounding is facilitated by means of comprehending the therapist's conflict in the countertransference as part of a complex relational body-mind system of parallel processes. It is posited that the therapist's body is an "ever-relevant aspect of the countertransference" but that attention only seems to be diverted to the therapist's body as an instrument when it "protests *in extremis*" and upon the eruption of disturbing somatic symptoms that exceed a peak threshold (Soth, 2006, p. 4) ; Soth (2006) laments the "*otherwise ignored and irrelevant plain of the body*" (p. 4) when examining somatic countertransference and claims that the therapist cannot confront the problems inherent in the dualistic conception of the body/mind relationship without fully addressing the psychic distress manifesting in

the body of the therapist; the spontaneous, autonomous subjectivity emerging through the body cannot be appreciated when an objective stance is taken against the body.

Many researchers have posited that the incorporation of the somatic countertransference in therapeutic work has clinical utility and aids in the comprehension and management of specific dynamics in the therapeutic relationship (Connolly, 2013; Lemma, 2010; 2016; 2018; Paniagua, 2004; Ross, 2000; Stone, 2006). Vulcan (2009) asserts that the paucity of current research and literature on somatic states in the countertransference, a phenomenon worthy of scientific investigation, can be explained by conceptual discrepancies of the term countertransference which engender operational and measurement difficulties when attempting to research affective and cognitive forms of countertransference that are essentially unconscious states. Shaw (2004) argues that psychotherapy investigates the intersubjective space and as such bodily reactions are the very basis of human subjectivity; Shaw's study investigated therapists' embodiment and the findings reported the presence of embodied countertransference in the encounter by focusing specifically on the lived-body paradigm in relation to therapists' physiological reactions to clients. Stone (2006) posits that somatic reactions are more likely to occur when there is a confluence of particular conditions, namely, when working with patients exhibiting borderline, psychotic or severe narcissistic elements; where a severe, early experience of childhood trauma has occurred and there is a consequent fear of expressing strong emotions directly; the particular typology of the analyst, for example, therapists with introverted intuitions as the superior function and inferior extraverted sensation are most susceptible to experiencing somatic countertransference (Athanasiadou et al., 2011; Meekums, 2007; Samuels, 1985; Stone, 2006; Vulcan, 2009)

Potgieter and Bloem (2017), in a South African study, assessed the degree of embodied self-awareness amongst social service therapist-practitioners registered with the HPCSA[3], and found that there was a conscious tendency of the participants to suppress or deny these informative sensory cues or alternately to rationalise them. They argued that the phenomenon of embodiment not only includes the corporal, body-as-object but also constitutes the body-as-subject, a "predominantly pre-reflectively lived body" (p. 564). Whereas the corporal body is tangible and devoid

[3] Health Professional Council of South Africa

of any subjectivity, an embodiment without self-awareness, the *body-as-subject* is manifested through the sensory system with its attendant implicit or 'pre-reflective' knowing about the self and others; it speaks more to a visceral process of perceiving how the body "expresses, experiences, and interacts with others and the environment" (p. 564). They assert that when potent somatic expressions of a client evoke or stimulate therapist bodily reactions which are obviated, deliberately or otherwise, a disruption occurs in therapists' lived experiences of their bodies. They note the relative sparsity of research and literature exploring the phenomena from within a South African context. Mlisa and Nel (2013) concur with this assertion and, in a South African study, have illustrated how phenomena such as "*umbilini"* (intuition) and "*ukunyanga*" (Xhosa divination) are frequently practiced by the *amagqirha*, traditional health practitioners yet largely understudied (p.564). In their research findings three themes distinctly emerged: somatic sensations and affective states, implicit somatic knowing during the therapeutic process, and suppression and control. They argue that attunement to somatic phenomena is crucial for making therapeutically sound judgments and decisions in here-and-now interactions but also facilitates regulation of the intersubjective field without recourse to or overreliance on a more constricting narrative agenda. Discounting or quashing somatic countertransference experiences and the implicit knowing yielded by clients' body schemas can even prove deleteriously counter-therapeutic to the therapeutic endeavor (Potgieter & Bloem, 2017).

In her review of existing literature Gubb (2014) reflects upon the heretofore marked overemphasis on the more mental forms of countertransference whilst neglecting possible somatic features of the phenomenon. She ascribes psychosomatic symptoms to *unmentalised phenomena* which are expressed by the 'language of the body' as opposed to the 'language of the mind' (p. 53). She notes how existing theories on somatic countertransference bifurcate with respect to the origins or source of the therapists' symptoms: whether from patients who rely heavily on early defensive mechanisms (e.g. projection/projective identification) or from the therapist's own psyche. Accordingly, she also cites Green (2001) who suggests that somatic countertransference emanates from a combination of patient's pathology and therapist's psyche wherein, for example, feelings of hunger and bodily deprivation experienced by the client find resonance with a deprived place residing within the therapist. This contested aspect of somatic countertransference which speaks nonspecifically to the uniqueness and specificity of the particular therapeutic dyad

and the inherent operative dynamics (including a potential asymmetry) remains insufficiently explained in psychological literature. Gubb (2014) discusses a case wherein uncharacteristic and consistent instances of borborygmi, hunger pangs and specific cravings, experienced when working with a profoundly anorexic patient, informed a more incisive interpretation when acknowledged and parsed. In order for such meaning in the context of the analytic dyad to become apparent she concludes that oversimplifying therapeutic somatic sensations as transferred/projected somatic experience tends to be of limited value.

The precise nature of more subtle and specific unconscious dynamics operating within the therapeutic dyad on a somatic level must be attentively reflected upon so that a clear mapping between the therapist's intra-subjective reflections, her self-focused reverie, and how they relate to an understanding of a client's internal world can be accurately discerned. Gubb (2014) argues that somatic countertransference can offer a vivid illustration of the internal workings and practices of therapy whilst supplementing developments in knowledge surrounding psychosomatic pathology. When therapists' somatic countertransference is either visible or audible to the patient, such somatic grumblings, including patients' reactions, must be fully explored and understood as a means to revealing the underlying dynamic. In order to elicit rich therapeutic insights and crystallize more intricate and subterranean dynamics the author claims that the therapist must mentalize and make meaning of particular somatic experiences through an analytic process of therapeutic reverie.

2.3 Trans-Subjectivities

The term *trans*, a term that is continually evolving, describes a heterogeneous set of individuals who share a felt sense of misalignment between experienced gender and the gender to which they were assigned at birth on the basis of observed sex. It includes individuals who find they need to modify their body in some gendered manner, and includes those individuals who identify as genderqueer or are situated along the gender spectrum (Langer, 2016; Saketopoulou, 2020). The phenomena of trans-gender has engendered (pardon the pun) a radical contemplation or overhaul of our existing ideas about subjectivity and the subject, whether trans-gendered or cis-gendered. Authors such as Amir (2022) define transgender individuals as those who live in, what they experience as their natural gender, regardless of their natal anatomy. However, trans also comprises people experiencing varying degrees of distress about bodily morphology, that is seen as

marking gender, as well as a subset seeking hormonal interventions to modify secondary sexual characteristics, a group feeling the need to surgically align their body with their self-identified gender or individuals only altering their social signifiers but interested in pursuing surgical/medical procedures (Saketopoulou, 2020).

Many authors challenge or reject the very notion of gender-binarism and instead conceive of transgenderism and gender identity as a process of embodied becoming, as a veritable form of gender nomadism, and as a rhizomatic experience that evolves over a lifetime (Glocer-Fiorini, 2022; Gozlan, 2022). Evzonas (2022) cites Ricoeur (1990) who introduced the idea of a "narrative identity" which never ceases to be written and is exhaustively rewritten by the self in constant relation to the other (Evzonas, 2022, p. 216). Evzonas (2022) and (Gozlan, 2022) maintain that it is impossible to reduce gender and sexual diversity to binary oppositions of male/female, masculine/feminine, heterosexual/homosexual, and cisgender/transgender or to organize individual identities and desires into arbitrary and porous categories which invariably tend to 'leak'. Rozmarin (2022) argues that subjectivity is neither innate nor coherent, but conceives of it as threshold phenomena that is perpetually emerging and shifting as an experience in-between; he likens subjectivity to a relay station for ideas and feelings and sensations, a fluid, nebulous territory which, despite one's best efforts, cannot be protected and maintained as something coherent and immutable.

Hansbury and Saketopoulou (2022), in enumerating various reasons why analytic thought about trans and non-binary patients remains so intransigently difficult, suggest that working with gender requires a particular knowledge base and countertransference attentiveness. They propose that countertansferential responses to trans-patients not only manifests in clinical work but also emerges in the form of occlusions to psychoanalytic theorizing and charge analysts with becoming unimaginatively concrete in the presence of a trans body. They view transphobic countertransference as a defense against the agitation that polymorphic infantile sexuality rekindles when cis-gendered individuals confront transgender bodies. The authors suggest that much countertransferential anxiety is staked on the fear that the patient will regret their transition and that therapists' countertransference reactions also typify the limits of schematic classifications. Saketopoulou (2020) claims that disturbances can be felt by some analysts, in the presence of trans-patients or genders and bodies that feel alien to the therapist; she conceptualized such disturbances as primitive gender terrors and suggested that they can arouse the therapist's own sense of internal alien-ness, which strains self-organization,

and evokes archaic unconscious anxieties around their own gender, bodily integrity and sanity.

Hansbury (2017) added to Winnicott's (1965) original list of 'unthinkable anxieties' and identified four basic transphobic countertransference reactions implicating sexual orientation, gender identity, the soma and the psyche wherein the analyst may fear that:

- they will be tricked, through a denial of reality, into homosexuality and lose a grip on their sexual orientation.
- they will become ungendered or slip outside of gender so that their relationship with their gendered/sexed body is under threat.
- their body will break apart or fragment and that important pieces will be lost.
- they will unwittingly implode and become crazy.

Porchat and Santos (2021) define 'unthinkable anxieties' as "defensive manoeuvers designed to manage unthinkable, primitive, and terrifying anxieties related to infantile fantasies of not having a definable form, skin, or boundaries" (p. 412). Hansbury (2017), in highlighting biases specific to the conscious or unconscious transphobia of therapists, suggests that such anxieties may surface when therapists experience trans-patients as a breakup of their own personal continuity or as a disruption to their own experiences of reality and embodiment. .

Glocer-Ferioni (2022) claims that, when consulting with trans-identities, countertransference can affect very sensitive and naturalized aspects in each psychoanalyst and trigger questions about gender and other sensitive aspects of the analyst's own subjectivity. Whilst an eagerness to classify may be reassuring and serve to lessen the discomfort generated by uncertainty, attempts at classification may also obstruct open listening (Glocer-Fiorini, 2022). Harris (2022) builds upon these perspectives and asserts that countertransference confusions, misgivings and enactments do indeed arise when working with gender-diverse patients owing to the overwhelming presence of the indeterminate, the emergent, and the co-constructed. However, authors, such as Rozmarin (2022), suggest that gender transition is just one of *many* transitions in subjecthood, which can evoke strong countertransferential intrusions and objections, and counter-argue that the phenomena of gender transitioning should be de-essentialized and apprehended as a mere expression of contemporary hybrid-becoming.

Blass et al. (2021) state that transgenderism forces analysts to examine what they take as their background assumptions about human beings and acknowledge that there are also

different basic assumptions within the analytic world. Saketopoulou (2021) argues the notion that trans, as an ideology, is as transphobic as the historical notion of the "gay agenda" and that it is *not* ideological to think in more complex ways around gender identity. She takes a more hardline stance pronouncing that countertransferential reactions or lack thereof can potentially arise from the therapist's need or desire to know or predict, and that this may counterproductively be the kindling of a therapist's omnipotent fantasy; she posits that possessing an attitude which overestimates a therapist's capacity to know or predict is simply a means of defending against being confronted with so much that is unknown and beyond the therapist's control. She further asserts that unanalyzed primitive gender terrors can become transphobic, and can "infiltrate the countertransference, traumatizing analysands, stagnating the treatment, and/or leading to premature terminations" (Saketopoulou, 2020, p. 1023). Evzonas (2019) recalls a types of transference in which the therapist can feel overwhelmed, bombarded, included to the extent of being rendered passive by the excessive excitement of becoming a dumping ground for the trans-patient's instinctual violence. He advocates a more receptive form of listening by the therapist since assuming a more "penetrating" role may run the risk of repeating a client's past traumatic intrusions.

Rozmarin (2022) more broadly conceptualizes a 'trans-subject', which he derives from the sense of transitioning as it pertains to trans-gendering, and which he extends to other categories of subjecthood. In so doing he aims primarily to capture the subject's potential to reform and even transfigure the precepts of subjectivity as it is prescribed for them. In recounting his countertransference experience, when working with an individual embarking upon a process of religious conversion and moving across various collective-social frontiers, Rozmarin (2022) demonstrates that the subject can be formed by and along various organizing principles and not solely constructed along lines of gender identity. However, Rozmarin (2022) also posits that examining the many possibilities which trans-gendering entails challenges and allows individuals to think more freely through other social categories and the transitions they can undertake. What might the general implications be for therapists and, more specifically, for their somatic countertransferential experiences, if a similar unencumbered stance can be adopted, one which displays an openness to re-conceiving, defying or even transgressing rigid binary categories of gender and other social categories? Conversely, what might the outcome be for therapists who fail to tolerate or sustain the mounting tension which gender-incongruence produces when unconscious excess cannot be contained within the

singularity of the gender-variant and nonconforming subject? (Olver, 2019; Rozmarin, 2022)

When considering the phenomena of trans there is a category of "difference" which transcends mere gender and sexual difference and pertains to difference as a recognition of otherness. This category of 'symbolic difference' depends on an interweaving of various axes of difference and comprises, on a multiplicity of levels, anatomical difference, racial, ethnic and cultural difference, psychosexual difference, linguistic difference, amongst others (Glocer-Fiorini, 2022). In latter days the growing prevalence and the de rigueur employment of trans-linguistics has become commonplace in quotidian life and increasingly rooted in notions of political correctness and modes of social conformity (Cavanagh, 2018; Laufer, 2021). Given that the process of becoming involves a gradual unfolding of difference and multiplicity in oneself over time is there a correlation between engagement with this process and the capacity of therapists to remain attuned to experiences of somatic countertransference?

When reflecting upon the political zeitgeist, which also influences therapists' perceptions of trans-subjectivities, Harris writes: "We want to keep clinical work as a free space. But we cure with contaminated tools. We are embedded in structures of money, hierarchy, and power and we must keep a double vision" (Harris, 2009, p. 62). Evzonas (2020) asserts that many psychoanalytic clinicians, using the pretext of analytic neutrality, blatantly despise politics for muddying the countertransferential waters and he laments that the mainstream is singularly and unfairly positioned to call its own views 'neutral' and 'apolitical' whilst deeming the views of the margin as 'political'. Are there negative implications for therapists caught in the crossfires of such heated political schisms and debates? Therapists, as well as their patients, have always been inscribed in the social with both dyadic parties currently immersed in a politically charged and polarized era which many perceive as increasingly puritanical, hardline and ultimately constraining. Can the therapist's ability to remain attuned to their countertransference, including somatic components, be disrupted when at the coalface of what Althusser (1970) referred to as 'the ideological apparatus of the state'? (Evzonas, 2020).

Harris (2022) admits that her countertransference tangles and phobic anxieties, when working with the vicissitudes of gender and trans-subjectivity, can carry an excessive and atypical degree of conflict and uncertainty; she acknowledges that her countertransference intensifies when the patient's gender manifestation is a carrier or

harbinger for psychological disturbances beyond the ordeal of transition. She also underscores the manifestation of erotic countertransference, when working with gender-variant patients, and thereby, being in the presence of freedom, regardless of whether that freedom is willed, constructed, emergent in-vivo, or even disavowed. Hansbury and Saketopoulou (2022) also emphasise how erotic countertransference by a cis-therapist towards a trans-patient has the potential to scramble the analyst's sexual orientation and they further explore how similar 'other' permutations can unsettle an analyst's 'stable' sense of hetero- or homosexual orientation. Harris (2022) considers the ways that her anxious and unsettling countertransference experiences tend to reconfigure or deny her a thinking space about gender and sexuality, usually experienced at the heart of her analytic work; she ascribes her countertransference anxiety chiefly to a fear of wrong moves or of outcomes that will unsettle whatever forms of gender and sexuality have heretofore evolved in her subjectivity. However she also questions if the deep structures of countertransference, which emerge when working with gender-diverse patients, may reveal a surfacing of inherent and latent forms of biologism or naturalism. Interestingly Harris (2022) makes particular mention of an element of her countertransference which prompts a reluctance to opening the clinical experience to conflict, risk and deeper exploration. Lemma (2012) states that "the core of the experience of the transsexual is, indeed, located in the visual order" (Lemma, 2012, p. 278) but is it possible that there could be excessive emphasis on the visual dimension? Interestingly, Langer (2016) takes aim at Lemma's preoccupation with transgender presentations and her conception of the trans experience as belonging solely to the visual wherein the trans-individual's non-passing image is consistently forced upon her. The author concludes that Lemma's countertransferential reactions derive from "unprocessed transphobic countertransference" (Langer, 2016, p. 309).

Amir (2022) asks whether contemporary analysts are experiencing a different and more acute countertransference with patients who are trans-identified or gender nonconforming. Gherovici (2022) also queries whether an unfortunate psychoanalytic or social bias towards trans-subjectivities has affected therapists' redirection of feelings towards their trans-patients and if this type of prejudice may be shaping the already complex emotional entanglements of countertransference. This study aims to locate an answer to such questions and to examine whether there are distinct somatic and affective dimensions of countertransference when working with trans-identified patients.

2.4 The Challenges and Utility of Countertransference

Key psychoanalytic concepts such as somatic transference/countertransference, intersubjectivity and the body self, experiences of psychological trauma, and implicit and explicit gendered identity processes are increasingly being reframed within the context of embodied knowledge (Malmeleira et al., 2019; Potgeiter et al., 2017; Shaw, 2004). Such an augmented understanding of the considerable role that the body plays in the analytic setting requires a conceptual and practical shift of emphasis since it is the primary task of the analyst to listen to what the body is expressing or concealing, within the analytic frame, on the basis of its relative noisiness or tranquility.

Central to the work of the phenomenon of transference, wherein clients attempt to re-enact their most primitive relationships within the analytic frame, is the corresponding phenomenon of countertransference. Countertransference refers specifically to the analyst's reactions and feelings to the client's projections of unwanted feelings; these typically represent the client's pre-verbal, unformulated experiences which can be exhibited as verbal and/or non-verbal behaviour. The phenomenon of countertransference provides an opportunity for both analyst and client to re-evaluate earlier relationships in order to facilitate a process of change by means of a corrective emotional experience. Countertransference assists the analyst when attempting to formulate the client's transference and has been referred to as an "instrument of research" and an emotional compass (Glocer-Fiorini, 2022, p. 305). According to Winnicott the analyst "must be able to be so thoroughly aware of the countertransference, that he can sort out and study his objective reactions to the patient" (Winnicott, 1975, p. 195).

When client defense mechanisms, including projection and projective identification, are unconsciously operative and the analyst comes to embody projected, unassimilated aspects of the client, various potent feelings can be evoked and unconnected associations invoked. Such manifestations necessitate strict self-reflection, self-awareness and restraint on the part of the analyst to safeguard against impulsively reacting to these urges (Elliot, 2001; Lemma, 2006; Ross, 2000; Saketopoulou, 2011; 2014; Suchet, 2011; Winograd, 2014). According to Booth et al. (2010), countertransference can be expressed in several ways, namely, evocation of a specific feeling in response to a client; emergence of fantasies during or after a therapy session; dreams which relate generally or specifically to a particular client; or through behaviour which includes the spontaneous arousal of physical feelings (Bady, 1984; Booth et al., 2010; Dosamantes, 1992, Lemma, 2006).

The phenomenon of countertransference has not always been considered a curative means to therapeutic progress and very different epistemological positions have been occupied at a meta-level (Blass et. al, 2021). Countertransference originally emerged in the Freudian narrative wherein countertransference was deemed a hindrance in the analytic process, but postmodern, relativist positions view it alternatively as a rich source of insight. Traditionally, countertransference was comprehended as an indication of a therapist's inadequacy or of "blindspots" that needed to be rooted out. Kern (1978) considered that the phenomenon of countertransference holds the same relationship to psychoanalytic work as wound infection holds to surgery, namely, that countertransference was an unconscious pathological response of the psychoanalyst to the patient. According to Lacan countertransference can appear as an obstacle to the achievement of a cure and is rather a form of resistance occasioned solely by the analyst's unanalyzed unconscious issues as opposed to the patient's (Gherovici, 2022; Suchet, 2011).

However, contemporary psychoanalytic theorists, who view psychoanalysis as an intersubjective dialogue, argue that the phenomenon of countertransference is an especially useful vehicle for understanding patient psychodynamics. A broader conception of countertransference was later proposed by Kernberg (1979) and others, one which involves the totality of the analyst's mental functioning (Glocer-Fiorini, 2022). This totalistic conception of countertransference, which includes the analyst's total functioning, is at the core of the post-Freudian clinical model. Additionally an integrated conception of countertransference, within a wider and more complex contemporary vision of the analyst's psychic work, includes the notions of the analytic frame, also referred to as the 'internal frame' as being central (Urribarri, 2007). More recently, Green (2003/2005), in constituting a new logic of the analytic pair as a triadic structure, has developed a triadic scheme with the concept of internal setting or analytic frame as a third element, constitutive of the analytic process: transference-countertransference-frame/internal setting. Countertransference is no longer defined as a symmetrical reflection of the patient's transference, but as an output of the analytic situation, conceived as a dynamic field (Green, 2009; Perelberg & Kohon, 2017; Urribarri, 2007).

It has also been posited that the uncritical imbibing of psychoanalytic theories can potentially permeate the therapeutic space in a deleteriously biased and prejudicial manner. Accordingly, since the very inception of psychoanalysis, countertransference has

underpinned an acknowledged inseparability between clinical praxis and theory (Evzonas, 2022). Evzonas (2022) emphasizes that countertransference refers to both the analyst's transference towards their patients and his or her resistance to patients' transference. Jean-Louis Baldacci (2011) concurs with this perspective and states that transference should not be situated exclusively on the patient's side and countertransference on the analyst's side given that, in clinical practice, both sides engage with and are immersed in the issue of transference. Rozmarin (2022) states that countertransferential reactions can include an indistinguishable mix of the subjective and the collective, of the personal and the historical and explains how distinct force fields materializing in two people can unexpectedly clash in a metaphysical and visceral conflict that is impossible to decipher. Gozlan (2022), in exploring specific cultural anxieties that emerge as a result of challenges to traditional or conventional understandings of sexual and gendered identities, questions the danger for analysts/practitioners who are unaware of their countertransference experiences. He suggests a myriad of perceived threats, including disruption, fragmentation, contagion, and amputation, that can arise and counter-therapeutically distort the therapist's attunement to their countertransference reactions.

According to Fairbairn (1958) the analyst has the sole responsibility for establishing a setting conducive to a restorative process claiming that relationship between analyst and patient represents the therapeutic kernel of psychoanalysis. Such heightened expectations when therapists, adopting the role of pseudo-reparative parents, are charged with maintaining a positive object relationship in which to provide a new and more salutary relational experience, can arouse intense regulatory anxiety and negatively influence therapists' somatic countertransferential experiences (Fairbairn, 1958; Smith, 2017; Wachtel, 2011). Gherovici (2022) opines that if hate in countertransference is a complex affair, transference love is not simple either (bodies).

2.5 Psychoanalysis and Gender Diversity

Psychoanalysis and the general psychoanalytic culture have been charged with being insular, myopic and having reached its limits especially with regards to the trans-subject (Gozlan, 2022). According to Aron and Star (2013) while psychoanalysis has "emerged from the radical edge of cultural life, it has also been part of the establishment, shaped by hegemonic ideas of normativity" (Aron & Star, 2013, p. 392). Evzonas (2022) argues that the 'truth', in the philosophical sense, is not the prerogative of the enlightened Socrates

but is instead the outcome of a disputation between different interlocutors, many who hold an array of conflicting and non-hierarchized views. Evzonas (2022) promotes the deconstruction of hegemonic language, as well as meaningful engagement with multiple voices ("polyphony and dialogism"). These voices should neither merge into a single perspective nor be deferentially subordinated to a pre-eminent voice which has heretofore monopolized and wielded a supreme, overarching power (Evzonas, 2022, p. 213). Psychoanalysis has been variously charged with dismissing the paramountcy of otherness in the construction of meaning, and for a preponderance of the intrapsychic over the intersubjective (Bakhtin, 1982). Despite being familiar with the Freudian paradigm of unconscious overdetermination and the inherent psychic complexity, blame has been levelled towards therapists for largely adopting an underlying pathologizing stance by deleteriously regressing to concrete and literal conceptions of gender and of trans-subjectivities (Evzonas, 2022).

It is evident that there *has* been a significant evolution of psychoanalytic theories in latter years (Benjamin, 2018; Person & Ovesey, 1983) yet many clinicians, experienced or otherwise, who have been inured to outmoded and anachronistic theoretical models, remain entrenched in ill-defined and reductive dogmas with a subtle heteronormative resonance with respect to gender and sexuality. Since the inception of psychoanalysis the clinical setting and theory have been at once inseparable and imbricated considering how the transferential situation is concomitantly influenced by both the therapists' responses to patients' psychic structures and by the introjected and drive-cathected metapsychological models that predispose and shape the quality of therapeutic listening. The latter refers to the notion of pre-transference or theoretical countertransference to designate the introjection of any psychopathological, methodological, and technical references that may permeate and transmute the therapeutic space (Evzonas, 2022). Glocer-Fiorini (2022) accords with this view that countertransference reactions can be influenced by theoretical understandings and perceptions which can erect bastions against open psychoanalytic listening. If theoretical countertransference can be implicated in reshaping analysts' transferences towards their analysands the question may arise as to whether the inverse can also manifest wherein a therapist's receptivity to countertransference, including the somatic component, can become compromised or impaired?

The primacy of theoretical countertransference is particularly relevant in the case of patients who challenge the socially established gender binary, especially when one considers existing and endorsed psychiatric and psychoanalytic discourses which seem to

promote and protect ideological interests and which are either imbued with or are surreptitiously contaminated by social biases or crude generalizations about the construction of individual subjectivities (Evzonas, 2021a, Olver, 2019). It has been accepted that gender experiences are situated in a broad spectrum of identifications and desires which have long surpassed socially constructed and historically contingent categories and cannot simply be treated "out of existence" (Saketopoulou, 2022, p.180). For example Givre (2021) examines the widespread phenomenon of the hybridization of identities in postmodern times and the countertransference effects in the clinical setting and on theory. The author illuminates the need for contemporary psychoanalytic discourse to deconstruct or dismantle foundational binary-based paradigms of metapsychology, which lack a trans-epistemological depth. By acknowledging the rampant chimerization and polymorphism of identities psychoanalysis has been periodically impugned for gross oversimplification of complex psychic functioning and for not fully appreciating the plight and suffering of trans or non-binary patients. Given that the construction of non-normative gendered subjectivities has exponentially proliferated, a demarcation line has shifted which needs to be conceived anew. Could such a collision between imbibed psychoanalytic theories and a polymorphism of gendered identities foil countertransference? (Evzonas, 2021a, Givre, 2021)

Saketopoulou (2020) posits that as a result of the exponential increase in rates of change within trans-discourse and the emergence of vistas that can generate new analytic thinking being opened up, current psychoanalytic theories and the general affective landscape of psychoanalysis offer inadequate guide-maps which can adversely result in enactments and other parapraxis. She asserts that the psychoanalytic study of trans would profit from 'conceptual triangulation', namely, exposure to an array of discourses primarily interdigitating body, gender and culture and comprising feminist and queer theory, trans studies, post-colonial studies and critical theory. Saketopoulou (2022) cautions that the Hippocratic Oath to not harm patients must also include stipulations to safeguard against imprecisely inflating the dangers of transitioning and coercing trans-patients into normative psychic paths; she insists that psychoanalysis must be rigorously attuned to the many levels of distortion, scotomization and confusion which analysts can inadvertently introduce into their work with this minoritized demographic. Saketopoulou (2022) aligns her own conceptions of gender identity and gender expression more with Lacan's theory of the 'sinthome', that is, of a symptom that does not necessarily need to be cured but, instead, is a creative, singular solution that someone finds to render life livable (Gherovici, 2022). However, it can be argued that a consensus of this stance

might not be shared by the majority of psychotherapists who, alternatively, may opt for less engagement with disciplinary otherness and psychoanalytic literature that is ideologically committed to the situatedness of the gender-variant patient.

Silverman (2015) explores what happens when a mind is not mentalized in order that thinking space can be opened up but instead is colonized or invaded by another person's mind. Could such a primitive process between child and caregiver be isomorphic with the therapist's relationship to obdurate and anachronistic psychoanalytic theory which inadvertently negates or occludes the emergence of potential selves and other non-binary gendered identities? It could be argued that pejorative or prescriptive psychoanalytic theories, in the context of anti-normative or gender-diverse patients, can be implicated in therapists' impaired capacity to mentalize. When the psychic space of therapeutic practitioners becomes laced with unprocessed psychic anxieties, primarily deriving from theoretical countertransference, to the extent that their subjectivities become obfuscated or erased, could this also extend to a compromising of attunement to their countertransferential reactions? (Hansbury, 2017). What, if any, are the psychological sequelae for therapists who cannot condone aspects of psychoanalytic theory and who may feel somewhat complicit or aggrieved about being moral witnesses to, as well as the beneficiaries of, theories and/or principles that fail to transcend binary modes of thinking? Straker (2007) suggests that a crisis of subjectivity can oftentimes emerge and counter-therapeutically embroil the therapist when tensions between different moralities or sensibilities become unsustainable and amplify a push towards dissociating different parts of the self from this destructive underbelly. Could therapists, in apprehending a lack of epistemological innocence or impartiality as a result of being invested or enfolded in unpalatable psychoanalytic discourses, experience such a crisis in subjectivity when working with a gender-diverse population, and what may be the implications for remaining attuned to somatic countertransference reactions?

Psychoanalysis has had quite a lot to say about countertransference and the particular analytic stance which therapists should adopt in relation to their countertransference responses; such perspectives have radically shifted over the course of psychoanalytic history. Benjamin (2006) deftly distinguishes the intersubjective perspective from traditional intrapsychic theories by employing the analogy of a two-way street to depict the co-creation of patterns by two active subjects, as opposed to a one-way direction of effects which illustrates the relationship between one subject and the other object. Her approach is in direct counterpoint to the stance of neutrality espoused traditionally. According to Freud (1920), who cautioned analysts about keeping their

countertransference ‘in check’, the neutrality mandated by the analytic frame protects both therapist and patient and preserves the continuation of the treatment (Gherovici, 2022). The role of the analyst as a clinical authority, and his or her position as an objective observer of analytical events, have been transformed and the subjectivity of the analyst as an instrument of knowledge has been integrated into the concept of countertransference, transference of the patient onto the person of the analyst was extended to the analytical situation as a whole, and concepts like projective identification and enactment were promoted to senior notions in treatment theory.

Gherovici (2022) also promotes and advocates for a form of benevolent neutrality which would keep forms of countertransferential prejudice in check, such as the imposition of potentially alienating, normative models of sex or gender. She asserts that when therapists can ‘abstain’, they let the client’s subjectivity take center stage, and that maintaining a position of neutrality when working with trans-identified patients allowed her to go beyond states of fear and pity, which led to a dynamic resolution. Benjamin (2006), in a counter-argument, holds that therapists have struggled to make good use of their own countertransference precisely because psychoanalysis has counter-therapeutically subjected them to a self-subjugating ideal of neutrality, promoted a detached style of engagement, and denied or discouraged the inevitability of reenacting with the patient injuries suffered in the past. Her critique of analytic authority, which chiefly derives from the analyst’s assumed accuracy as observer of countertransference and transference, suggests that such an approach tends to correspondingly de-authorize the patient, who is passively relegated to the role of inanimate object of observation. Lacan (2006) adds his contribution to this melee, asserting that analysts can often go astray when wishing to do good for their patients and he considers such virtuous intentions as countertransferential hindrances. He expresses the belief that the best empathy an analyst can exercise is, in fact, abstention and approximates a stance of empathy to a stance of apathy which does not bring to abreaction negative feelings and fantasies (Aron, 1998).

The field of psychoanalysis thus holds differing views on how countertransference should be managed or how its attendant tension should be sustained. Despite Freud (1920) calling analyzed and demystified (“*purified*”) countertransference a “*blessing in disguise*”, Gherovici (2022) cites Lacan (2006) who, inversely, defined countertransference as “the sum total of the analyst’s biases, passions, and difficulties, or

even inadequate information, at any given moment in the dialectical process" of the treatment (Lacan, 2006, p. 183). Lacan (2006) also considered negative countertransferential experiences as "moment[s] of stagnation" (p. 184) or immobility with Gherovici (2022) insisting that such occurrences must not be addressed in the immediacy, even when manifested as forms of acting out, lest they become productive barriers or obstacles to therapeutic progress. She argues that the analyst's task is not so much to interpret in countertransference, which she equates to a wheel digging deeper into sand. Might knowledge of differing creative techniques and clinical practices, with respect to experiences of somatic countertransference lend itself, to facilitating therapists' abilities to grapple with somatic phenomena?

2.6 Working Therapeutically with Gender Diversity

Historically, psychological literature has tended to incorporate much pathologically pejorative language when engaging with the subject of gender dysphoria and/or gender non-conformity, designating and therein stigmatizing such patients as narcissistic, obsessive, perverse, borderline and putatively psychotic gender-outlaws (Chiland, 2000; Hansbury, 2005; Harris, 2011; Kubie, 1974; Latham, 2018; Quinodoz, 1998). Whilst research and literature concedes that pathology can manifest in cases involving gender dysphoric clients (with high incidence rates reported for depression, anxiety, suicidal ideation, self-harm and substance abuse) it has been posited that the greatest barrier between the analyst and gender dysphoric patients is the former's tendency to eschew confounding and discomfiting somatic countertransference resulting in "therapeutic nihilism" (Hansbury, 2005, p. 20).

According to Saketopoulou (2011; 2014) analysts who strive to work within their patient's gendered experiences have tended largely to leave unaddressed the analysands' body dysphoria and the onerous intersection of psyche, soma, and culture, including clients' unique unconscious phantasies and the associated defensive mechanisms which undergird them. She assessed the hitherto "problematic theorizing of trans experiences" within the field of psychology wherein treatments have tended to view disturbances in gendered embodiment as "indices of underlying narcissistic disturbance" (Saketopoulou, 2014, p. 776) and dismissed their experience as "delusional and pathognomonic" (Saketopoulou, 2011, p.198). Moreover Saketopoulou (2014) posits that there are deleterious developmental implications ("psychic perils") when the given natal body of the client has not being adequately mentalised in the course of treatment (p. 775). In

discussing the dichotomous and overly facile conceptualisation of transsexual phenomena as it pertains to the analytic frame she asserts that the pitting of body dysphoric clients' internal psychic experiences against external reality (with both implicit and explicit social forces including cultural understandings of body morphology) can be a source of immense suffering for clients. Marcus and McNamara (2012) argue that gender variance cannot be tolerated by psychotherapists, with binary gender identities being preferable over a multiplicity of gender narratives which run counter to gender essentialism and potentially give rise to gender unease, a mode of therapeutic gender countertransference whereby gender norms are unwittingly enforced. They argue that gender fluidity and ambiguity can threaten therapeutic neutrality, challenge theoretical constructs, negate the vicissitudes of gender identities and produce countertransferential disturbances which meld states of affective abjection and excitement (Marcus & McNamara, 2012).

Harris (2011) challenges canonical and expectable thoughts surrounding gender identities and their formation as they pertain to socially inscribed narratives and ideologically shaped theories, especially when gender is inflected through race and class and rigidly held to strict ideals of consolidation, integration, maturation and psychic health. Harris (2011) argues that gender congruence has more to do with the gendered mind than it has to do with the gendered body. With regards to the potency of invasive objects in a client's intrapsychic life and the fact that no stable identification may be possible as a result of such powerful early intersubjective circumstances, there are distinct implications for the extensive and ongoing complexity of development including gender identity, stability and forms of desire and gender arrangements. Moglen (2008) examined the dissonant experiences of the transsexual experience ("experiences of the uncanny") which are based on deprivation of an imagined body, as opposed to loss, and exposes deep fissures "between inner and outer, psychic and material, familiar and strange" asserting that the work of psychoanalysis is in retrieving and working through material that has been disavowed or forgotten (p. 298).

Lemma (2018) argues that the identity label of transgender encompasses a complex range of internal psychic positions in relation to gender identifications especially for young clients who are desperately seeking medical intervention for gender dysphoria which entails extensive and oftentimes irreversible body modifications. These clients experience profound distress given the self's disturbed relationship to the body and the associated unconscious identifications. She cautions that working with such clients poses many challenges for the analyst, not least countertransferentially and that these body-alteration desires, frequently irreversible, have the potential to emotionally arouse the analyst

(Lemma, 2018). The analyst may wish to protract such a drastically extreme process whilst a client, out of an inverse sense of desperation, may urgently wish to expedite the process through the enactment of a solution (Lemma, 2018). The tendency of the therapist to prematurely and narrowly interpret unconscious meaning from a potentially biased internal position in order to metaphorically cauterise an ostensible wound may induce significant tension in the client (Lemma, 2016). Oversimplifying an interpretation on the assumption that one is dealing with a homogenous group and so can accordingly apply a single theory fails to acknowledge and appreciate the spectrum of meanings of a transgender identification and tends to pathologize (Lemma, 2020). Intense countertransference when working with clients with gender dysphoria is not uncommon as a result of powerful projections into the body of the analyst owing to the client's desirous and envious appropriations of the analyst's body or perceived difference (Lemma 2006; 2008).

When discussing the notion of "*embodied alterity"* which speaks to the fundamental opacity of the other that is at the core of our embodied experience, Lemma (2018) claims that there is an essential unfathomability or inaccessibility of the 'other' which resides in every individual (p. 1101); this embodied alterity is ultimately grappled with through the direct manipulation of embodied experiences and correspondingly the representation of our bodies in our minds; with more adaptive ways of managing the otherness inscribed in our bodies our sense of who we are can be integrated into our identity. She makes clear that undergoing cosmetic surgery must not be held in isolation as an indicator of pathology per se but that the state of mind which underpins its pursuit is the key evaluative criterion of pathology (Lemma, 2018). She concludes that repetitive and embodied scripts are not demanding execution through enactment due to harboured self-destructive fantasies but as "attempts to form new representations, to translate in novel ways an array of previously unrepresented sexual and gendered permutations" and that the analyst must sustain an equidistant curiosity (p. 1101).

Lemma (2020) reviewed the use made by clients of the analyst's body and, in some instances, the setting of the analyst's room when they have experienced an early undercathexis of the bodily self; she underscores and explains the significance of the analyst's receptivity to this form of psychic appropriation which requires metabolization and containment (that goes beyond declarative and linguistic means). She also reflected upon these patients when they become locked in identification with a ruthless superego resulting in the concomitant projective identification of an intrusively scrutinizing and harsh object into the analyst. She recommends that instances when the patient tries to

make an "aesthetic link" with the analyst in order to derive embodied emotional scaffolding should not be overlooked or misinterpreted as erotic/idealized transference or as disorganised behaviour which masks a developmental thrust (Lemma, 2020, p. 59). An aesthetic link occurs when the client attempts to make a connection, on the basis of sensory appreciation, with a desired but, as yet, unrealized embodied self and which can only be experienced through an identification with perceived aspects of the analyst's physicality or analytic setting. Lemma (2020) explains this aesthetic link by conflating Bollas' (1979) notion of a transformation object with Meltzer's (1988) concept of the "aesthetic conflict". The latter notion of an 'aesthetic conflict' speaks directly to a unpalatable asymmetry in human primal relations, between the mother and child, wherein the child can apprehend the mother's beauty but yet be simultaneously exposed to a felt-withholding of empathy and/or knowledge by the mother. Lemma (2020) explains how an "aesthetic link" must be restored within the dyad in order to consolidates the patient's experience that perceived beauty and goodness can be shared. The author also draws on the importance of Roussillon's (2004) notion of reciprocity and "aesthetic sharing" which mediates primary narcissism through cathexis of the baby's body by the mother-as-mirror, as conceptualised by Winnicott (p. 59). Lemma (2020) posits that clients who are experiencing varying degrees of gender-related body dysphoria are inexorably seeking a developmentally necessary idealization of both the analyst's body and sensoriality, claiming that this unconscious entreaty for a vital connection originates from a primitive libidinal under-cathexis. The perceived body of the analyst is regarded unconsciously by the client as a libidinally cathected 'body-of-hope' which the analyst appears to comfortably inhabit (p. 57); the client instinctually perceives that this aesthetic link can ultimately facilitate development of a more integrated and positive relationship to their own body. This notion also implicitly extends to the physical space of the consulting room and how the analyst qualitatively engages with their surrounding environment. Quillman (2013) argues that therapists often fail patients by not disclosing their somatic countertransference to them, thereby allowing patients to flounder in their dissociation, which can result in either punitive withdrawal or other defensive measures (Bollas, 1979; Lemma, 2020; Meltzer, 1988; Quillman ,2013; Roussillon, 2004).

Lemma (2016) also highlights the notion of the temporal link, as a pivotal feature of human identity, and the effects of its disruption in transsexuality. This temporal link which provides continuity between different representations of the 'self' over time can be disrupted significantly as a result of artificially halting the given body's biological trajectory through the use of hormone blockers. This artificial suspension of puberty and

the desired and deliberate suspension of a client's physical time can have implications also when a suspension of psychological time ensues; herein there is a marked distortion in a client's relationship to time owing to this biological and psychic detour which can adversely impact one's capacity to manage reality. For many clients with gender-related body dysphoric symptoms there is a tendency to struggle with establishing continuity with their past and to remain suspended in an atemporal present. The facticity of the given body and its indelible links to the parent's body entails much psychological adjustment also irrespective of the various surgical body alterations undergone throughout the dynamic process of transition.

Lemma (2016) argues that continuity between the given body and the objects and/or origins it inevitably ties to cannot be severed or overridden irrevocably through extensive body reconstruction; a psychic fact remains unintegrated - that the given body is indelibly imprinted and bears the trace of 'the other' (p. 361). Given that the configuration of the body in the mind is inherently temporal Lemma (2016) claims that, notwithstanding idiosyncratic refashioning of the given body, stable adjustment and self representation cannot be achieved by the client. This occurs when the modified body has been successfully integrated into a psychic dwelling where the parental couple can also reside and co-exist. This has implications in the therapeutic setting where there is an inevitable psychic corollary. Lemma (2016) considers complex unconscious motivations on the part of the client which permeate the therapeutic encounter as a result of a pseudo-psychological *stasis* including the client's poor capacity to live in time. She discusses clients who retreat into an omnipotent, timeless state of mind during sessions where they can avoid confronting a past which cannot be integrated into their present. She concludes that there is a temporal dimension to the dyadic relationship in which ruptures can unwittingly occur as a result of ongoing unconscious phantasies and a client's powerful resistance to confronting their history and aligning their outward appearance with their inner experiences.

2.7 The Role of the Other in Gender Identity Development

Much contemporary psychoanalytic thinking and theoretical developments about early attachment and affect regulation have informed clinical and theoretical understandings of the problems of gender and sexuality. In psychoanalytic theory pertaining to the development of individual subjectivity, ideas have been radically recast and have shifted away from Freud's notions of 'Oedipal' structures and inborn 'drives', toward more

equivocal or ambiguous perspectives; these perspectives include theories from psychoanalysts such as Lacan and Laplanche. One generally accepted premise that has been revised is the notion that an isolated mind in which development occurs, or in which the self or subject is constructed out of pre-existing and inherent contents, is no longer tenable (Hinton, 2009). Fletcher (2000) contests the primordiality of the Oedipus and castration complexes and claims that psychoanalytic theories actually purloin understandings of gender development and the body, as a means of explaining how individuals subjectively experience their gendered and embodied lives. He asserts that, in the process, psychoanalysis withholds explanations of the social production of gender categories and gendered positions. Evzonas (2020) concurs by stating that cultural messages relating to the contingent category of gender can infiltrate the individual's unconscious. Contemporary psychoanalytic thought argues that the developing individual is immersed in an ocean of signification from conception, and that subjectivity develops from an enigmatic matrix. Author such as Lacan and Laplanche have engaged with this formidable gap in psychoanalytic theorizing and contributed many vital conceptualisations (Hinton, 2009).

Gender was introduced into French psychoanalysis by Jean Laplanche who proposed the growing view of a 'decentred' subject that develops in the face of an enigmatic Otherness and contrasted this with the original view of a Self or centre which exclusively guides the development of the subject. A postmodern ethos has emerged which bolsters this notion of an 'otherness' that cannot be fully understood, and this postmodern ethos posits that the 'subject' develops or emerges out of the ambiguous interface between the enigma and incomplete attempts at discursive understanding. According to Laplanche, the child is initiated, as part of their earlier relational scaffolding, into collective narrative patterns by his/her intimate socius, namely parents and other libidinally invested adults (Evzonas, 2020). Laplanche, in underscoring a verticality of social transmission, explored how ambivalent gender assignments, in the form of enigmatic prescriptions, come to be implanted in the child's body ego by a constellation of seducing and invested caregivers. According to Fletcher (2000) the infant is confronted, in a relational context of generalized seduction and primordial bodily care, with a set of ambiguous sexual messages, as well as bewildering gender assignments. Evzonas (2020) claims that infants' enigmatic signifiers become somehow "parasitized" by adults' infantile polymorphic sexuality (p. 641). As per Evzonas (2020) such inscriptions become contaminated - saturated by the adult's drive-fueled and over-knowing unconscious - remaining enigmatic for both the sender and the receiver and marked by a quality of "too-

much-ness". According to Evzonas (2020), Laplanche asserted that cultural phenomena, through the horizontal circulation of cultural messages, can also be a purveyor of enigmatic signifiers which participate in our subjective constructions of gender. The primitive impingement by the other, through processes of implantation and intromission in the skin ego, can be equated to the violent inscription of the norm, as depicted by Butler (1990, 1997), which depicts the individual's submission into the prevailing disciplinary ideals of gender, class, and race (Evzonas, 2020)

Laplanche underscores the original helplessness of the infant who is bathed, over the course of a 'primal seduction' stage, in enigmatic messages, often sexualized in nature or compromised by the unconscious sexual significations of the over-inciting adult other (Evzonas, 2020; Fletcher, 2000; Hinton, 2009). Laplanche located the problematic of gender in the context of what he referred to as "the fundamental anthropological situation", the aforementioned situation of primal seduction, with its innate mechanisms of reciprocal communication between caregiver and child (Fletcher, 2009, p. 106). Despite such enigmatic adult messages being partly or largely unconscious, on the part of the infant's intimate socius, they can potentially be difficult for the infant to metabolize to the point that, in a process of 'primal repression', unassimilable elements can remain internally quarantined at the unconscious core of subjectivity (Evzonas, 2020; Fletcher, 2000). The fundamental anthropological situation can potentially consist of two moments: the moment of inscription and implantation of the message from the other over the course of 'primal seduction', followed by primal repression of the untranslatable elements of the message (Fletcher, 2000; Hinton, 2009). According to Laplanche, the child is invited, from an early stage, to translate an array of enigmatic assignments emanated by the socius (Evzonas, 2020). Metaphorically bubbling under the surface, untranslatable messages can disrupt psychological life, including illusions of meaning and coherence, whilst concurrently striving to convey a sense of signifying something to the subject - but precisely what they signify remains an enigma. Hinton (2009) uses the analogy of an individual trying to locate a hieroglyph in a desert and claims that relationships, as well as culture, drive repeated attempts to translate these enigmatic messages and to respond to them. Evzonas (2020) posits that the child, in facing the adult, seeks a progressive movement in which to translate the gender assignments prescribed by the latter, which can reactivate the adult's infantile sexuality and retranslate anew the enigmatic gender messages that they themselves once received. This ongoing translation process between child and caregiver may be isomorphic with that which may be unconsciously enacted in the analytic dyad.

This background stage of primary seduction has impacted analytic thought and practice also. Laplanche asserts that enigmatic gender assignments arouse a primary "identification by the other" thus setting in train an inherently alienating gendering process (Evzonas, 2020, p. 642). Laplanche underscored the profound asymmetry between the adult, the bearer of unconsciously determined enigmatic signifiers or messages, and the infant who has been assigned a gender on the basis of adult perceptions of its pregiven biological anatomy (Fletcher, 2000). According to Fletcher (2000) this assignation to a gender appears as an enigmatic question, posed precociously to the infant, and one which the individual attempts to symbolize or translate afterwards in terms of infantile sexual `theories' and their associated fantasies. According to Laplanche individuals may, throughout life, be continually attempting to translate and bind an assignation to a particular gender - an assignation which has been encapsulated within an enigmatic message containing the unconscious wishes of the adult (Fletcher, 2000). Hinton (2009) argues that the vicissitudes of the clinical situation can also illustrate the vital importance of the enigmatic signifier in the development of the subject including their gender and sexual identity. One may posit that therapists, perceived by their clients as bearers of unconsciously determined enigmatic signifiers or messages, may become negatively implicated in the transference and that instances of gendered forms of power and subordination may dynamically unfold in the intersubjective space. It is also possible that the "yet-to-be-translated", namely, the highly charged elements or resistant residue of untranslatable, alien materiality can emerge and become enacted within the analytic dyad (Fletcher, 2000).

In addition to recent theories of affect regulation and attachment, Laplanche's idea of 'excess', which has become an important transitional concept, integrating real experience with fantasy in sexuality, has also been incorporated as a means of understanding gender identity development (Celenza, 2010). Laplanche's idea helps to explain the association between sexual excitement and early affect-regulation, showing how excitement can become dangerous, with the effect of impeding or distorting desire. The 'too-muchness' of excitement recalls the primitive experiences of a stimulated, overwhelmed, unsoothed child and how such experiences may influence a gradual inability to tolerate sexual arousal and the excitement affect (Evzonas, 2020). Benjamin and Atlas (2015) enlarge upon Laplanche's idea of excess or 'too-muchness', to illustrate the early overwhelming of the psyche which affects the formation of sexuality making a case for a connection between attachment trauma and shameful experiences of gender identity as an area of trauma. They also argue that symbolic formulations and fantasies, in this case ones

associated with gender, are always embedded in interactions and fantasies that bear traces of crucial early attachment patterns and their pre-symbolic representations. It is worth considering how these traces may also emerge and become enacted in the clinical setting. In the same way that authors such as Stoller (1964, 1979) and Atlas (2011, 2011, 2013, 2015) claim that adult sexuality expresses residues of early intersubjective exchanges between infant and caregiver, Benjamin (2005, 2022) also suggests that early infancy exchanges may form the matrix of later gender development. She asserts that early interactions and their pre-symbolic representations can, *ipso facto*, result in difficulties with arousal and excitement or too-muchness within the sphere of gender excess and is not confined to the realm of sexuality.

Relational theorists such as Stein (1998a, 1998b, 2007, 2008) have subsequently enlarged upon Laplanche's earlier ideas contained within his extensive metapsychology, with an emphasis on the intersubjective perspective on development and clinical practice. Benjamin and Atlas (2015) exemplify the need to work, within the treatment setting, with the articulation of attachment trauma in the language of gender, wherein what it means to be male or female expresses the dilemmas of transferential love and hate. Benjamin and Atlas (2015) reflect upon the psychological sequelae of constructed gender subjectivity, owing to experiences of lack, wherein babies have been deprived of opportunities to playfully interact with the body of their caregiver and to luxuriate in a close bodily contact. Such sequelae may include a lack of agency as well as submission to and/or aggressive resentment of the other. In exploring thwarted primitive bodily interactions, the authors deftly evoke the experiences when a baby is not permitted to pleasurably abandon itself to sensation as a result of being subjected to an arbitrary breast and/or to an inconsistent or evanescent object.

Stein (1998a) also emphasizes the need for sexuality to diverge from functionality towards play as a means of bringing the erotic into existence. He (1998b) demonstrated how an active, masculine, controlling stance was adopted by an adult patient in order to renounce the passive baby position and a neediness which the patient feared would repulse the mother and destabilize their attachment; this mode of relating may be typically indicative of an anxious-preoccupied insecure attachment style. Benjamin and Atlas (2015) suggest that babies deprived of or denied the possibility of playing with the body of the other must remain in a constant and active state of unsatisfied desire wherein they have to tolerate their own internal tensions without help from the caregiver.

The presence of an enigmatic, destabilizing nucleus of experience can provoke the development of an ego that continually seeks to 'bind' those over-stimulating enigmatic elements which feel like black holes and are experienced as gaps in reality, gaps and holes that exert an ongoing, destabilizing effect on personal structure. The ineffability of these gaping gaps or holes in the patient's 'reality' can evoke sense of loss and melancholy that underpins the latter's wish to bind the stimulating implantations, to substitute its own signifying sequences as solutions to the enigmas of the other's desire (Fletcher, 2000; Hinton, 2009). Hinton (2009) argues that such enigmatic elements or nuclei of experience can provoke and have an ongoing, destabilizing effect on personal and cultural structures, and, at the extreme, can feel like 'black holes'; he adds that these enigmas are also the basis of our freedom to endlessly navigate and re-translate or re-imagine these gaps so that reflective capacity can emerge. Laplanche introduced the concept of mythosymbolic translational codes stating that the individual needs to have recourse to mythosymbolic grids, namely "preformed narrative patterns" provided by the surrounding culture. Evzonas (2020) refers to historically and socially contingent hermeneutical tools including myths, tales, proverbs, symbols which help the child construe the adult's enigmatic signifiers.

It is possible that aspects of Laplanche's metapsychology may become enacted within the therapeutic clinical setting when working with gender-variant patients. It is accepted that the communications of both analyst and patient are invariably influenced by unconscious elements and are not 'pure'. According to Evzonas (2020) therapists are also caught in mythosymbolic structures of power and hierarchy. He adds that when master signifiers, such as 'castration' and 'sex difference', shift to coercive and pathologizing usages the analyst's anxiety and infantile *sexuality* can be at stake. Accordingly, they need to be deciphered through the psychic work of translation by drawing on relational, anatomical, cultural and social codes (Evzonas (2020). Levinas (1998) also describes peculiar moments of 'otherness' or 'subjection' to otherness, which can manifest as moments beyond words, experiences of the unsayable which are sudden and unexpected; these may even include moments of inexplicable laughter which are subjectively experienced as maddening. Hinton (2009) also refers to the enigmatic quality of subjectivity as deriving from a "trace of the infinite" which cannot be reduced to personal or ontological terms (p. 652). It is arguable whether gender-variant patients may also report similar subjective experiences of the unsayable which can be ascribed to primitive experiences of the enigmatic other and whether such phenomena manifests during the therapy process. Is there a likelihood that parallel processes may unfold for the therapist, which mirror

experiences of ‘primal repression’ and ‘too-muchness’, and which may fuel unconscious transference-countertransference enactments? Is it possible that the therapists may be overly receptive or attuned to untranslatable enigmas, associated to the unknowability of the other, and which can potentially arouse dread and anxiety? Fletcher (2000) asserts that adult implantations are targeted at particular bodily sites, including the mouth, breasts and genitals, and suggests that specific erogenous zones can transmit enigmatic excitations that are taken in and submitted to the infant’s binding symbolizations. Accordingly, might therapists experience somatic countertransference in erogenous zones that were the target of adult implantations, such as the breasts and penis?

In conclusion, the developmental origins of these phenomena have been explored by Stern (2010) who, through his work on infant development, describes issues of vitality forms which he defined as “a whole. … it is a Gestalt that emerges from the theoretically separate experiences of movement, force, time, space and intention” (Ammaniti & Ferrari, 2013, p. 367); this sense of vitality is transmitted to the spectator through body movements whereupon the vitalizing function of self-object experience contributes to the coherence and vitality of the self; the individual is afforded a sense of organising competence through the acquisition of self-efficacy and self-agency. As yet this gestalt has no specific conceptualization in the field of psychoanalysis despite the recurrent emergence of the theme of vitality which represents an enduring and underlying lived experience in an individual’s life as well as in relation to others. George Klein (1976) defined vitality as “the sensual pleasure which originates in bodily induced sensations … vital in affirming a sense of physical and psychological identity” (Ammaniti & Ferrari, 2013, p. 367). This study hopes to focus on these vitality forms and issues of somatic expression and communication between therapist and client, so as to contribute to filling a gap in the existing literature. It also hopes to enrich the literature on therapeutic process with clients presenting with gender dysphoria.

CHAPTER 3: METHODOLOGY

3.1 Research Questions

When treating clients with significant gender-related body dysphoria:

1. What are therapists' experiences of somatic phenomena within their own bodies in the analytic setting?

2. What are therapists' experiences of the phenomena of somatic transference and countertransference in the analytic setting?

3. What are therapists' experiences and understandings of defensive resistance deployed in the therapeutic encounter?

3.2 Research Design

A qualitative approach to research was adopted in this study in order to generate meaning and understanding through rich material. An interpretivist paradigm was employed whose ontology examines the perceptions and experiences of therapists who have treated clients with significant gender-related body dysphoria. This paradigm was considered preferable as it is a flexible method which allowed for the systematic identification and organization of patterns of meanings (or themes) across a data set offering insights into both obvious (or semantic meanings) but which also can interrogate latent meanings (Braun & Clark, 2012, p. 58). The paradigm employed a subjective epistemology with a qualitative mono-methodology. This question-led approach allowed connections to be made with existing theories and assisted in avoiding repetition or overlap with previous studies. This approach also facilitated clarity of research ideas in order to reflect on the definition and operationalization of relevant concepts and to link these to an appropriate research design (White, 2013).

Hinshelwood (2018) maintains that specific limitations can constrain the parameters of psychoanalytic research causing the endeavor to ultimately founder. He highlights the problem of subjectivity in contrast to the bedrock of objectivity in the natural sciences which will be discussed in relation to self-reflexivity. It has been argued that interpretations cannot be based on brief interviews containing anecdotal reports with non-

generalisable findings. All interpretations have been made tentatively, especially when pertaining to the clinical material of only one participant. Most often, interpretations have been made only when there was sufficient evidence across multiple interviews.

3.3 Theoretical Framework

A psychoanalytic theoretical framework was employed which draws on psychoanalysis to map subjectivity. Owing to the sophistication of somewhat abstruse ideas derived from the field of psychoanalysis and an openness to the investigation of particular 'meanings', this framework offered a 'thickening' or enrichment of interpretive understanding in its application to personal narratives, especially those articulated in interview settings. A more thorough and rich interpretive re-description of interview material could be offered which could provide useful links to clinical perceptions and practices. Instead of relying dependently on flimsy assumptions to comprehend subjects' positions the psychoanalytic framework and methodology offers interpretive strategies which helped to illuminate, concretise and buttress the psychological processes, including both conscious and unconscious associations and motivations, underlying a subject's investment in any rhetorical or discursive position (Braun et al., 2012; Bree et al., 2016; Maguire et al., 2017).

Personal experiences as narrated by the participants were understood to be principally mediated by relational dynamics and unconscious processes and material was viewed through the lens of the psychic realm. However, the psychic structures that organize individuals' internal worlds in particular ways were also understood to be informed by social structures that speak to actual events. The privileging in subjects' dynamic accounts of unconscious affective experiences assisted with the investigation into ulterior dimensions of the text. This intricate excavating of nuanced, unarticulated or conflictual material was facilitated by identifying discernible patterns that were considered indicative of anxieties, defences and/or idiosyncratic modes of relating that may have originated in the particpants' personal histories and been recurrent throughout their lives and practice. Various assumptions and theoretical expectations of the analyst needed to be interwoven into the manifest material in order to derive or reveal more latent aspects. This focus on individually demarcated reality and intrapsychic processes rendered more accessible the complex psychological properties or structures that psychoanalysis is primarily interested in. Acknowledging this subterranean domain of expressive meaning primarily implied that the unconscious is a domain of prohibited speech and that conversational devices

have defensive functions that need to be penetrated (Braun et al., 2012; Maguire et al., 2017).

The psychoanalytic framework employed acknowledged awareness that individuals are embedded in social and cultural contexts, with unique ways of being, but also with individual orientations to these contexts. It acknowledged that individuals are uniquely invested in discourses in an inordinate number of ways that are influenced by conscious and unconscious wishes. This approach regarded narratives as dynamic processes which, despite appearing ostensibly comprehensive, retained some opacity in its resistance to becoming fully revealed (Frosh & Saville Young, 2017). An inductive approach predominated which was experiential in its orientation and essentialist in its theoretical framework so that the experiences and meanings conveyed in the data could be expressed (Braun et al., 2012; Maguire et al., 2017; Peterson, 2017).

3.4 Sampling

The participants were sourced using a non-probability snowball sampling technique. Given that the research participants are members of a special population of clinical psychotherapists, a few individuals, known to my supervisor and her colleagues, were initially approached and invited to participate in the study. Those who participated were then requested to approach other potential candidates who have experience of working with gender-related body dysphoric clients, and some provided details of others who they believed may be interested and eligible to assist with the study. This respondent driven snowball sampling strategy facilitated access to this specific population of psychotherapists (Laher & Botha, 2012). Efforts were also made to achieve methodological rigour in sample composition by striving to ensure that it was a representative sample and inclusive of different ethnicities and races. However, the majority of the sample that accepted the invitation were Caucasian and Indian participants with no black psychotherapists.

Owing to the intense and in-depth nature of the study a medium sample size was chosen and this decision was also based on the instrument method of gathering data (Laher & Botha, 2012). Participants were chosen specifically on the basis of whether they had experience of working with clients presenting with gender-related body dysmorphic issues and no participants were considered for inclusion who lacked experience working with this niche demographic. Ideally these participants should have worked with a minimum of 2 clients from this client profile. The participants were required to have a

psychoanalytic orientation but it did not have to be their dominant orientation and an eclectic orientation was acceptable.

In the end, thirteen psychotherapists were interviewed. Of these six of the participants identified as male and seven identified as female. Twelve of the participants were white and one was Indian. They practiced in both state and private practice settings in Johannesburg and Cape Town. Further identifying information, including preferred pronouns, have been disguised or have not been included to uphold participant anonymity. The pseudonyms used were Dolores, Eric, Jane, Justin, Linda, Mary, Mike, Nicky, Rachel, Ralph, Richard, Ruby, and Simon.

3.5 Semi-structured Interviews

For the purposes of this research the primary data was obtained by conducting thirteen semi-structured interviews in total from which anonymized interview transcripts were prepared and analysed. Interviews lasted approximately one hour each. I conducted each of these semi-structured interviews online, as it was each participant's preferences considering covid guidelines, at the time advising social distancing. These online interviews were conducted at a time convenient for the participants. Potential participants were presented with an information letter via email which outlined the purpose of the research and the rights of the interviewee throughout the process. Consent forms were also presented to the participants prior to participating in the interviews to expressly inform the potential participants that, with their permission, the interview would be video-recorded. Given that the topic referred specifically to the body it was deemed preferable to use the medium of video should a participant wish to demonstrate specific physical gestures, facial expressions, unique patterns/styles of movement to pinpoint specific body parts. For the purposes of this report, pseudonyms were allocated to all participants, and any other identifying information that was disclosed by the therapists during the course of the interviews was also anonymized.

A semi-structured interview schedule was used to provide a broad structure for the interviews, however, interviews tended to follow the participants' narratives in order to clarify meanings. Amongst the questions which were posed within the interview schedule, the most pertinent questions, within the context of somatic countertransference and other related psychoanalytic phenomena, pertained to the direct experiences of the therapists during the therapeutic encounter. The interview did not pose probing or

invasive questions about their clients which could be considered prurient in nature or that would breach ethical practices or guidelines relating to confidentiality or other therapeutic standards of propriety. Video-recordings will be deleted after examination of the study and anonymized transcripts will be kept on the researcher and his supervisor's password protected computers for possible future research use, with participants' permission.

3.6 Data Analysis

An Interpretive Thematic Analysis was used to analyse the transcript data derived from the interviews as it is the most foundational form of qualitative analysis that can be honed or narrowed on the basis of the research aims (Peterson, 2017). This approach systematically identified, atomized and offered insights into patterns of meaning (themes) across a complete data set so that collective or shared meanings and experiences could be comprehended. While there was a focus on what is common to the overall nature of the discussion and made sense of such commonalities, unique and uncommon or idiosyncratic meanings and experiences were also highlighted when deemed important to understanding the topic area (Braun et al., 2012). The themes did not superficially correspond with the interview questions nor did they summarise the data in any overly simplistic way (Braun et al., 2006; Maguire & Delahunt, 2017). It was essential that all data collected from the interviews was triangulated by using multiple sources of data to examine somatic countertransferential phenomena and the data was analysed in a thoughtful, professional and thorough manner in order to ensure that any results and findings were valid and reliable (Bree & Gallagher, 2016).

Thematic Analysis offered a theoretically flexible and accessible approach in which to atomize the data and it is a method that is independent of and not wedded to any theoretical framework or epistemology; it was not limited or constrained by being theoretically bounded. Its application can span a range of theoretical and epistemological approaches, and through the psychoanalytic approach that this study used, it provided a rich, exhaustive and complex account of the data that is theoretically and methodologically rigorous (Braun et al., 2006; Liamputtong, 2009; Maguire et al., 2017).

Both inductive and deductive approaches were implemented so that, during initial analysis, the data was not categorized on the basis of a predetermined coding frame when the coding was conducted; this safeguarded against analytic preconceptions by ensuring that the collected data drove the analytic process (Bree et al., 2016; Maguire et al., 2017). A deductive approach was assumed later in the analysis process where themes were

interpreted according to psychoanalytic understandings of transference and countertransference dynamics and defensive processes, and findings were compared and contrasted with existing psychoanalytic literature.

An open mind was maintained throughout all stages of the analysis so that alternative views could be considered (Bree et al., 2016). The analytic process was not rushed and was recursive and iterative rather than linear so that the data could be optimally harnessed. The data was initially transcribed and initial ideas were noted down. Familiarity with and immersion into the data was established during this initial phase with some evident semantic themes being initially discerned along with somewhat more latent themes emerging. Initial codes were generated in a systematic fashion across the entire data set for interesting features and data was collated specific to each of these codes which appeared to represent potential 'chunks of meaning'. Themes were then derived from the codes and were grouped by their significance and meaning as opposed to their prevalence. Associated data relevant to each theme was collated resulting in a potential clustering of themes. These themes were reviewed in order to ensure that the themes worked for both the coded extracts but also in relation to the entire data set and also to ensure that context was not lost; some themes were jettisoned, combined, refined or separated over the course of the data analysis stage after more thorough deliberation with my supervisor. The analysis of the themes moved from a descriptive form to a more interpretive form (Bree et al., 2016; Maguire et al., 2017).

Thematic analysis afforded primacy to collected or shared meanings across the data set and this ensured overall consistency and coherence throughout, however, 'outliers' or opposing views and experiences were also noted. The themes were then linked to broader theoretical or conceptual issues (Braun & Clarke, 2006; Braun & Clarke, 2012). The research was located on three continua which each carry a particular set of assumptions. Coding and analysis used a combination of an inductive, bottom-up approach (which was primarily driven by the semantic content of the data) and a deductive, top-down approach (which consisted of a series of related concepts and ideas brought to the data) when interpreting the data.

I also committed to a subjective process of continually engaging with my own sense making and documented salient thought processes and bourgeoning ideas in a journal which facilitated deeper analysis of these themes. The specifics of each theme were refined and reformulated in an ongoing consolidating analysis so that clear definitions

and names for each overarching or superordinate theme and the more atomized sub-themes could be generated. A thematic map was then devised which accurately reflected meanings, prevented against overlap or redundancy of data and was more representative of the data set as a whole. When certain themes were deemed overly-ambiguous or overly-distinct further refining and revision of codes was undertaken and prior stages were revisited. The report produced relates directly and cogently to analysis of the research questions and the reviewed literature. This report has synthesized the compelling findings and interpretations and has included a tight analysis of vividly apposite extracts in the overall context and ones that are especially pertinent to the arguments embedded throughout and in specific relation to the research questions (Braun et al., 2006; 2012; Bree et al., 2016; Clarke & Braun, 2013; Javadi & Zarea, 2016; Liamputtong , 2009; Maguire et al., 2017; Peterson, 2017).

3.7 Credibility, Trustworthiness and Reflexivity

Within qualitative research epistemological issues pertaining to credibility, trustworthiness and reflexivity are highly significant concepts. The authentic representativeness or credibility of qualitative research findings should not be critiqued using positivistic criteria but instead the establishment of credibility necessitates a 'shared vision' with other informants to guard against research bias (Cutcliffe & McKenna, 1999). In order to establish trustworthiness, two main concepts have been acknowledged; namely dependability and transferability. The former refers to the consistency and reliability of the research findings and the transparency of the research process and reflect notions of replicability and 'truth'. Transferability determines the degree to which the findings of a research inquiry can have applicability in or be extrapolated to other contexts or to a wider population (Guba, 1981; Korstjensa & Moser, 2018). To ensure credibility within this study I explicitly acknowledged and documented my initial pre-suppositions and subjective judgements when reading the transcribed findings which could potentially preclude more holistic interpretations being achieved. Additionally deeper insights were gained and intellectual rigour and integrity ensured by enlisting the support of Professor Bain, my research supervisor, in order to verify and objectively discuss the various formulated theme categorisations. This mode of triangulation and engagement with another researcher to corroborate themes has ensured consistency and prevented against single perspective bias as well as permitting counter-patterns

as well as convergences in the data to be identified (Lincoln & Guba, 1985). Displaying key or exemplar excerpts/quotes or data extracts as expressed explicitly by the participating therapists was another means of ensuring greater transparency, and thus credibility and trustworthiness (Quinn Patton, 1999).

The most significant element of qualitative research is reflexivity. In order to produce a well-crafted analysis with carefully rendered meanings a reflective appraisal of the data was essential where rigorous and routine introspections were conducted of any intrusive or misleading subjective experiences which emanated and ran the risk of leading to potential 'garden path' interpretations. The results of this study were chiefly a co-construction between Professor Bain, the interview participants and myself. I conducted the interviews and transcribed the findings as well as interpreted the data. In order to ensure reflexivity, a self-assessment of my subjective experiences was necessary. The aim was not to eradicate bias, but rather to acknowledge my positionality and frame of reference and the influence of this on my interpretations of the data. A reflexive approach ensured that my position, as principal researcher, has not manifested surreptitiously in the findings, rather it is yet another visible piece of the data to be taken into consideration and analysed, and this has yielded useful insights (D'Cruz, Gillingham & Melendez, 2007).

Given my position as a student psychologist any preconceptions and/or biases were interrogated given that this has been a collaborative research undertaking. Accordingly, any dominant researcher worldviews have not skewed or distorted the *prima facie* experiences of the participants discussing their experiences of somatic phenomena in the analytic setting. Whilst the researcher is an inclusive element of the world examined by the interviewed therapists noteworthy and emergent discoveries were considered a function of the relationship that exists between the qualitative researcher and the subject matter expert who is essentially the figurative master of their domain (Larkin et al., 2006). In the interests of transparency a reflexivity journal was kept throughout the data analysis phase of the research and multiple consultations with Professor Bain served as a means of support and guidance.

As part of my reflexivity process, I engaged in continual internal dialogue and self-appraisal of my positionality by being mindfully conscious of the manner in which I approached and interpreted the transcripts' contents (Berger, 2015).

I recognised, in advance, the potential effect of gender and race dynamics inherent within the interview process given that I, as the interviewer, am a white male who was engaging with a data corpus that touches upon gendered and cultural aspects pertaining to the physical body or who may be engaging with therapists from a different race or gender and who practice within a different theoretical orientation. I was mindfully conscious that I do not have any superior access to truth on the basis of my identity position. I also held in mind that the individual voices of the participants' patients, whom the therapists are discussing, have not been included in this study and how transphobia can potentially manifest given that the interviewed therapists and I have all been raised, socialised, and analytically trained in cultures and metapsychologies that treat normative gender as the expectable, unquestionable endpoint.

Throughout the process I also considered my own personal gender identity development and my family culture. I reflected upon the fact that I was socialized in a strictly gender-binary manner by parents who adhered to inflexible and restrictively normative conceptions of sexual and gendered life, and who valorized compliant modes of gender expression or presentation that met expectable forms of gender. It was important to bear in mind how such an objectively narrow process of gender socialization may have influenced my own biases and prejudices around gender. I was mindful of not having had any direct experiences with a family member or friend who has had sex reassignment surgery or reported experiences of gender dysphoria. I also considered factors including age and the fact of growing up in the Generation X demographic group, and how these elements have influenced my subjective stance on gender; this is especially salient given the rigid standards of gender performativity which prevailed, the dearth of cross-gendered individuals visible in society during my childhood and adolescence, and my consequent lack of cumulative interactions and identifications with gender-nonconforming others. I had to be cognisant throughout that, despite ideological commitment to gender-diversity, the reality of gender fluidity could tangle me in strange knots and these had to be discusses with my supervisor.

I devoted significant attention towards contemplating my own identity as a white male who has been raised in Ireland and who comfortably inhabits his body and has never experienced any form of gender dysphoria. I was also mindful of the challenges that I have grappled with concerning my sexual orientation and the internal conflicts that it engendered such as estrangement from the 'other'. I also

reflected upon my own subjective feelings and individual views with respect to the role of the non-directive, empathic therapist who typically adopts a stance of restraint and neutrality and how this may produce dissonance when dealing with a gender dysphoric client with a known or suspected pathology. Over the course of the research I became conscious of a crisis in my own subjectivity and the manifestation of an anti-analytic third, as experienced by several of the therapists interviewed and, which called for deep self-reflection and a need to locate myself in the broader social context. Greater understanding of what was dynamically unfolding illuminated an inhibitive desire to self-censure owing to imagined fears of offending readers of this research. Enhanced self-reflexivity also revealed emergent feelings of shame and guilt occasioned by excessive moral self-judgement on the basis of social discourses and the power of interpellation - a trauma of morality as conceptualised by Straker (2006).

It was also important to be aware of my own judgements and assumptions regarding the clinical material elicited from the therapists who were interviewed and to acknowledge that there is much background context to which I may not be privy. By including clinical material at the limits of my own known theories and constructed subjectivity I was also attuned to my own countertransference reactions including somatic experiences. I became aware, on occasion, of an impaired capacity to think and, similarly, of a tendency to defer to an unhelpful anti-analytic third which constellated when interpreting clinical material. I also experienced an acute and vigilant attentiveness not to convey or express any offensive pronouncements that may be considered biased or prejudicial, particularly during the interviews and throughout the research process. Engaging with psychoanalytic theory, as a pre-given third, was the primary means in which to understand what was occurring intrapsychically and, in the process, assisted in restoring mindfulness and recovering my capacity to think. When conducting the interviews the majority of the therapists exhibited curiosity about the research topic and expressed an interest in developing more awareness of their own bodies in the therapeutic setting. However there was an occasional sense that several of the participants appeared ill at ease being interviewed by a trainee therapist and possibly feared judgement.

It was important to acknowledge my partial perspective, in the overall context of situated knowledge, and owing to several divergent aspects of my subjectivity including gender, sexuality, age, culture and disciplinary orientation. I attempted as far as possible to ensure that I remained unbiased in my interpretations so that the

risk of amplifying my own interpretive voice was diminished. Being exposed to certain truths contained within the transcripts and challenging personal expectations and attitudes in addition to various consultations with Professor Bain facilitated a more open and holistic approach to data interpretation.

3.8 Ethical Considerations

Ethics clearance was obtained through the internal research ethics process of the School of Human and Community Development at the University of the Witwatersrand. The thirteen participants who volunteered to be interviewed by the researcher were each asked to give formal written consent to participate in the study and for the researcher to make a video recording of the interview. None of the participants belong to a vulnerable category and were selected as experts. Neither the participants nor the researcher were exposed to any foreseeable harm or risk. Thought was given to a distress protocol in the unlikely event any participant became distressed. If that had occurred, I would have discussed options for supportive psychotherapy with the participant. Prospective participants were furnished with an overview of the study and were expressly informed in writing that they were free to withdraw at any stage from the study without imposed penalties or adverse implications. The privacy and confidentiality of the participants was assured in writing by the researcher and personal identifiers were removed from the transcripts by means of employing pseudonyms. Any other identifying information such as, for example, geographical suburban locations of the participants' clients and their geographic locations, was also removed from the original transcripts. The anonymity of any third parties referred to in the interview transcripts was safeguarded by using pseudonyms. Additionally, the interview data has remained strictly confidential and has been secured rigorously by the researcher and his supervisor on a password protected database. The raw video research data has also been stored in a password protected cloud file and will be deleted once the research report has been examined. The researcher has promised within the bounds of this particular study that the transcripts will not be shared with anyone other than the study's research supervisor and this assurance will be honoured and upheld. With permission from the participants, the anonymized transcripts will be kept for future research purposes indefinitely, on the password protected computers of the researcher and his supervisor. Details pertaining to all ethical considerations have been included in the appendices.

CHAPTER 4: FINDINGS AND DISCUSSION

EXPERIENCES OF THERAPISTS

4.1 Introduction

Nine main themes emerged from the interviews, outlining the multiple experiences of thirteen psychotherapists who have worked, to varying degrees, with a gender-variant population. It is important to note that while these broad themes emerged as a useful way to capture the experiences of these therapists, some of their experiences often fell into multiple categories, suggesting that the themes intersect and overlap and that the experiences of these therapists are not as clearly delineated as the following categories.

The first theme outlines therapeutic stances which therapists tend to adopt in working with gender-variant clients. An emerging theme which details the impact of the Zeitgeist in shaping therapeutic approaches follows. Therapists' experiences of somatic countertransference are enumerated in a separate theme which may have been influenced by particular therapeutic stances along with perceptions of the Zeitgeist. The following two themes investigate factors which may have impeded therapists' abilities to engage with their experiences of somatic countertransference including unthinkable anxieties in the countertransference and the manifestation of an anti-analytic third. The next theme explores how therapists make sense of their own and their client's experiences of gender and embodiment within the treatment setting. A separate section details therapists' experiences of working with child and adolescent patients and whether it influences their qualitative experiences of somatic countertransference. The penultimate section examines the role of supervision and training pertaining to the body when working with a gender-diverse client population. In the final section two contrasting approaches which appeared to emerge for the therapists are explored, as well as an analysis of the merits of one approach over the other.

4.2 Therapeutic Stance

Although the particular and singular actions taken by psychotherapists of various schools or orientations derive their meanings from the unique analytic setting and relationship as

a ‘total situation’, and are inevitably embedded, to varying degrees, within the analyst’s personal life (Shapira-Berman, 2022), a common therapeutic stance was found to be adopted by these therapists when working with a gender-variant population. The therapists collectively suggested that their stance is primarily rooted in the *experience* or the ontological, as conceptualized by Ogden, and not the epistemological, foundations of psychoanalysis. All of the therapists appeared to make an implicit distinction between epistemological psychoanalysis which “refers to a process of gaining knowledge, arriving at understandings of the patient, particularly understandings of the patient’s unconscious inner world and its relation to the external world” (Ogden, 2019, p. 5) and ontological psychoanalysis which “refer[s] to *a dimension of psychoanalysis in which the analyst’s primary focus is on facilitating the patient’s efforts to become more fully himself*” (Ogden, 2019, p. 6).

The majority of the thirteen therapists stated a foremost *conscious* desire to be experienced by their clients as ‘unobtrusive object analysts’, a concept employed by Grossmark (2018) to describe analysts who are deeply engaged yet not liable to iatrogenically impinge upon their clients. This is in direct counterpoint to Bion’s notion of the obtrusive analyst who, notwithstanding a sense of curiosity, is unable in the immediacy to withstand being the receptacle of parts of the patient’s personality; aspects that neither patient nor analyst may yet know, much less describe or navigate. This notion of the unobtrusive analyst will be examined further when discussing countertransference and, specifically, how the unconscious, as a politically incorrect agent, can hinder the therapist’s conscious desire.

Many of the therapists privileged and valorized a more restrained approach where the therapist becomes a tactful and connected companion and witness (‘with-ness’) in the overall unfolding and flow of their patients’ enactive engagements. This is achieved by utilizing a ‘holding’ and psychologically grounding position (Grossmark, 2018; Reis, 2009; Shapira-Berman, 2022). Justin expounded upon the benefits of such a stance:

> *I think, in order to do the holding, you don't actually, necessarily, need to be the expert. You don't necessarily need to know what's happening or where the person is going, but it is creating a safe environment for them to be able to explore and for their true self to emerge and their true gendered-self to emerge. So I think, I think that's put me more at ease. I see myself as more creating a holding space rather than being the expert that knows and needs to determine something for a person that needs to force them into a space where I determine something for them.*

The majority of therapists appeared ostensibly prudent yet almost hesitant or vigilant during the interviews; each uniformly agreed that therapists are in uncharted territory on the topic of trans-identities and they were, accordingly, fearful of committing errors of either commission and/or omission. Each therapist avowed an intent and sense of incumbency to adopt a relational trans-affirmative stance, when working with a gender-variant population, which has historically been treated as subaltern or putatively pathological, for the sole reason of transgressing gender norms or the gender status quo, and to adhere to an inclusive model that is not informed by power relations.

The therapists held a uniform conviction that there is no single developmental line for the establishment of trans-identities and that similar developmental end points frequently originate from distinct developmental routes (Saketopoulou, 2014). These therapists reiterated the Freudian view that the emblematic feature of unconscious reactions to what constitutes a complex psychic process is over-determination and not linear or monocasual understandings (Evzonas, 2021b). In the following passage Justin conveys his unease when probed for possible hypotheses:

> *Hmm to be honest, I feel a bit uncomfortable with that question. Yeah, I think I do steer away from the idea that gender identity could be caused by some sort of other pathology. I know that it is very much possible and I think it is obviously trying to always sit with that possibility. But I think, often psychologically, it is very easy to go there, that gender diversity is actually some sort of pathology that stems from early attachment difficulties or stems from some sort of relationship difficulty. I think that it is obviously always a possibility to hold in mind. But my understanding and I think where contemporary research is going is that, actually, gender identity is something that's innate and it is a natural form of diversity; it's not necessarily something that is caused by bad parenting or bad attachment. So I think that I'd rather tread quite cautiously there because I think it is very easy* [*to pathologize*].

In line with Saketopoulou's (2014) understanding, the therapists preferred to think along developmental lines of variation rather than lines of aetiology, which can implicitly insinuate pathology, and, a priori, holds an expectation that the analyst determine causative factors to "account" for their patient's gender per se. this group of therapists rejected the notion that locating causative agents regarding gender, or the impact of possible formative pathways, can be clinically fruitful to an extent where its explanatory force can magically transmute atypical genders. They were discernibly reluctant to rely

on explanatory hypotheses as doing so can erroneously and reductively narrate the course a particular patient's gender has taken, and actually produce an alienating and counter-therapeutic effect on trans-individuals, a vulnerable population of various genders, embodiments and self-identifications. These therapists argued against nomothetic explanations, and stated their appreciation of the psychic intricacies inherent in gender development, and how this recondite and controversial subject requires an in-depth understanding of the contextual issues surrounding the singular individual experience. The following excerpt, narrated by Linda, captures how the majority of therapists felt on this matter:

> *I've never found one model that we can fit everybody into; I think that's problematic - as we could say with anybody developmentally. I don't try to fit a model to any person who comes into the room; I try [to] understand what's going on for them. But even as I say this to you, it is still almost pathologizing each of them, because it's still coming up with a way of explaining why they're needing to do this - rather than accepting their felt experience - which is that something happened and that their body and their inside are not aligned.*

The majority of the therapists who were interviewed charged the clinical mainstream with impropriety through the contemptuous adoption of forms of theoretical arrogance and its deleterious tendency to overreach and make broad generalizations and reductionisms, which unabashedly subsumes the personality of gender non-conforming patients. Some therapists explicitly rejected outright heretofore embraced, yet oversimplified, formulations, for example, 'the wrong body' narrative. Therapists did not subscribe to that tenet or any similar forms of transphobic bias which renders trans-patients susceptible to indiscriminate and reckless pathologisation through the application of diagnostic insults. The therapists refused to allow their minds to be subjugated by psychoanalytic orthodoxy or convention and suggested that the paucity of intellectual rigor with respect to gender variance should, in itself, preclude clinicians from making far-reaching pronouncements on the trans-experience. Justin made the following cautionary remark:

> *I think we need to be quite aware of just how easy it is to be cis-normative. So in a sense just because someone's diverse, blaming it on an attachment issue or other [issues]…., you know, obviously we've done that in the past with gay people and we've done it in the past with autistic people. The analytic community and practitioners have been really notorious for very*

> *easily blaming parents or very easily blaming attachment for difficulties. I think it's probably quite important just to caution against that.*

Another therapist, Eric, reiterated this stance by stating that normative gender should not be conceived as the superior outcome wherein those who choose to live outside of gender's binary regime are perceived as socially unintelligible, and, accordingly, deprived of social recognition to an extent where one feels psychically incoherent, even to themselves. In the following extract Justin adds that:

> *I really see the value in psychoanalysis, but I think sometimes it does overshoot and I think often the affirmative stance is the most important; the primary thing for me [..] it is obviously thinking about contemporary best practice and de-pathologizing gender diversity and then using psychoanalysis to fit in with that rather than psychoanalysis determining these things. So yeah, I'm a bit wary of that because I think I can understand how they could be used offensively or there could be difficulties with that.*

Several therapists conveyed an acute sense of discomfort and even mild irritation when asked about plausible theoretical formulations surrounding atypically gendered people; they did not conceive of this demographic as a predefined clinical entity who should be subject to narrow objectification but as a fluctuating and diversified social group who wish to resolve their gender conflicts and who should be engaged with from a pluralistic perspective.

All of the therapists demonstrated a stance of curiosity about the trans experience and some stated that they prefer not to make the patient's gender a central focus and that a more free-floating attentiveness in the therapist can arouse a concomitant curiosity in the patient about their own gender's trajectory. In this excerpt Linda explains:

> *So to some extent, I want to say the work is the same because I don't focus solely on gender when I'm working with someone; although that may be very present for some, for some it isn't. For some they come in and this is a part of the story. But we're looking at all the other stuff like, maybe, what it's meant for them to live most of their lives in an inauthentic way where there was this mismatch between their bodies and their felt-being and how traumatic that was for them or what that has done to their family relationships.*

There was a consensus amongst all the therapists that there is no 'master trans narrative', uncontested intervention, or universal psychoanalytic patterns which therapists can adhere to for such a heterogeneous set of individuals. Therapists argued against a nomothetic approach (supported by writers such as Bell (2020), Chiland (2000), Millot (2006)), preferring idiographic inquiry which recognized that there exists an assortment of multiple complex narratives, as recommended by Saketopoulou (2014). They alluded to psychoanalysis's unwillingness to revise, despite the wide-ranging and heterogeneous discourses of gender-creative people, its biased, bigoted and intolerantly patriarchal dogmas (especially deployed within the field of psychiatry) pertaining to the gender diverse population (Blass et al., 2021). Ralph demonstrated this stance in the following excerpt:

> *No. I am very strong of the opinion [that] this is not a pathology and that being trans and gender diverse is part of a naturally existing spectrum. So obviously, as a gender affirming healthcare practitioner and I'm on ..* [mentions a number of local and international organisations]. *I have done a lot of the research and I do a lot of the psychoeducation stuff. So no, absolutely. I do not believe that psychodynamic theory has* ***any*** *position in offering any hypothesis or theory as to why people present with diverse gender identity. I really do believe that the overwhelming evidence is that essentially a template is established by a number of processes […] there is fairly good evidence with regards to fetal development, fetal brain development. There's a number of the genetic studies, the brain development studies, the hormone flashing studies, etc. that, to me, quite convincingly leads to - that every child is born with a preexisting template - and that there are challenges as we're born into a world that's still very much binary in it's gender perspective […] But yeah, I do not believe that in any way is being trans some manifestation of any mental disorder or attachment or any other kind of pathology - in any way!*

In lieu of identifying possible etiological underpinnings which therapists believe solely serve to treat the transsexual experience as a unitary phenomenon, in the past therapists have largely opted to conceptualize the trans experience as complex compromise formations, psychic products of unconscious defensive mechanisms, and the end point of heterogeneous developmental pathways (Sakeotpoulou, 2014). There was a pervasive condemnation or repudiation in the interviews of the concept of absolute gender binarism or the fixed idea that gender, ultimately, has a final, biologically predetermined

destination irrespective of psychic life. These therapists shared the view that such gender dichotomous positions can lead to unhelpful polarizations wherein gender identity is presumed to be organized by sexual difference alone as opposed to an intricate weave of anatomical, psychological, and sociocultural factors. Accordingly they concluded that searching for unitary explanatory factors to account for one's felt sense of gender misalignment is unwise and can lead to singular and inflexible understandings of individuals. Therapists appeared to stress the significance of adopting pluralistic and intersectional approaches in order to disrupt the normative unconscious at the root of repressions, splittings, and denials of both a psychic and theoretical nature (Evzonas, 2020).

Linda objected to the degree of inequality in unscrupulously asking etiological questions of non-normative genders when normative or socially-accepted genders are not routinely subjected to etiological inquiry. Most therapists were strongly opposed to any essentialization of transness in which gender non-normative clients are perceived or judged as being organized in excessively bound and rigid ways. Instead, therapists considered self-determination as a trans-individual to be equivalent to any other typical or atypical conscious self-definition as Linda indicates in the following statement:

> *I suppose coming up with these stories for ourselves to make sense of it, and we are too invested in them, I think that even if they're not overly simplified and reductive, they're still in a way negating the individual's own experience and explanation of how they've come to be who they are.*

In explaining and defending their therapeutic stance when working with a gender-nonconforming population the therapists expressed an active concern about the perpetuation of situations of discrimination, psychic-violence, and oppression through the hegemony of norms and hegemonic structures of thinking which some clients may have confronted in the past. Therapists promoted a more intersectional psychoanalytic approach to working with non-binary gender identities by considering the adverse impact of power relations. They claimed that such power asymmetry finds expression through pervasive gender expectations, extant preconceptions, and/or the enjoining of regulatory or disciplinary gender idealities.

Specifically several therapists outlined how cultural patterns of oppression and cultural messages, pertaining to contingent categories such as gender, can not only inscribe the

social but can, additionally, infiltrate the individual unconscious when implanted destructively by cultural purveyors. There was a uniform desire amongst those interviewed to be perceived as a 'safe' therapist who does not inadvertently amplify their patients' distress through acts of commission and omission (such as misgendering) arising from cis-normative presuppositions; this salient principle, which emerged throughout the interviews, appeared to guide their clinical work. Jane captures this stance as follows in the following section:

> *I think if I wasn't .... if you're not accepting of gender identity, I could imagine it would be very traumatic. So I try and really make that very evident that that's the priority and that I'm very affirming of you. We are just trying to make sure that this process goes as well for you as possible. And I find it's helpful because there will be normal stuff that comes up that then we can talk about, like the fear of the surgery and it being a big deal. And what are the side effects? What is my risk for things like breast cancer? Suddenly, then we can unpack it without somebody, the patient feeling like I'm going to suddenly say 'well, if you have any doubts, obviously you shouldn't do this' because that's not what I'm saying, but I think that's their fear.*

During two of the interviews, when therapists happened to erroneously misgender their clients, they acknowledged their lapses with a notable measure of guilt, adding that they need to be mindfully attentive to their clients' altered social signifiers including name changes and pronouns.

Therapists were keen to denounce any anachronistic, biased or pejorative views pertaining to trans objects of analysis which could be deemed cis-normative or transphobic and which could inadvertently veer towards the clinical and theoretical mistreatment of patients. Most of the therapists were acutely aware of their privileged social positions and almost contrite in acknowledging how these unwittingly permeate and influence their respective clinical and theoretical stances. Linda echoed the views of the majority of the therapists:

> *Also, with regards to wondering around envy I'm aware that I sit here as a cis-gendered female and that there is privilege in that as I sit here [..] So I wonder if they look at me as a cis-gendered female with tremendous envy, you know, and I'm aware of my privilege often in the session, in various ways, you know, what it is that they desire and what it is that they*

> *maybe recognize they won't have, you know, those who are taller and want to be petite because they associate that with femininity. I'm always aware of my body as we speak about bodies and gender.*

Additionally several therapists, unprompted, directly addressed the implications from working in a political climate which advocates transgender activism and visibility via a burgeoning transgender rights movement, and how a perceived lack of legitimacy, can impede on clinical praxis and render the therapist invisible or muted. Mindful not to iatrogenically fence gender nonconforming patients into a clinical gender category, which traditionally bears the weight of binary orthodoxy, the participant therapists instead discussed a preferred analytic attitude of neutrality, which is not aligned with any ideological positioning and which involves a more open-ended exploration, as opposed to a targeted course correction towards a predetermined end.

Owing to an oppressive history of coercive heteronormatization and pathologization of non-normative sexuality, therapists were, accordingly, resistant to gender classification and discrimination, on the basis of gender, or to treat cases of gender ambivalence as illness by patriarchal heteronormativity (Porchat & Santos, 2021). Therapists expressed a desire to essentially liberate their patients from the object position in the subject–object relationship (de-objectivication), defined for them by the such heteronormative structures within which gender operates, so that their patients can accede to a subject position.

Many of the therapists rejected gender positivism and formal classifications of gender which regards gender as stable and permanent and they discussed the arbitrariness of this relationship. Justin asserted that problematic assumptions, which issue from the gender taxonomy, can ineluctably reinstate, albeit in a disavowed and subtle way, a binary of its own (gender as binary vs. gender as continuum):

> *I think the assumption that it's obvious that I'm cisgender, for example, I think that's actually quite cis-normative. I think that it is actually quite problematic; I just assume that everybody can see that I'm cisgender. So for example, I've made those assumptions actually in the past where it is actually a very cis-normative thing to assume that everybody is cis-other unless otherwise proven. So I think just needing to be very aware of those assumptions.*

Several of the therapists considered one’s gender identity as a gendered adaptation and psychic construction/solution which feels congruent at the level of the ego. There was

discussion on the interpolative and organizational structure of gender in the social order and how this has contributed to gender-variant patients being subjected to clinical mistreatment and theoretical arrogance. Simon acknowledged his wish to offer a corrective experience for patients who have had negative experiences with the healthcare system, perceived as almost a monolithic representative of the patriarchal order:

> *But it almost feels like it's a bit easier to have a safe starting point - just knowing how many clients have had very bad experiences with practitioners, with doctors, with medical professionals. Often I'm not the first therapist people have seen; they've often seen a previous therapist or previous therapists that actually have been quite problematic - they have pathologized their gender identity, they have played gatekeepers.*

One of the therapists, Eric, asserted that the role of the therapist is not to act as a gatekeeper or arbiter:

> *When I see trans-clients, particularly in a context where they want letters or where they have been referred from a doctor, one of the first things I do is to say that I'm not here to diagnose you or to judge your transness or to write [*a letter endorsing further intervention*] ... if you want a letter I'll get you a letter. I'm not going to assess your personality, or your identity rather, your gender, because that tends to be a barrier in therapy in terms of general experiences [..]*
>
> *No, fuck gatekeeping!! ... I'll even say it like that. I feel very strongly about the ethical principal or the ethical correctness of a properly enforced informed consent and, for me, the role of a therapist in gender-affirming healthcare is not to assess but to ensure that people have the correct thought systems in place, that they get access to the systemic stuff that they need to get access to [..] I'm not here to question your gender identity.*

Justin also articulated a sense of relief when therapists are not cast into the role of gatekeeper:

> *There was a massive relief ... there is a colleague in Cape Town, a Doctor Anastasia Thompson, who is a trans woman and a medical doctor. She has written an article in one of the local South African medical journals on the ethics of an informed consent model versus a gatekeeping model. I*

> *think that was a very big change for me, and I think that's become more common practice. I think often the gatekeeping model is still pushed depending on which doctors the clients are consulting with.*

Notwithstanding the fact that the particularly transformative actions of each therapist, which afford psychic growth, are never isolated from the context of the therapy, and are also contingent on the whole of the transference-countertransference relationship, it could nevertheless be determined that the therapists were cognisant of the limits of the therapist's understanding and the importance of waiting and not interpreting impulsively. Largely, when discussing their therapies with trans-patients, their specific therapeutic interventions, over the course of these dyadic interactions, varied upon how each therapist specifically assessed the nature of the dynamic equilibrium at any particular time. However, despite engaging ostensibly in consciously spontaneous and intuitive acts, as opposed to impulsive reenactments of repressed experiences, it appeared that many of the therapists tended not to initiate, and even appeared to lack, the distinct quality of creativity espoused in Winnicott's theory of playing. The wish to be unobtrusive seemed to create an air of caution that precluded spontaneity; this atmosphere extended to the interview processes with some therapists being able to engage more playfully with discussions about their or their patient's bodies and gender identities. These therapists also demonstrated a capacity to think more freely and reflect upon relational dynamics which may have unfolded within the therapeutic dyad.

Drawing further on contributions from within the relational tradition, where authors (such as Hoffman (2000); Ringstrom (2003); Ogden (2018)) advocate a more growth-promoting and untraditional "dialectical" approach, including analytic improvisations, it is the contention of this author that many of the therapists interviewed did not evince a strong and unfettered capacity for the spontaneity and freedom required for interdependent and mutual play between the patient and therapist. Accordingly, in facilitating the patient's sense of being fully alive and true to their own self, and mirrored by the analyst's own capacity to think freely and to mutually play, most therapists appeared unable to respond with alacrity to their patients, from the therapists' own experiences within the analytic situation, and in a manner that was not unduly impeded or strangulated by the stilted caricature of "analytic neutrality" (Ogden, 2018, p. 696).

Several therapists alluded gingerly to a struggle to free themselves of constraints and depart from internalized conventions in order to become more personally expressive and

involved in a "moment of meeting" with their clients (Stern et al., 1998, p. 904) - in a manner akin to the spontaneous reproduction of earliest mother-infant communication. In the following excerpt Simon discusses his struggles with making interpretations with his client pertaining to the body:

> *I'm not the best at it. I'm a bit clumsy around those kinds of interpretations. I'm generally, I think I'm still finding my feet with that, but I have definitely allowed my body to be a source of something. So I've allowed people to know that my body exists by speaking about it, you know?[..] But I think it's definitely harder to talk about certain things that are more sexual in nature, or closer to the patient, or more intrusive or invasive or* [at least] *I would struggle, I know in myself, to talk about some of my own bodily experiences because I have struggled to integrate them in my own life.*

This can be equated to the notion of the "act of freedom", as conceptualised by Symington (1983), when both a therapeutic shift in the patient and insight, learning and development in the analyst is more likely to occur as the result of an inner act of freedom in the analyst; such acts of implicit relational knowing have the effect of cathecting the analyst's deed and can ultimately redound to the benefit of both parties in the analytic dyad (Shapira-Berman, 2022). Stern's (2003) assertion that rendering the unconscious conscious necessitates "freeing oneself to articulate or construct what one has refused to think about" (p. 844), signifies the practical challenges which several therapists faced in the analytic task of reverie and, particularly, in describing, as fully as possible, their inexpressible and ineffable states of authentic being and enlarging upon the specific nature of their experiences of the interplay of individual subjectivity and inter-subjectivity. Simon exemplifies this point in the following excerpt:

> *It's something that I've had to develop in myself [..], listening to my body - just generally in my own life, but then also obviously in my practice. As much as I say that that's been a process for me – absolutely!! When I have become aware of it* [Simon's body], *when I'm conscious of it and aware of it, I do include it because, in my own therapy and in my own experience and coming to learn and coming to terms with my own body, I've realized just how valuable that's been for me. And that was only done because my analyst was able to listen to her body and to my body.*
>
> *I think I can say without a doubt that through my own analysis or through my own ... whatever's going on in my life, that's making me more, you*

> *know, helping me to become more aware and more in touch with myself and my own body - my body is definitely becoming more available to my patients. 100% I would say [..] I feel like my body is one of those things that I haven't yet folded out fully. I don't have access to <u>all</u> the tools that might be available inside of that aspect. And so I'm trying to unfold that.*

The stance of therapists may also have been influenced, somewhat unwittingly, by the therapist's articulated and conscious awareness that they are indeed implicated subjects, implicated implicitly in structures of social domination (Benjamin, 2022). Perceiving themselves as inculpated in some way, therapists may have an overcompensating desire to counterbalance their position by being more inclusive and trans-affirmative. Mike explained how he preferred to view gender non-binary patients as 'gender-creative' individuals whilst Eric expressed an equal desire to promote neologisms such as 'gender euphoria' instead of narrowly fixating upon gender dysphoria. Linda stated the importance of validating physical changes in her patients' appearances as they undergo physical transition:

> *It was important even for me to validate it by saying 'I can see how your face is changing and your bone structure', and then when we were on Zoom, I said, 'Do you have facial hair!!!?' You know he was so pleased that I noticed so then in that space there is something really validating because, maybe, he doesn't have people in his life who, would firstly notice, and [who] would secondly celebrate it with him.*

Transphobic prejudices *can* incontrovertibly compromise analysis and the analytic setting. However, it is equally important to concede how an altruistic therapeutic stance – which, inversely, incorporates transphilic biases and presuppositions - runs the risk of premature foreclosure of a more complex and nuanced problem; this can result in the therapist's dis-identification with specific dynamics as they unfold by hastily relegating informative, unconscious reactions to the realm of the transphobic (Evzonas 2021b). Is it possible that a strong idealization of patients can preclude the therapist's capacity to confront competing self-sates within both themselves and their patients? Porchat and Santos (2021), argued that in pursuing non-transphobic psychoanalysis, as a means of eradicating the potential for transphobic bias, the analyst must *still* be able to oscillate between acknowledging countertransference feelings and appraising them critically and rationally. Porchat (2021) outlined how her idealization of the trans condition led her to a paralyzing and myopic identification and alignment with only one aspect of her client's 'double position' - the fluid aspect of their gender concerned with multiplicity; some

trans-patients may need to preserve binary gender as a viable experiential position so may need *both* the idea of multiplicity and the idea of a certain essentialism and gender stability, and Porchat (2021), owing to transphilic bias, grappled to adopt a pluralistic approach.

Evzonas (2022) also demonstrated how an attitude of excessive empathy and heightened attunement to the systemic violence endured by a nonconforming gender population might be as misleading as the excessive neutrality and indifference toward the involvement of the social in clinical encounters. Evzonas (2021b) explained how a profound over-identification with his non-binary patient along with a concomitant need to be perceived as a safe analyst deleteriously compromised his insights. The ensuing need to be an accommodating therapist who is "actively concerned about the perpetuation of situations of discrimination, violence, and oppression" (Porchat & Santos, 2021, p. 413) resulted in his preemptively and impulsively distancing himself from valuable transferential material and/or from interpretations, perceived as transphobic, in order to protect his patient from pathologization.

Overall therapists expressed a collective hope for an epistemological shift which will further embrace a paradigm of "situated knowledge" in clinical praxis by recognizing that knowledge is indeed "embedded in, and thus affected by, the concrete historical, cultural, linguistic and value context of the knowing person" (Evzonas, 2021a, p. 375). Therapists pointed out a distinct conservatism of the analytic milieu currently which reflects the rigid and inflexible cultural codes which hinder the psychic integration of identifications situated outside the gender binary.

4.3 Implications of the Zeitgeist for therapists

Contextually we are in the midst of a markedly turbulent and polarized epoch where the neo-liberal practice of social activism is pervasive and where it has become increasingly common for prominent figures to be rebuked and penalized on a public stage when their views departs from the moral attitudes of the zeitgeist. The latter-day phenomena of "de-platforming" or "cancelling" public figures for their stated views and the ambient exposure of emotive, fraught and ideologically-driven disputes concerning value-laden issues of our era, including gender identity and gender ideology, are compounding an already polarized and contentious political climate. At the time of writing, Vivek

Ramaswamy, an American 2024 presidential candidate, has asserted in the mainstream media that transgenderism in youth is a de facto mental health disorder. Notwithstanding the advancement of social justice causes being an important means for minority groups to hold privileged and powerful voices to account, the interviewed therapists voiced their concerns about being inevitably embroiled and implicated on the frontline of a potential culture war, a war in which the healthcare profession has been charged with systematically shoehorning undeveloped and confused children and adolescents for surgical mutilation. An acute awareness of the current zeitgeist was noted in the narratives of the therapists interviewed for this study as well as a discernible tension. The following subsection will explore how intersectional realities can inexorably disrupt the clinical setting and contaminate the analyst's countertransference.

Justin offered insight into the dynamics within the South African psychoanalytic community when contemplating the realm of gender identity:

> *And we've had the Institute of Psychodynamic Child Psychotherapy …* [this organization] *has had three workshops over the last year. They initially had someone from the UK [..] a very controversial analyst that previously headed up the Tavistock clinic, who eventually was fired or was removed, or quit the Tavistock clinic - I cannot remember the dynamic. But there's been a lot of drama at the Tavistock around various court cases and things that have come up.*
>
> *They invited him over to Johannesburg and conducted a workshop. There was a lot of concern, raised by myself and other people, in the community just around, what does it mean to bring this person over who had a very negative perspective on transitioning, and really wanted to gatekeep, really wanted to hold people back. He saw very few positive outcomes for people transitioning. So there was a lot of concern and backlash from that.*

Notwithstanding this collective position, in order to think analytically, on matters of great sensitivity, such as the complex and highly charged issue of transgenderism, one must have analytic freedom of thought - to be able to freely wonder about the involvements of inner unconscious forces, even where this entails questioning socially accepted ideas. Against the backdrop of a quasi-ideological schism within the psychoanalytic community surrounding the discourse of trans, and undergirded by an increasingly hegemonic zeitgeist of postmodern times which is altering clinical praxis, several therapists outlined

issues of concern when working with trans-identities and conveyed the impact of the zeitgeist on their own subjectivities and relational degrees of freedom.

When Rachel was asked about any working hypotheses about the trans condition she was resistant to engaging in exploring formulations:

> *That's tricky because I think obviously there's so many politics around, so much politics around transgenderism. And, you know, you know, to go down this road, I mean, we can talk about it, but in a sense I think there's a big resistance to ascribing it to early childhood experiences and attachment.*

When another therapist, Mary, was asked the same question her response was more forthcoming but was issued with an unambiguous proviso:

> *Something that I have noticed, which might which might actually be quite controversial - and I think in the wrong hands, it could be quite dangerous - but I have noticed a bit of a pattern where for some individuals what emerges in the work is that a trauma, some kind of injury that they've experienced that has been either gender based violence or some kind of sexual assault or some kind of injury to their sense of themselves and their gender [..]but I'd be very, I'm very cautious about talking about that because I think in the wrong hands that notion would be completely…would be exploited and used to, you know, to advocate against transitioning and particularly teenagers.*

Therapists articulated the practical struggles when inscribed in the social, and caught in the crossfire of identity politics – namely, the workings of power relations – wherein the traditional stance of neutrality is compromised (Bell, 2021; Blass et al., 2021; Evzonas, 2022; Gherovici, 2022). Mike emphasized the importance of recognizing that the analytic dyad is embedded in a larger political framework, with associated discourses, and the attendant responsibility to dislodge any normative gender biases or ideological interpolations that reign and are unconsciously at work (Olver, 2019):

> *But, at the same time, still being very aware of what I could actually introduce into the room and am I thinking about certain things or certain biases? I think, even though I'm largely practicing more analytically, more from a kind of relational, psychoanalytic, psychodynamic perspective. I*

> *think that there is an importance of thinking about power dynamics. I think that's very present, and I think that's where, often, the relational, psychoanalysis or schools that go in that direction … there is more room to incorporate current political understandings, sociopolitical understandings of gender identity. And I think that there is a need for an awareness of that.*

The psychotherapists variously discussed their clinical and ethical concerns regarding the exponential surge in individuals being referred for therapy for gender dysphoria related matters or to specialist Sex Reassignment Surgery (SRS) centers. One therapist, Richard, conveyed moderately ambivalent feelings apropos the rapidly evolving gender landscape:

> *It's a kind of a global awakening or a global softening around gender, although I think there are countervailing forces too around that; more and more young people are identifying on a spectrum of gender.*

Another therapist, Simon, explained how colleagues in the field are hesitant to work with trans-patients and was tactfully diplomatic in not speculating or offering possible reasons as to why this population may be considered non-grata by his colleagues:

> *I was working in a multidisciplinary team. And for some reason, no one really wanted to touch …. none of my colleagues would take those cases.*

Therapists also acknowledged the broader determining socio-cultural context, which has contributed to a highly charged atmosphere which has imperceptibly infiltrated the analytic setting, by drawing attention to the looming presence of strident trans-lobbies and gender-diverse affinity groups. Therapists spoke hesitantly about the unbinding effects which a militant activist milieu has wrought in the field of psychoanalysis.

Eric gave expression to the concomitant pressures placed on psychotherapists not to adversely impose upon the patient by unwittingly displaying any form of heteronormative or cis-gender bias. Eric remarked how easily a clinician's sincere efforts to understand can rapidly devolve into objectifications embedded within a tarnished history of analytic thinking:

> *It was a bit of a first experience for me in taking someone through that kind of [*process of transitioning*]… I hesitate to use the word 'evaluation' because I think there's a lot of politics around it now and models of working with trans clients have shifted more to a sort of collaborative*

approach, rather than the therapist checking out if you are trans enough. It's really 'how can I help you? What do you need?'

A second therapist, Mary, admitted to being especially fearful of betraying a dissenting viewpoint when treating gender non-conforming clients. Accordingly, Mary appears to adopt a more retributive stance for the wrongs of her colleagues and links this to the many injurious fallacies historically propagated by the psychoanalytic community when treating both homosexual and trans-patients:

You get scared. I think this is what I've heard from any other colleagues is that you almost get scared to offend the person and they're so aware of, 'Oh, I don't want to ask an offensive question'. And having said that, I get where this is coming from, because I can tell you also horror stories about what some of my patients have been asked by other health care professionals, be it general practitioners or psychiatrists or whatever specialty.

Simon specifically referred to the various interdictions against therapists as a result of state overreach and coercive sociogenic forces in operation; he discreetly alludes to an enforced practice of compelled speech:

I have a colleague in the UK who used to work at the Gender Unit in the UK, you know, the NHS one. And he tried to take the same type of approach as me, which is to say, let's think about this from the point of the personal meaning for each individual patient, which I believe, for a psychoanalyst, is the core anyway - doesn't matter what the general idea or theory or belief about something is. And he was absolutely shouted down; he was absolutely, you know, he was put on cautionary watch as if he were not qualified. He was told 'you are not allowed, in any way, to question this person's gender identity' and he wasn't questioning their gender identity.

He was just trying to say 'you know, let's think about this….and it was too threatening to the political thrust of the time which was [that] you <u>have</u> to accept, it's full acceptance, there's no questioning…..although I've not been in that punitive environment, there's a part of me that feels 'well, how do I approach talking about my patient's body with them when the body is also the source of the conflict for them'?

The aforementioned therapists appear to lament the manner in which the enforcement of such a narrowed or confined stance can incontrovertibly arrest the generative process of enquiry so characteristic of psychoanalysis. The therapist implicitly states that in yielding to an outside force therapists lose their autonomy and are obligated to adopt non-analytic positions. Saketopoulou (2022) in a counterargument opines that the crucial issue is, not why the patient is unwilling to explore their gender identity, but why the analyst insists that the patient must do so. The therapists in this study did, however, acknowledged the many levels of distortion, scotomization, and confusion that other well-intentioned therapists have inadvertently and iatrogenically introduced into their work with transgender patients. Saketopolou (2022), in turn, acknowledges the turbulence occasioned by trans-patients, but states that this should not impede therapists' capacity to think but rather present them with a challenge to refine or optimize their modes of thinking and further analytic thought (Saketopoulou, 2022).

Whilst the majority of psychotherapists insisted that there is no single causative factor to gender variance and that it is a highly complex issue with multiple causal pathways they largely advocated for an idiographic approach which does not neglect the unconscious and considers multiple elements. Psychotherapists tacitly cautioned against employment of a procedural model which obviates deep psychological inquiry and which is being espoused in this era of liberalism. Despite the fact that each of the interviewed therapists refrained from openly asserting that the underlying socio-cultural changes can act as a negatively tendentious force they were hesitant to adopt the more permissive approaches promulgated by trans-affirmative lobbies who tend to endorse trans-ideological support by aligning with the patients' desire to transition.

In the following extract Justin discusses the inner conflict that emerges within therapists who feel torn when faced with a conflict of interests of sorts:

> *So I think that there is this weird discourse around how we need to protect people from going ahead versus actually just allowing people to find their way. So yeah, I think it is quite a loaded thing to think about, and I think I felt a lot more easier dealing with adults whereas I think with children, I still struggle with that a bit more because there is a lot of….. Yeah, I think that feels a lot more controversial, and I think particularly, I think some of the Tavistock cases where they are being taken to court in the UK and stuff like that, I think, you know, that has been around minors and minors accessing hormones and things like that…*

One psychotherapist, Jane, suggested that, notwithstanding the interplay of powerful social forces and intrapsychic factors, it was important for patients to explore and be curious about their gender identity which can be impeded by a lack of thoughtful and critical engagement by both therapist and patient with the issue of gender:

> *I think I can see where therapists are coming from…I think we are in a very … we are in a period now where you do need to…. and it's not socially acceptable to <u>not</u> be accepting of somebody's gender identity, which of course is right because we come from a history of not accepting people's gender identities. And I think sometimes therapists are now almost scared to talk about the origin of someone's gender identity - as being the same as saying that it's not valid, and that doesn't have to be that at all. We can say that you are …. of course, that you are absolutely valid in whatever gender identity you choose, but it does come from somewhere.*

Ruby discussed the risks to young children and adolescents of ill-considered surgical interventions where adequate time is not afforded for assessment and described the attendant tension when the need to expedite the medical and surgical treatment forecloses thought so that the therapist is deprived of sufficient thinking space:

> *I have found it to be incredibly difficult…. to be honest, being asked by doctors to endorse surgery when I've known this young person for a few weeks - it's very difficult and it creates all kinds of tensions being approached to tick the box for a mental health screening so that, you know, a 13 or 14 year old can proceed to have top surgery. So it creates all kinds of tensions and conflicts and ethical dilemmas for me in ways that other psychotherapies have not.*

This issue of temporality, specifically, the adoption of a 'watch and wait' policy, for the purposes of protracting the process of surgical transition, has also divided opinion and it appeared to weigh on some therapists. The notion of 'watchful waiting', as a practice of care, which ultimately redounds to the benefit of the patient, has been challenged in various circles. While the patient's press for time (owing to an urgent desire to medically transition or to delay or forestall the development of secondary sex characteristics) does not afford analytic time or space, some argue that prolonging the process can induce more severe gender dysphoria or increase the risk of suicidality. Therapists indirectly

referred to Eriksson's stages of identity development including the nebulous stage of identity diffusion during the identity moratorium but several therapists reported the state of felt tension when adolescents wish to impulsively embark upon surgery which irrevocably commits them to a cross-gender and leads to identity foreclosure (Watts et al., 2013). One therapist, Simon, discussed his sense of disquiet when a patient, after four sessions, stated that they were transgender and proceeded to solicit the therapist's support in liaising with the various medical stakeholders:

> *And I remember immediately telling the patient that I'm sorry, I can't do that because I have not spent enough time with you, we've not assessed this with much thought. This is the first time hearing that you believe you are trans. It was a really, really difficult experience for a beginning therapist because again, it was really early on. That has forever, I think, made me wary about somebody who comes to me and says - and I have had people come to me that I've turned away - people that I have subsequently said, I'm sorry, this is not something I can do or that I can help you with. And I referred them on.*

Therapists conveyed considerable unease and explained a similar need to be scrupulous by not using stigmatizing diagnostic labels and/or disqualifying terms given the performative power of speech. They explained how ostensibly innocuous ideas or statements can be misconstrued as anti-trans rhetoric. Such heightened vigilance and a pronounced need to deconstruct aspects of hegemonic knowledge, which do not match transgender logics, was evident during the interview process.

Therapists also discussed how the therapeutic process, including the frame, can feel somewhat constrained, owing to a perceived sense of autocratic control and of being censored or coerced by third parties who are external to the therapeutic setting; these include the family system, medical stakeholders and the educational institutions. Ruby remarked:

> *It comes with immense tension. It's hugely controversial. I have to deal very often with the network - with a family, with the parents, with a school. I have to think quite systemically. I can't just work in a vacuum and offer psychological therapy to an individual, I'm so mindful of the repercussions for this young person, in their relationships and their family and as they transition how that impacts on their identity in the world. So it*

feels like it's a lot more complex, far more, you know, very controversial, very difficult.

However, the abovementioned psychotherapist's viewpoint of the shifting relationship between therapist and patient appears to align with Bell (2020) who posited that the nature of the therapist-patient relationship *has* transmuted from patient-hood and degenerated into a more perverse form of customer-hood, especially in the national public health setting, where patients are fast-tracked for surgical procedures. In this transformed state, under the veneer of democratization, gender identity has come to manifest features of the commodity form where it has moved to a more transient structure, one where it is exchangeable and can be reformulated rather than grappled with (Bell, 2020).

Some therapists expressed concern that patients were engaging superficially or perfunctorily in the therapeutic process as a means of proceeding with reassignment surgery and that such a lack of critical engagement can deleteriously foreclose exploring the ordinary turbulence and confusion of adolescence. In the following excerpt Rachel voiced her concern in this regard:

Yeah, I guess that does create some anxiety for me, some apprehension that there is a very fixed agenda and need for me to enable something to happen, that I'm being called upon to endorse something very particular. So it does make me anxious when someone comes in with that expressed wish for that outcome. It also makes me a bit concerned about, you know, how authentically they will engage with the work because if they know that they need something from me, then they might be, as I said before, they might be selective about how much they allow themselves to express and what they reveal in the work.

Therapists articulated their various misgivings and expressed a uniform guardedness or resistance to introducing an element of triangulation to the therapeutic process, in the form of competing perspectives. Given that powerful social forces have misrepresented such triangulation as a form of patriarchal power-play, irrespective of its constructive capabilities, attempts to introduce externality and deeper exploration collapse (Bell, 2021). In the following excerpt Ruby alludes to a potent sense of disapprobation by societal forces including the heightened wave of trans-activism:

I feel like there's a lot that I still need to understand, and I think there's a lot that all of us professionals still need to understand and figure out in

terms of particularly, this incredible wave that we're seeing. It's almost like there's something in the zeitgeist. You know, there's so many things that we're trying to make sense of that are culminating in a massive increase in referrals of young people who are identifying as trans. So I think it's very exciting at times, incredibly nerve wracking, complex [..] But I think that there is also a lot of tension around trying to be careful of discourses around passing or putting expectations on how this body should be or pushing bodies in a certain direction.

Therapists alluded to an implicit gag order of sorts, given the turbulent political zeitgeist, and where trans-identities and the condition of gender dysphoria have been formulated as tension points which require analysts to adopt non-analytic positions and capitulate to prevailing social trends or ideological forces. There was an avowed hesitancy or prudence about what it means to think freely, in the form of an unconstrained internal process. There was commensurate hyper-vigilance around an imperative to safeguard the dignity of trans or gender nonconforming patients by censoring, filtering and constraining what is verbally communicated to such patients. In this sense, therapists appeared to suggest that psychoanalysis is not a neutral or ahistorical discourse which obviates or hovers above the prejudices of a given historical time, and as such cannot escape the intrusion of national politics, of social coercions and organizations, and of the deep social and political work of normalization and emancipation. However, they did appear to wish to be able to hold onto the process and some of the principles of psychoanalytic psychotherapy which advocate for a deliberate, slow, thoughtful 'allowing' of tensions and conflicts to emerge, in order for clients to be able to make decisions from positions of 'knowing' themselves.

4.4 Therapists' Experiences of Somatic Countertransference

Each of the therapists discussed their experiences of somatic phenomena in the countertransference with a tranche of the therapists recalling specific occurrences and the remainder demonstrating how psychosomatic phenomena can frequently become, consciously or unconsciously, undermined, neglected and/or ignored in the treatment setting. Varied findings emerged also with respect to individual therapists' processes of relating to the patient's body in the countertransference. The results outlined in this section will address some of the factors that constitute therapists' processing of their

respective somatic experiences, including awareness of interoceptive, proprioceptive, and affective cues, as well as the dynamic interaction of psychological and somatic processes.

4.4.1. Working with somatic countertransference

Several therapists disclosed specific instances of somatic countertransference in the form of visceral responses and other bodily felt senses. They explained how they make sense of this process of embodied self-awareness which comprises associated affect states. Some of these therapists, in proffering explanations for the respective phenomena, appeared to display an acquired implicit knowing or pre-reflective knowing about the self and others which ostensibly serves to regulate dynamic aspects of the intersubjective analytic field (Potgieter & Bloem, 2017).

A variety of somatic sensations were mentioned by this group of therapists, including:

Nausea

In this next excerpt Jane spoke of feeling nausea in instances where patients negate the actuality of their genitalia by employing unconventional linguistic devices, including the use of euphemisms, and other forms of gestural communication:

> *I do experience…nausea…especially when patients are referring specifically to their genitalia. I find, as a trend, my patients don't like to refer to their genitalia with the biological terms; they'll have terms, nicknames or code words almost. [*For example*] I have one patient who calls it [*the penis*] "the thing", somebody else who calls it "that" and then makes a motion that looks a little bit phallic like a penis. I've had other people call it "the downstairs" or "what's down there". And then I find at that specific moment I will often feel, like, a wave of nausea. It's like, as they think about it, I will then experience that kind of nausea feeling, that really pure feeling of disgust -and it passes very quickly - but especially when they're referring to that.*

Rachel also recalled conscious feelings of nausea, ostensibly derived from disturbingly explicit and graphic material content offered by the patient. It is also conceivable that implicit feelings, which are being unconsciously communicated by the patient via projective identification, are impulsively avoided by the therapist:

One of my patients was actually a 'nullo'. So it was a male patient who wanted to get rid of his genitalia, so not transition further than that, but just wanted basically ... like, almost as if, like, a eunuch. But when he'd describe the kind of methods that he'd used to try and cause sepsis in his penis and scrotum to form a, I mean, I think there was quite a ... like my stomach turned in the sense of re-imagining how much pain that must have caused him [..] But I remember when he showed me the photos of the scarring, I think there was also the kind of visceral response.

Headaches

In this next passage Ralph reported uncharacteristic somatic episodes of induced headaches, typically preceded with nauseous sensations. Such occurrences are putatively ascribed, by the therapist, to a collision between the latter's felt-state of ennui, issuing from a possible resistance on the part of the patient:

*I've had it happen a few times with [*trans*] clients where somewhere during the session, I start getting a headache, almost pre-migraine headache. I'm not a headache sufferer, so it's not something that I struggle with…And yeah, so that's happened a few times and there would be like a pre nausea sensation. So realizing and noting the headache ... which was interesting - I remember, often my reflections is, like, I can link that this is somatic and this is linked to the session. But often what was happening in the session, at the time, is - the session was very superficial at the time. And I remember sometimes it was like just before the headaches started, I was feeling a bit bored. It's like that sense that there's more material here.*

Restriction of the chest

In the next excerpt Ralph recounts an experience of feeling a tightness of his chest:

But what I would be feeling in this session is this tightness and this heaviness on my chest. And sometimes it would actually happen in the session that the patient would break through and I could actually feel that I could start breathing again, and it was almost this immediate, reciprocal kind of somatic countertransference - and that, as my client pushed through, I realized part of my role was that I was holding with my client and my body was co-holding that tension up until they were able to.

> *I mean, there were times where that didn't happen, and I sat with that tightness and heaviness on my chest for some time. And realizing also that that pre-conscious material is sitting there now - that will probably come if I just hold and contain and maintain.*

Ralph's account, including his idiosyncratic interpretation, implicitly speaks to the erogeneity of the body and the body's dynamic functioning as a libidinal outlet of libidinal energy and other instinctual conflicts (Athanasiadou & Halewood, 2011). He further accounted for the dispersal of somatic phenomena tentatively ascribing it to the patient's cathartic process of abreaction.

In the following excerpt a second therapist, Simon, also recalls the sensation of a tightening chest and referred to a session wherein a trans-patient is recalling an incident of painful betrayal in a relationship:

> *And I suddenly started to get a pain underneath my rib where my heart was, you know, and I suddenly had a very strong feeling of having a knife thrust under my rib cage. And at first, I thought to myself 'well, you know, I've recently taken up rock climbing [..] But I thought to myself, I haven't been feeling uncomfortable like this in the daytime [..]*
>
> *We were talking on and at some point later on, I said to the patient, I don't know if it feels like a stab in the back so much as a stab in your heart. And she started to cry, which I think was some acknowledgement of that feeling a little bit closer to the truth because before she was holding on to the anger - the stab in the back - and then when she felt the sadness. And immediately this pain went away, immediately that twinge or that pain left and I thought to myself, there's no other explanation for it, but for it really to be a somatic countertransference.*

Drowsiness

Several therapists explored their soporific experiences during therapy sessions with gender-diverse patients. The therapists did not necessarily interpret such instances as unconscious enactments. In the following Nicky discloses:

> *Ok, so, in terms of like that, those symptoms nausea, headaches, I haven't. I must say they are few in my countertransference. The only thing that really stood out for me and I thought a lot about this, I would feel really exhausted after a therapy session. And with the one [*trans-patient*], in*

particular, so much so that I would think, is it the time of day? Is it me? What is it? Let me switch around. Let me see if I have more energy in the morning for this. And it wouldn't switch. So there was that. And I'm not sure if it's that sort of projection where I would feel really, really depleted after a few of my sessions with a few patients. So that stood out for me a lot. I don't know if that is somatic in any way, but I was very much aware of that tiredness and what it was doing to me. That would always stand out for me and something I struggled with because I don't often experience that.

In the next excerpt Justin recalls similar experiences to Nicky and, in the process, demonstrates how making accurate interpretive interventions can assist the therapist in potentially transcending moments of impasse with the patient:

One of the things that came to mind more prominently was a sleepiness, almost a shutting down. It feels more like a shared experience often with clients and not coming purely from me, but something we'd almost co-create in the room. [..] But just a battle to reconnect with stuff or to get into stuff; sometimes it's almost like a fogginess a battling to think, but also just generally feeling quite sleepy and almost having to ... almost really push against the sleepiness.

I think that's something I've got used in the past when it becomes really hard to unpack something or to get into something. I think clients, especially when there's been very, very strong dysphoria. I think definitely that that has been something that [..] has been used in the room [..] when we are feeling disconnected or dissociated in a way, I think almost talking about it, actually putting that into language and articulating it. I think that has been useful for making meaning.

A third therapist, Richard shares the same sentiment around his experiences of drowsiness in sessions:

Yeah, the sleepiness does become quite prevalent or this disconnect becomes quite prevalent. It does feel quite useful to understand why it is coming in and often would happen with both myself and clients. I've had trans-adolescents also fall asleep in sessions to the extent that there's been a real shutting down and not been able to deal with stuff.

No somatic countertransference

Four of the therapists, including Dolores in the following extract, described experiencing very little or no somatic countertransference at all when working with trans-patients. Dolores states that:

> *You know, I can't say that I've been conscious of those kinds of experience….yeah, in terms of my own body, as you say, more awareness than actual physical experiences [..] But as far as their body symptoms, I could have a lot of compassion and understanding. A lot of … with them [*gender non-binary clients*] it's often a lot of, you know, I could understand where they're coming from …. with a lot of empathy in that [..] No, none of that! [*experiences of somatic countertransference*], no, it's not a physical - there was no physical sensations, it was more emotional empathy and compassion. But physically, I wouldn't say that there was [*sic*] any reactions. I very rarely get a physical reaction that I'm aware of. It's more emotional.*

A possible explanation for Dolores's lack of somatic countertransference experiences is her inflexible commitment to a holistic approach, which deliberately obviates the therapist's self-experience and focuses primarily on the unconscious of the patient. This is suggestive of a defensive process of disconnection from somatic experiences. However, not all the therapists specifically identified this as a form of conscious resistance to reflecting upon embodied responses or the meaning of shared affective communication. Some accounts indicated varying tension levels which may have informed therapists' phenomenological experiences in the form of bodily reactions.

Another therapist, Nicky, also expressed surprise when asked about her experiences of somatic countertransference:

> *It's interesting you say that, because now that you brought it up, I actually .. I haven't thought about that and even in our peer supervisions, it has never come up [..] So if I think, at the top of my head, I would say, no, I didn't. I think what we did experience is a lot of our own countertransference, but not on that level that I think you are looking for - in terms of a somatic level - yet. No, not, I mean, I would imagine that, you know, when we have supervision that this would have come up - if not for me - then maybe from one of them* [supervisees], *but not that I can recall. [..] Is that something quite common? Have you been finding that that's been happening?*

While this lack of somatic response may or may not be defensive, according to Forester (2007) the course of therapy as well as the therapist and patient can be placed at risk when somatic countertransference is dissociated or neglected rather than attended to and processed.

4.4.2. Disembodied Experiences

Many of the therapists interviewed reported feelings of disembodiment. In the following excerpt Simon admits to consistently experiencing a sense of disembodiment when treating clients who situate themselves on the gender spectrum as non-binary:

> *The first thing that comes to mind for me is working with a male to female trans-patient and how she … how I was so aware of my own penis when she was talking about how uncomfortable she was with hers. So I think one of the ways in which it stands out, [..] where I become conscious of my own body the most is actually, interestingly enough, in my countertransference to my trans-patients, particularly when they're talking about sex because [..] you know it can be quite arousing or it can be, in some way, evoking bodily responses that are similar towards desire or you might get an erection or you might feel your body reacting in some sympathetic way, right?*
>
> *Yet, interestingly enough - in fact, I can say this for all of my trans-patients - is that when they have spoken about sex, it's been a very disembodied experience. It has been very much an experience of 'okay, hold on a second. I don't feel this' even though they might be talking with the same amount of detail or the same amount of intensity in terms of explaining their sex life or explaining what happened. It's interesting that my reaction to that is to not feel the sympathetic reaction or to feel the type of reaction that I would normally feel in certain situations.*

When reflecting upon the therapist's affective relationship to thinking about his patient's genital arousal, there are several possible interpretations. The therapist speculated about his own shame about having a penis and wondered whether this was a process of projective identification, reflective of the patient's shame about her penis, and subsequent disconnect from this body part. It may also illustrate the phenomena of kinesthetic empathy or mimesis, both forms of empathic response, the former's relationship to somatic countertransference being analogous to empathy's relationship to cognitive and affective countertransference (Forester, 2007).

Evzonas (2022), who emphasizes the interweaving of sexuality and gender, may interpret the abovementioned therapist's 'flaccid' somatic countertransferential reaction to sexually charged and erotically stimulating clinical material as a defense against the agitation of polymorphic infantile sexuality that can be typically aroused by transgender bodies. According to Evzonas (2020) therapists' polymorphic infantile drives can also infiltrate their metapsychological models. Hansbury and Saketopoulou (2022) also suggest that such a disaggregation of gender from the sexual can be an anxious defense against polymorphous perversity and psychic bisexuality which trans-bodies can ignite in analysts of all genders, and especially in cisgender analysts. One may posit that the therapist has dissociated or dis-identified owing to the commensurably greater prohibitions concerning the body of a gender-diverse patient or that the polymorphous nature of infantile sexuality has stirred up in the analyst a sexual reverie that calls forth phantasies concerning the state of tumescence of his patient's genitals (Evzonas, 2022).

In a similar vein, Amir (2022) argues that gender dichotomy typically collapses into a saturated state, where identities become fixated and essentialized by the dominant White, bourgeois, masculine, and heterosexual norms so that only a minuscule degree of gender, if any at all, is transformable. However, the inverse involving a "radical unsaturation" of gender dichotomy, may turn into an unbearable threat for some, including ideologically committed trans-affirmative psychotherapists. In this scenario the linear, hierarchical "tree-like" relations of body and mind, traditionally organized around structures of intelligibility and lucidity, are transformed into a nonhierarchical method of constant deterritorialization referred to as 'rhizomatic thinking'. Such a process of deterrorialization can pertain to hegemonic structures of thinking as well as gender and constitutes a multiplicity in motion (Amir, 2022). Amir (2022) suggests that in the latter situation some, such as the therapist in the previous excerpt, can experience an intolerable challenge to leaning on the common coordinates of thinking.

A second therapist, Ruby, also retrospectively reflected upon the conscious disavowal of her gendered and sexual body when working with trans-male clients. This instinctual change of body boundary, which emphasizes contraction over expansion, may also be associated with the phenomena of kinesthetic empathy or mimesis (Potgieter & Bloem, 2017):

> *I guess something that I'm aware of - when I'm working with a trans male - I've become very aware of my own breasts because they [*trans-male clients*] talk so much about loathing their breasts and they [*the breasts*] are unwelcome - and when there's a strong emphasis on that, I feel almost*

> *like a guilt. But that's not so much a somatic experience, but I almost feel like I need to downplay my own femininity, kind of neutralize things.*

In the following passages several therapists reported the tendency to deny, suppress, or control their felt body sensations and explained how their own subjective bodily experiences may have contributed to the build-up of their defenses against somatic experiences.

In the following excerpt one of the therapists, Eric, explained why it is difficult to register somatic phenomena in the countertransference and demonstrates the significance of the après-coup in making meaning (Evzonas, 2021a):

> *What I most often experience is a sense of … almost dissociation [*and*] wanting to dissociate, like, wanting to flee or cut off - which is funny because I think that that was my [own] dysphoria repression mechanism for very many years. So, in hindsight, I can make sense of that experience a bit more. But that is definitely something that came up often.*

In the following passage Linda also acknowledges an inclination to predominantly shift into the cognitive realm despite her sensory awareness:

> *I can speak about an awareness of my body in relation to the other person's body, but I can't recall feeling something in my body and that might not be about them. It might be about me, you know, or maybe it's a disembodied experience for them that I'm feeling too. I'm aware of it but it's more an emotional response or an intellectual response in relation to the body. Also, with regards to wondering around envy I'm aware that I sit here as a cis-gendered female and that there is privilege in that as I sit here.*

Linda's deployment of the defense mechanism of intellectualization, may suggest a vigilant need to over-regulate immediate dynamics in the intersubjective field owing to an imminent sense of interoceptive danger or foreboding. There is an implicit sense that when the material body does emerge, or insinuate itself in the analytic setting, it materialises in the realm of verbal psychotherapy. The focus of verbal, and especially psychodynamic, therapy tends to be on affects and cognitions where somatic experiences and somatic ways of knowing tend to be devalued and sidelined (Forester, 2007). The

therapist in the example appears to struggle to discern consciously whether this habitual mode of response amounts to an implicit, unknowing form of enactment, at an embodied level; however there is a partial conceding by the therapist that full experiential body awareness is being displaced or compromised by a more dominant sense of the body-schema-in-relation, as posited by Potgieter and Bloem (2017).

A second therapist, Richard, concurred with the sentiments of Linda and the valorization of the cognitive and affective components of countertransference over somatic experiences. Additionally, Richard reveals how an over-identification with a trans-patient set in motion a parallel process stemming from Richard's subjectively-held perceptions about his lived body and its constellation of physical shortcomings:

> *I suppose it's almost less at a bodily level and more at an intellectual level or emotional level [..] I mean, with this client that I talked about, he wishes he had a more masculine body, and that's very triggering for me because I have also wanted that my whole life. So I can say that at that level, it's probably triggered me to think, well, what is it? What about my body? Is it good enough? Is it masculine enough? There are parts of my body that I like, and [..] I wouldn't say it's dysmorphia, but maybe discomfort with aspects of my body as being not masculine enough. So that is a sort of a counter-narrative to my own inner dialogue about not being acceptable.*
>
> *But I think, what I can say is that working with trans-clients, whether they're trans-men or trans-women is that it definitely makes me think about what is an acceptable body and why; what are the requirements that society imposes on us or that we end up imposing on ourselves for what is a desirable body? Because I'm not only skinny I'm short. So in some ways I don't meet the societal requirements of the hegemonic male in any shape or form.*

Various authors query the precise impact that a bodily disconnected therapist, lacking somatic awareness due to defensive operations, can have on both client and therapeutic relationship and suggest that it could result in disturbances in empathy and relatedness which deleteriously cascade down to compromise the therapeutic alliance and process. The above example suggests a high level of permeability in the body boundary between therapist and patient, due to a shared set of interoceptive sensations and emotions, which can result in a contracted body schema (Potgieter & Bloem, 2017). Many therapists are less likely to bring subjective accounts of their own bodily experiences to supervision, owing to feelings of shame and embarrassment; thus such somatic experiences tend to be

ignored, minimized, or devalued. This can increase their impact over time, the clinician's vulnerability to them, and the risk that they will derail the therapy rather than inform it. This is identical to that which occurs when affective or cognitive countertransference becomes obfuscated and not analyzed (Athanasiadou & Halewood, 2011; Forester, 2017).

Another therapist, Mike, when probed on his experiences of somatic countertransference, further exhibited how a destabilized internal analytic setting, the psychic arena of the analytic mind, can obstruct a therapist's bodily awareness and capacity for reflective awareness of somatic countertransferential experiences:

> *I'm really not…. I haven't. And it might say more about my not noticing. So I do miss* [fail to register somatic countertransference reactions], *you know, I do… I mean, when we talk eating disorders, then that's different. Then my somatic countertransference is much more clear [..] And that reflects my own issues with body and body image. So much earlier, in my youth [..] I was very, very thin, and I didn't have body dysmorphia per se [..] but I wanted to be a very particular way. I wanted to stand in a particular way, and there were very many different reasons for that.*

A therapist's low awareness and perception of the body may signal disturbed feeling-thinking relational processes which can adversely impede or obstruct a therapist's capacity to experience and tolerate negative affect and to assist patients with resolving their own traumatic conflicts. Given that the internal analytic setting demands a freedom of self-experience, devoid of assumptions, expectations, judgements and other considerations which operate elsewhere in the analyst's mind (Parsons, 2007). In the next excerpt Linda echoed a similar ambiguity stemming from a lack of body-based clarity about boundaries:

> *Yes, not necessarily. And again, that might be me; because, I mean, that's not necessarily that I wouldn't - it could be specific to me …. that I don't feel in therapy, that I don't experience* [somatic] *countertransference, necessarily always in that way. So who's to say that it's specific to them? - although we could. Maybe it's an embodied …. maybe for those who struggle to have a relationship with their bodies it might be a part of why I don't feel my body as much in the session.*

A therapeutic capacity for bodily awareness, to an extent where the therapist's body can be separated out and differentiated from that which is being mirrored from the patient's experience, is essential and facilitates accurate attributions of somatic ownership (Rothschild, 1998). It can be argued that the therapist, in the preceding example, whose

impaired capacities to process somatic experiences engenders dissociative phenomena, must refine their sense of their own and other's boundaries especially when working with gender-dysphoric, dissociative or traumatized patients (Forester, 2007; Parsons, 2007).

Several therapists acknowledged a state of disembodiment, as conceptualised by Soth (2006), and reflected upon a perceived sense of loss of identification with the body when working with gender-variant patients. In the following extract Jane recounts her experiences of feeling disembodied:

> *I definitely do get that feeling of being disembodied, I very much feel* [it], *especially if somebody's still very early* [in the therapeutic process] *and the gender dysphoria is very acute. I feel like we don't spend much time in our bodies; like, things stay very much within the head almost, and that the body is kind of seen as something very overwhelming. [..] I've had a fantasy before with a patient, with just two floating heads almost. And that's what the patient would also prefer to really be because the body is too overwhelming to really be inside of.*

In the next passage Ralph also narrates an experience of feeling disembodied and, when prompted for clarity by the interviewer, alludes to a state of being eviscerated:

> ***Therapist:*** *The one other somatic* [feature] *that I did recall, well it was more like sitting in session and having this sense of …. not an upset stomach, but feeling less a hole, like an emptiness in my stomach area while sitting across from a client [*and*] wondering … what was this sense* [as if] *my stomach drops into what feels like a deep - like a dark hole. Like, it's like this … a cave of empty….*
>
> ***Interviewer:*** *A hollow, a hollow, disembodied feeling?*
>
> ***Therapist:*** *Yes, hollow!! So I've had that and sat with that and sensing that the feeling of it for me at the somatic level was symbolic of where my client was within their psychic experience.*

Several female therapists highlighted some singular moments, as surgical interventions are approaching and looming large, wherein somatic tensions carrying a greater emotional charge and significance, can escalate. Ruby acknowledges such situationally-

induced experiences but distinguishes such occurrences from experiences of de-facto somatic countertransferential phenomena:

> *I do feel, particularly when they're undergoing surgery, and I know on the day of their surgery, I'm super aware of the double mastectomy that's taking place, and I feel a bit of a ….. I don't know if it's a somatic response, but I think* [it's] *just a tension around the procedure and kind of clocking 'ok, now it's 7a.m. or 8a.m'. So I'm acutely I've become acutely aware of their body and my body in that process.*

In this next extract Ruby also acknowledged a state of feeling anxiously discombobulated at the onset stages of surgery and how it can evoke somatic reactions:

> *So surgery for me, I think, is quite an evocative…..as a therapist, it's quite evocative, and I suppose it creates some anxiety around like, what if, what if they do regret at some point and you know, I find myself trying to talk myself through that and having an internal dialogue so there's something quite cerebral, visceral, emotional, somatic that that is evoked for me around surgery.*

The aforementioned excerpts serve to display how the concept of embodiment, including clients' non-verbal and somatic expressions, can evoke bodily reactions in the therapist. The narratives also signify that somatic countertransferential reactions can potentially cause a disruption in the lived experiences of practitioners, their material bodies or essential bodily self-awareness, each of which are necessary to regulate the implicit and explicit dynamic aspects of the intersubjective therapeutic field (Potgieter & Bloem, 2017). It can be deduced that there is a bodily dimension of affect defense, which can be chiefly determined by the vicissitudes of the development of the body–self, where instinctual id impulses and primary anxieties are defended against by characterological defensiveness (Hartung & Steinbrecher, 2018; Reich, 1949). Some of the therapists did acknowledge their bodily defense mechanisms and outlined a variety of self-holding mechanisms. However, it is also important to form a deeper understanding of what additional contextual factors can compromise therapists' somatic countertransferential experiences.

4.5 Unthinkable Anxieties in the Countertransference

Many of the therapists acknowledged some non-specific experiences of somatic countertransference but also, in the process, opened up about their experiences of embodied anxiety or "gender panics" when confronted with trans-patients. Others recalled countertransference-based fantasies or dreams which manifested over the course of the therapeutic process (Saketopoulou, 2022, p.8).

It is recognized that, as therapists, the patient's bodily states of mind will inevitably impact on the therapist and are, in turn, impacted upon by the therapist's bodily states of mind; what patients communicate through their bodies, in the form of projective processes, will also be modified by the analyst's own internal world and subjectivity. The embodied nature of the therapist, including body-based blind-spots, will inevitably pose a challenge as well as provide a vital register of what is transpiring between patient and analyst. One can argue that because the analytic dyad operates in the realm of pre-symbolic functioning, there is the likelihood that the therapist's capacity for symbolic elaboration of their own bodily experience can be temporarily disrupted or impaired so that bodily experiences do not become thoughts with a thinker (Lemma, 2018).

A distinct theme of 'unthinkable anxieties' and transphobic countertransferential neuroses, was noted in the narratives of the interviewed therapists. Interestingly, this theme supports the findings of Hansbury (2017), who explored 'transphobic countertransference' through a century of psychoanalytic literature pertaining to transgender patients. Hansbury (2017) specifically describes four basic "unthinkable anxieties" that appear to underlie transphobic countertransference reactions in cisgender analysts who are working with transgender patients. According to Saketopoulou (2014a), there is a considerable negative effect on treatment of unchecked countertransference homophobia or transphobia and states that "a careful tending to countertransferential anxiety is also critical" (p. 799), especially in light of Straker's (2006) argument that when you change the countertransference, you change the patient. This section will explore some of the therapist's accounts of their experiences of countertransference and will explore the broader meanings and context.

In the following excerpt, Ralph, who identifies as a gay man, recounted the following dream scene:

> *I mean, I don't know what their gender identity is, but [..] it looked like what people call a lesbian scene, for example, what looked like female bodied persons – I don't know their gender identity, a lot of tattoos and they had vibrators. And*

the sexual encounter between these, what I was visually seeing as two woman and I'm primarily attracted to men. You know, it had an intensity, an almost, like, an aggression, a physicality to it. And I remember like being really turned on and going, 'this doesn't make sense. These are two women'.

I think part of what made me to think this is …'well lean into it [..] what is it that's happening here?' Similarly, as I need to lean into the lens that my trans clients present when they're describing what their struggles were, and [..] my 'how?'[question] *was that there's an androphilic energy, there's the energy of the sexual encounter* [which] *I'm reading as masculine - in its feel - and that's what's turning me on here or why I have become aroused by it? [..] the fact that they're female bodied persons wasn't the primary element of what I was being aroused by. And I do think my ability to have that nuance to the lens is shaped by my work with my trans clients.*

While Ralph's ability to "lean into" the discomfort of what his dream had evoked, and to link it to his work with trans clients, reflects a well-developed capacity for reverie and 'thinking', despite anxiety, it also highlights the ubiquity of transphobic countertransference. Hansbury (2017) describes Ralph's experience as the manifestation of one of the basic "unthinkable anxieties" that appear to underlie transphobic countertransference reactions in cisgender analysts working with transgender patients, even when the analyst is unaware of having any biases against transgender people.

One may hypothesise that Ralph, in the previous extract, was possibly experiencing a psychic disruption, as a result of preverbal anxieties, fearing in his idiosyncratic elaboration of the unconscious fantasy, that any inner contradictions might possibly lead to the loss of his sense of internal cohesion. Ralph alluded to losing a grip on his sexual orientation and being lured into a complementary heterosexual orientation. Hansbury (2017) posits that a form of prejudice can emerge in which the trans person is not viewed as legitimately transgender but as one who has a capacity to deceive the other and stir unresolved Oedipal conflicts and gender anxieties in the therapist.

The therapist, in his desire to get out of the knot of a transphobic countertransference and remain a non-defensive, thinking analyst, referred to his process of leaning into the 'how?' question. This may be an oblique reference to Saketopoulou's proposal that therapists pose 'how transgender' instead of fixating on 'why transgender' (Saketopoulou, 2014a). Hansbury (2017) would argue that the therapist has been unsettled by changing bodies and harbours an unconscious fear that the patient's transitioning body will rock his own gender stability. Hansbury (2017) also suggests that

there might be an underlying faint glimmer of envy by the therapist that a trans-patient gets to be both sexes. Winnicott (1965), who originally introduced the concept, ascribed such unthinkable anxieties to the infantile fear of annihilation that belongs to an early stage of psychic development and to the infant's fear of falling into a precipitous state of psychotic madness and of suffering a breakup of a personal continuity of existence (Hansbury, 2017; Winnicott, 1965).

Another therapist, Richard, who also identifies as gay, recalled a similar experience of encountering a trans-male. This person was not a client but the interaction appeared to unsettle the therapist:

> *As the day progressed, I came to realize it is a trans-man. And I remember when I first met him thinking that he was attractive to me and how I felt a sort of a frisson of sexual something that runs through a human. And as I became to realize he was trans I was challenged to think about desire and bodies because I'm drawn to male bodies and male characteristics. Although if I look at sexual partners and romantic partners that I've had in my life it is quite a broad spectrum.*
>
> *It made me think about what is it that I desire in a male partner? Is it that they have a penis; in those respects they are genetically male. Would I be able to have a relationship or experience desire in a sexual encounter with a person who would probably still have a vagina? That was sort of an interesting inner thing that went on inside me. I never came to a conclusion, but I think I felt in me the possibility of that desire still being present, which was quite intriguing because I've always felt that my sexuality is quite focused in some ways.*

The therapist does not enlarge upon this experience but appears to endorse Laplanche's original conceptualization of gender as a psychic category, inseparable from sex difference and polymorphic infantile sexuality (Evzonas, 2020).

In the following extract Linda discloses her disturbing feelings of countertransferential anxiety and explores how a patient's discordant visual gender markers can be unsettling:

> *I mean, it's interesting, [..] and this has been something I've struggled with and I've really had to think about. I've got a patient who's transitioning to female, but it's been a very gradual thing. And she would arrive still looking very masculine, you know, with facial hair - and our brains are programmed in such a way that we look at certain things as gender markers and we respond. So I would have to work very, very hard to remind myself that this person identifies as female*

despite looking very, very masculine. So I'm aware of that, and I have to be aware of my own stuff around [that].

Just because this person has not shaven and is dressed like a man does not mean that they don't identify as female. And also being sensitive - back in in the old offices- that if I call this person from the waiting room, do I use their chosen name? Because everybody would look in a very strange way because it's a very feminine name, and here is a person who looks very, very masculine. So I'd be very aware of that.

The therapist, Linda, may be alluding to an evolving process of ungendering which appears to deviate from the normative or traditional gender binary to which she is accustomed. One could argue that her fear of calling out the patient's chosen name, in public and before the gaze of the other, ignites fearful concerns in her about reifying a cis-trans binary. Hansbury (2005) and Winnicott (1965) would suggest the possibility that the therapist, triggered by stressors, has an unconscious fear of 'going to pieces' or descending into madness which implies a breakup of a personal continuity of existence. The infant, according to Winnicott (1965), is constantly on the verge of these anxieties as is the discombobulated therapist who has to remind herself vigilantly of her patient's gendered position. Unthinkable anxieties must be thought according to Hansbury (2017), and relational analytic theory also asks that the therapist be self-conscious in the work (Goldner, 2011) so it is positive that the therapist in question creates a thinking space in her mind for the patient to exist.

In this extract Rachel speaks about her somatic countertransference reaction when her patients discuss their physical bodies:

Yeah, I mean, I think almost my chest tightened up when I saw the photos of the top surgery. It was almost as if I got a .... like, I caught my breath, and it was very much around this region [points to breast region]. *Definitely it didn't last very long. So I can't say that it persisted in the next days* [or] *that I noticed anything [..] Sometimes when my male to female patients will talk about having to hide their penis - there might be a sense of feeling that in some way, even though I don't have a penis, but like what that would mean in terms of tucking it away. But yeah, sometimes there's almost a cringing ... around the binding or the potential, sometimes, for self-harm around ... even a female to male who's got dysphoria around breasts [..]. So there is a sense that there is, like, a cringing,* [an] *internal cringe around that, when that kind of behavior is described.*

Hansbury (2017) states that such experiences, as disclosed by Rachel, of castration anxiety (of breasts or penis), can be a defense deployed by cis-gender therapists who are disturbed by their transgender patients. The therapist's use of the word "cringing" above

suggests an emotional response beyond empathy that could be linked to fear. One of Hansbury's (2017) specific transphobic countertransference reactions, namely the therapist's sense of fear that their body will break apart and important pieces will be lost, is brought to mind. The author claims that the therapist may, consciously or unconsciously, cast or frame an act of surgery as a "mutilation" and consider the patient a Frankenstein monster in order to disavow a deeply unconscious wish for a cross-gender embodiment or gendered-presentation. Rachel's multiple use of the terms 'cringe' and 'cringing' may also suggest the evocation of a sense of the 'uncanny', as conceptualized by Freud (1919). This phenomenon refers to "a psychological experience of an object, impression, or situation as frightening, eerie, strange, or mysterious", one which can arouse and accentuate a sense of uncertainty, dread, and horror (Harvey, 2020, p. 1). Harvey (2020) maintains that an individual's own sense of subjectivity is constantly open to disruption and destabilizing effects, especially when confronting a sense of the uncanny, and can lead to the amplification of ambivalence. It is possible that encountering gender-variant or trans-identified individuals can produce an experience of the uncanny in cis-gendered people and can engender patterns of identification and dis-identification with the 'Other'. It may also result in the employment of various defenses including idealization, avoidance, and projective identification as a means of maintaining psychic stability (Harvey, 2020).

The abovementioned excerpt may also signal an experience by Rachel of kinesthetic empathy, a phenomenon which has been previously discussed in Section 4.4.2 (Chodorow, 1999; Forester, 2007). Forester (2007) may contend that this is, rather, an example of the transmission of vicarious traumatization which can relate to dissociated kinesthetic mimesis. Kinesthetic empathy's relationship to somatic countertransference equates with emotional empathy's relationship to cognitive and affective countertransference. According to Forester (2007), when kinesthetic empathy is attended to and processed, it can serve to enhance the therapy. Correspondingly, when the phenomenon is neglected or dissociated, it runs the risk of placing the course of therapy, the patient, and even the therapist at risk (Forester, 2007). Of course, it is imperative that the attendance to and processing of such experiences do not negatively impose upon or over-extend the patient in any way, and that any reflections, by the therapist, which amount to forms of self-disclosure are titrated, timely and judicious.

Creating space to think about body anxiety in the countertransference is essential. Suchet (2011) addressed her countertransferential anxiety by imagining her patient's changing body in reveries and dreams, while Offman (2014), by employing judicious and

calibrated self-disclosures about her countertransferential discomforts, managed to create a space in which the bodies and genders of the analytic dyad do not have to be the same. Despite the centrality of an attentive therapeutic approach there too exists an encroaching ethical tension between therapists' desire not to harm the patient, or the patient's body, and an overarching wish to elevate patients' qualities of life (Hansbury, 2017; Molinier, 2021).

It is through mentalizing patients' transgendered bodies, the locus of so much unthinkable anxiety, that therapists can reach dialectic synthesis, and create a thinking space in their minds for their patients to exist in whatever form they desire (Hansbury, 2017). If the therapist, like a primary caregiver, can accurately picture the child, then that child will have the chance to "find himself in the other" (Fonagy, 2000, p. 1132). It is important to acknowledge that what the therapist *does or does not do* with the unthinkable anxieties which arise can potentially become more of a problem in the therapeutic setting, than the presence of the actual anxieties.

In the following excerpt, Jane, recalls an experience of her trans-female patient, abruptly and unexpectedly, exposing her breasts to Jane:

> *I had a trans-woman flash me once which was…. obviously in the moment, my bodily reaction* [voice trails off]. *So she flashed me her breasts and my bodily reaction was very intense. I felt very violated and I felt intruded upon. And it was the first time I've ever had a client display themselves in such a vulnerable way. And it took me a while to kind of unpack why I felt violated. Part of it was that I think it felt like the therapy space had been violated or something that had been intrusive - to bring nudity into the room.*
>
> *But eventually I unpacked it a little bit more. And I realized … what she said straight afterwards [..]. So it started with her basically showing me she has an eating disorder, right? So she was showing … she wanted to show me that she's lost weight because she's been struggling to eat. So it started with her lifting her shirt to show me her stomach and that her rib cage is quite prominent. And she accidentally flashed me part of her nipple and then pulled her top up again and was like 'we're all women here. You've seen these before'. And when I thought about what she'd said, I actually realized it was a fusing as opposed to something feeling violating, which is how it initially felt to me. It felt violating.*

Jane was gradually able to put her experience into words and hold her anxieties in mind. She managed to recognize the importance for this trans-client to have a moral witness to her corporeal transition and/or her trans-subjectivity as a means of possibly establishing a relational twin-ship with the therapist. Given her eating disorder, the patient may also

have held an unconscious desire to display to the therapist the embodiment of the damaged container of her mind, the ruptures in her psychic skin and in her reality, in the hope that the therapist could now meet her where she needed to be met (Grossmark, 2018). It may also be a way for the patient to establish an aesthetic link with the analyst wherein the latter becomes embodied emotional scaffolding for the patient. This identification could also be an instance of a developmentally necessary, idealized maternal imago and/or erotic transference (Lemma, 2020). What counts is that the therapist's reflective capacity is functioning and that she is able to make meaning of this enactment.

Similarly the therapist's reaction may touch upon Lemma (2018) capturing of the interpersonal tension of Sartre's (1965) conceptualization of "the look". Sartre (1965) describes two distinct forms of looking and the attendant affects. The 'voyeur', who is the 'me who looks', at some point, gives way to the 'me who is on view', the 'spectacle' wherein the tables become turned. In the aforementioned example the patient appears to abruptly reverse the roles of voyeur and spectacle so that the therapist is cast as the spectacle ("we are all women here" implies the patient is acutely aware of the therapist's breasts). The realization that the world assumes coherence in relation to the perspective of the other is deeply threatening, not least because this other perspective is no longer inaccessible and insofar as the spectacle cannot control the voyeur's thoughts, feelings or perceptions and is stripped of a prior sense of illusory mastery. The therapist, being cognizant of her own specularity, can be confronted with a profound countertransferential anxiety which requires mentalization.

In a similar vein, another male therapist, Ralph, offered the following experience:

> *But I don't know if this is particular to me. So [..] a lot of my clients stuff that is projected onto and into me, that I find that I'm holding and processing, manifests in dreams. So I will have particular dreams, and when I wake up I'll know and I can link the content of that dream to the client I had that day or the day before. So, for example, it's not uncommon for me to like, for example, maybe to have a dream where in the dream I'm presenting as female or as a woman, but I know I'm me. And in this dream, having this overwhelming - whether it be experiences of fear or terror or anxiety - or that, kind of, 'I'm not being seen' - kind of, feeling invisible in the dream because I'm trying to tell the people in the dream who I am, but they're seeing this woman.*

This example may also capture Sartre's notion of the spectacle and the concomitant feelings of invisibility. This may represent a parallel process for the patient who has formatively experienced misrecognition or felt like an invisible force, un-held or unseen

in the mind of the other. Again, there are multiple possible interpretations of the prior example. It may be a projective identification of the subjective experience of the patient, 'not-me' or disavowed self-states that are being split-off; or the scenario may imply a lack of differentiation or a specific fear of merger or of the mind being colonized. One can also consider the category of 'difference' beyond mere sexual/anatomical or gender identity difference and consider symbolic difference as a symbolic tool in an intersection of planes (Evzonas, 2022; Gherovici, 2022; Glocer Fiorini, 2022). All of these interpretations, however, grapple with an aspect of experience that has been previously unthinkable and unarticulated in the therapy.

A salient observation is that many of the therapists were unable to enlarge meaningfully upon their understandings of such relational phenomena and only one of the therapists discussed the role of supervision in facilitating deeper exploration of these complex relational dynamics.

In this excerpt Ralph recalls an experience with a trans-female client who identifies as pansexual. The trans-female tended to adopt a dominant sexual position with her girlfriend but wanted the roles to be reversed and take a more submissive role:

> *I've had a few of those* [dreams] *I remember the one [..] And so she had this struggle where (and as she put it), she said "I also want to be the pillow princess sometimes" - where she wanted the partner to take charge and she wanted to be the one that was made love to - where she was more in the submissive role and the partner in the active role. And she was sitting with the angst of this and struggling with 'how can she find the words to ask this of her partner?' I remember around that time [..] I was having a dream where in the dream I was a woman in the dream, and it was this sexual dream where I was with a man.*
>
> *And just disclaimer, I am a gay man, [..] But in the dream I was, I was a woman and I remember - the feeling in the dream was this need to have this man treat me right. In the dream there was this frustration that he wasn't doing what I needed him to do and I didn't know how to get him to do .... to put it rather bluntly, I needed him to fuck me and fuck me in a way that I was going to feel like a woman. That was like the thoughts and the imagery and the dream and I woke up from that thinking 'Shoo OK' and then immediately linked it that my psyche was somehow in the dream processing some of the material. So, yeah, so that's definitely for me where a lot of my clients stuff goes and manifests in dream.*

Again, this particular therapist's use of his dream to understand the dynamics in his patient and between them is an example of where the anxiety experienced by both patient and therapist is initially unthinkable, but is then 'worked through' unconsciously.

Possibly his desire to submit to the dominant other is an over-identification with the plight of his patient but there is also an aggressive undercurrent running through this narrative. Despite the existence of a battlefield of multiple warring primitive parts, the disoriented therapist may be identifying with the part of the gender non-conforming trans-patient that has been consistently misrepresented and unable to find themselves in the other, through situations of being misgendered. The therapist, by referencing his desire to be penetrated, may be alluding to an under-cathexis of libidinal investment by the other; this may relate to pre-linguistic, drive-cathected enigmatic gender signifiers that are transmitted to the child by over-inciting adults (Evzaonas, 2020).

A final example of unthinkable anxiety has been mentioned in a previous excerpt. We may recall how the therapist, Simon, registered an evident dampening of his characteristic bodily reaction to intimate clinical material and expressed how he experienced a more detached relationship from his body genitalia when engaging with trans-patients. One may hypothesize that this was a transphobic countertransference reaction, as outlined by Hansbury (2017), and that the therapist unconsciously fears that he may be tricked, through a denial of reality, into either complementary homosexuality or heterosexuality depending on his innate sexual orientation.

The examples discussed above clearly support Hansbury's (2017) theorizing around unthinkable anxiety in relation to work with trans-patients, however, it is important not to dismiss the fact that the therapist is a decentered subject who develops and is dependent on the enigmatic Otherness and is not only a subject driven by her or his unconscious; the therapist is also inscribed in the social and is inevitably caught up in the workings of power relations. When reflecting upon unthinkable anxieties and transphobic countertransference reactions the chief aim is not the overcoming of resistances or the lifting of repressions in the patient. Rather, Grossmark (2018) advocates for the facilitating of a creative and emergent interactive process, between patient and therapist, wherein what was unformulated can take shape and find meaning. So that the multiple and sometimes incompatible parts of themselves come to be enacted and brought to consciousness.

We may think of Ralph's experience as a form of repression, specifically what Freud (1920) called 'secondary repression'. This concept describes the activity of the psyche in putting aside experiences which might create anxiety (Hinton, 2009). One may also conclude that such unconscious countertransferential enactments may pertain to a parallel process in the therapist which mirrors the act of 'primal repression' as conceptualized by

Laplanche. This act primarily consists of two moments: the moment of inscription and implantation of the message from the other, over the course of 'primal seduction', followed by primal repression of the untranslatable elements of the message. Is it possible that the therapists are overly receptive or attuned to untranslatable enigmas, enigmas that are associated to the unknowability of the other and which can arouse dread and anxiety? Hinton (2009) argues that such enigmatic elements or nuclei of experience can provoke and have an ongoing, destabilizing effect on personal and cultural structures, and, at the extreme, can feel like 'black holes'; he adds that these enigmas are also the basis of our freedom to endlessly navigate and re-translate or re-imagine these gaps so that reflective capacity can emerge.

Intersubjectivity can thus lift the repression that weighs on the subjectivity of the therapist, who is systematically reduced to an intrapsychic object in classical psychoanalysis. An intersubjective approach that considers the subjectivity of both therapist and patient and the intersubjectivity between them invites a space of creative play and discovery, wherein both can be found. However, this entails a willingness from the therapist to tolerate the dread and anxiety.

4.6 The Anti-Analytic Third and Crises in Subjectivity

This theme emerged as several therapists recounted multiple instances where their subjective feelings of guilt and shame compromised, in the immediacy, their capacity to mentalize and contain their patients in order to perform the alpha function, a process whereby raw material of sensory experience (beta elements) are converted into elements suitable for mental 'digestion' (Benjamin, 2018). This author proposes that therapeutic capacities during these episodes were undermined by the presence of the 'anti-analytic third' and/or the 'trauma of morality', as conceptualized by Straker (2006), which led to multiple crises in the therapists' subjectivities. It is the author's contention that, perhaps, the site of optimal transformation, for the therapists interviewed, is in fully appreciating that not only is the personal the political, but that the political is also profoundly personal and can deleteriously infiltrate the clinical setting. This aligns with Straker's (2006) claims that being with another is not a monolithic, uncomplicated model, considering the contradictions of the relational matrix into which therapist and patient are both inserted, and which both idiosyncratically elaborate.

Similar to their clients, therapists also embrace a plurality of subjectivities and identifications for particular contexts and, accordingly, implicitly transmit, embody and convey social and political formations. When the subject is constituted at the limits, work is required at the intersections between these multiple subjectivities as these subjectivities are not always concordant; they are each imbued with distinct fields of otherness, the myriad structural tensions and fault lines of state and culture, and "the symbolic". When the constitution of multiple subjectivities is based on heterogeneous factors, which act in tension and never reach dialectic synthesis, tension between these fostered, context-bound moralities can become unsustainable (Amir, 2022; Glocer Fiorini, 2022; Harris, 2022; Rozmarin, 2022).

In this section therapists explore clinical dilemmas when there is a collision between their political selves and their personal selves. Justin, when asked whether he initially takes much notice of his trans-patients' bodies, outlined the contradictions, often unconscious, which can surface in moralities when multiple subjectivities are embraced:

> *Are they, kind of, a form of cis-normativity?[..] Is there a policing of bodies? I suppose knowing that I could very easily be a part of that. So I think there's [..] some initial noting [of the body] and then an unpacking of what does that mean? Is it okay or what am I picking up? Is there something about them? Is it useful therapeutically or is this a cis-normative bias?[..] And I think that's where my gender identity would come in - actually what am I bringing to this case? Or am I pushing things in certain directions? Am I relying too heavily on certain discourses or certain understandings? Am I imposing something on the client? Am I also pushing for a creation of a different form of false self? What am I introducing into this space? So I think an awareness that the focus is on me [..] or am I actually overstepping and that whatever I do actually could be problematic.*

There is an evident tension or dissonance for Justin who appears to grapple with the implications of his gender normative identity and whether his positioning as a political, ethical, and theoretical subject could lead to possible transgression. According to therapists' accounts, performativity, as evinced in the vast array of embodied and language social acts, was inadvertently enacted in the consulting room and such practices of identity appear to be premised on differentiated power relations and original class position. Therapists variously spoke of mounting feelings of guilt and nameless dread, a psychoanalytical term firstly introduced by Wilfred Bion, when contemplating how their natal bodies, their acquisition of habitus, or cis-normativity may be perceived by their

clients and expressed a conscious desire to conceal the body as a means of preventing gender envy (Bordieu, 1980). The therapist who has a desire to occupy an ethical position can also experience a degree of tension that becomes wholly unsustainable when ethical and spiritual survival clashes with material needs including safety and financial prosperity. For many therapists this conflict can be so immense that it becomes repressed and sequestered from consciousness.

Another therapist, Linda, acknowledged onerous feelings of guilt and a sense that she was being acutely observed, on the basis of evident and amplified states of difference, which pervade the clinical setting.

> *I do feel a strong sense of my own gender privilege at being cisgender, and I'm often aware of the flashes of envy or jealousy. It hasn't happened to me yet. It has more come up in ways where I feel maybe an impulse to acknowledge my privilege in the room, often, to acknowledge it - that I <u>am</u> cisgender and that that could be something that plays out a bit - like my race as well. So I find that it just adds another layer in the room of just needing to be brought up because it's definitely present … like, everyone's aware!*

In the above excerpt Linda recounts how she has been brought into a very close encounter with the fact of her own gender and race, an encounter that has the potential to create a crisis in the therapist's subjectivity.

Therapists deferred to various social discourses throughout the interviews, including homophobic and transphobic discourses, which appeared to create multiple crises in their subjectivities and contradictions in their moralities. Given that individuals are inextricably enfolded in discourses and through personal and social histories, that precede and shape drives, desires, and decisions there is no ontological innocence and everyone is implicated according to Straker (2007).

In the following excerpt Justin questioned how his gender and sexual orientation may adversely impact treatment:

> *I suppose for me, I think often it is just my own focus and understanding where I stand and what does it mean? So, for example, speaking to how a client sees me and what my cis-ness could be in the room, I suppose I identify as queer [..] but what does it mean for a client to see me as cisgender or what does it mean for me to be cisgender? [..] I think previously there was a strong need to prove I'm safe, I'm not going to hurt*

> *you, I'm actually not here to be transphobic. I'm not here to be homophobic [..] I think there is often an awareness of that – am I ..... And I think in in many ways I would like to think that I'm not problematic. I'm not causing any kind of cis-normativity or introducing that into the sessions. But I think, over time, being quite aware that is very easy to do that and* …..[he forgets what he was going to say].

Justin's loss of a train of association may be indicative of a disjunction of the inner logic of the psyche, once he considers the adverse implications of introducing cis-normative bias or prejudice. Hinshelwood (2018a) may posit that Justin has actually gotten inside the anxious mind of the patient, in this moment, and is struggling to be with it. Hinshelwood (2018a) employs Bion's concept of 'O', the talent human beings have of "getting inside each other's minds, and being their experiences with them" and this may explain Justin's inability to think and link (Hinshelwood, 2018a, p. 208).

Other therapists reflected upon moments in their sessions where they struggled to say anything or bring their subjectivities to bear on the situation due to a massive disruption in subjectivity. Therapists acknowledged grappling with how many of their differences with their clients are a function of power, gender, class, race and religious positions and the extent to which they are a function of their own personhoods. For example, therapists alluded to difficulties in managing unconscious feelings of complicity with moral judgements which they may not necessarily condone. Richard expressed alarm in the next excerpt at the asymmetry in power relations and how heteronormativity can be inadvertently communicated to patients in various cultural settings including the treatment setting:

> *But at the same time, I think also I'm probably .... what I am anxious about is the idea that surgeries, for example, might alter the opportunities for sexual pleasure. And personally, that's important to me still - the idea of my body as a site of pleasure, my genitalia, my penis and other parts of my body. So I suppose there would be an anxiety in me that I might impose ideas about pleasure and desire because I feel there is an interesting tension in trans-clients between wanting a body that conforms to the inner desires and fantasies. I feel that intellectually I'm able to have those discussions, but I think I would want to be led by a trans person and where we go with that conversation. But I'm also anxious, I think, <u>now that I'm thinking this through with you</u> - about imposing ideas about acceptable/unacceptable genitalia, what is possible, what is acceptable.*

Richard specifically drew attention to the presence of the interviewer and how it aroused anxiety. One may surmise that the therapist's political self, as evidenced by the imagined gaze and ideology of his receptive audience, took over from a more personal self, prompting heightened feelings of anxiety and an anticipated fear of disapprobation. It is important to note how an imagined audience, as well as socially hierarchized intersectional realities, can inexorably contaminate the analyst's countertransference and result in fluctuating or rotating states of mind. There was an ostensibly heightened sense of vigilance or guardedness about the therapists during the interviews which could reasonably be imputed to therapists' harbouring of fear that their imagined audience might be judgemental, censorious or condemnatory with respect to the therapists' moral and ethical stance and clinical praxis. The moral dilemmas that ensue when one is encouraged to condone, on a political level, actions that, at a more personal level, offend one's sensibilities can indeed materialise in the clinical setting and lead to the same mechanism of splitting that one would associate with trauma. When these contradictions or tensions become unsustainable it can provoke a need to dissociate or dis-identify (Straker, 2006).

The following extract examines how Dolores responded when asked, in a non-specific manner, whether therapists, in general, need to be more attuned to what is happening in their own bodies:

> *Definitely, I'm always aware. That's why I know for sure I never get nausea, and if I do …. but I never have with those symptoms; I always work on my own therapeutic process as part of my own body's things. But at the moment with them* [gender non-binary clients], *I've only had positive things. I've never had to work on that because it's so intriguing to me [..] So it's not something that would give me a trigger, that could make me uncomfortable, or have a body thing like that. If anything, what does trigger me is an emotional feeling of sadness, of pain that they're going through, which triggers off my pain. But it's not a physical thing, it's more of an emotional thing […]*
>
> *Yeah, I use it as an opportunity for me to heal me, and I believe once I've healed it in me it's going to be helpful for them anyway because they learn by role model and I rather become that role model and live it and change it in me and heal it in me because that in itself, I believe, has got therapeutic value because the unconscious mind learns by role model and*

it sees, and it imprints and it copies. So I always believe that I'd rather be the role model of change and offer that, but by first healing it in myself.

On the basis of the response it can be argued that Dolores is experiencing a disruption or crisis in her subjectivity and has not consciously realized the parts of herself which may have become disavowed and split off. The therapist's experiences are rendered inchoate and incoherent and the therapist, in a process of inner sequestration, tends to exclude less organized, non-represented self-states, and aspects of non-relatedness; it is noteworthy that linguistically she refers in a detached manner to the "body's things" and the "body thing". The enactment of dissociated and unformulated states, as a result of intrapsychic conflict, appears to supersede a more creative and productive intersubjective engagement by analyst and patient. Grossmark (2018) cites Stern (2003) who claimed that such mutual enactments occur when a dissociated state in the patient invokes a dissociated, 'not-me' state in the analyst; such enactments rigidify clinical relatedness and interrupt each person's capacity to serve as witness for the other. The therapist's impaired capacity, in the above example, to mentalize and the interruption of narrative may result in a failure of representation. When crises in analysts' subjectivities result in patients' expressions of selfhood being met with disconfirming responses, marked by non-recognition, it can be counter-therapeutic. It is not clear whether Dolores struggled to remain in dialogue with her client. However she does mention that she felt a strong countertransferential state of sadness in relation to her client, which remains unresolved. Dolores concludes that her sadness is a subjective state and not related to projective processes of affective communication. Despite protestations to the contrary by the Dolores, Straker (2007) argues that when there is a crisis of subjectivity in the analyst when both analyst and patient are challenged to look at how much they can "really tolerate the otherness and subject status of the other" (Straker, 2007, p. 162). Despite Dolores adopting a trans-affirmative stance and articulating a veneer of idealization around the therapeutic process (which, in actuality, may be a moribund process tainted by dissociative dynamics), the analytic dyad is not brought into dialogic relatedness or reverie and this can ultimately stymy the flow of enactive engagement (Grossmark, 2018).

In the next extract Ruby explores how her cis-gendered orientation pervades the therapy setting:

I guess the thing around my breasts is a big thing; I almost don't want to, kind of, almost … don't want to offend or … my breasts to be too present or physical or in the room, so I find myself, maybe just, you know…yeah,

> *concealing gender … [wearing] a big scarf or just covering, trying to just downplay a little bit, a sense of feeling some guilt or also wanting to downplay my… just wanting to neutralise or dampen my gender expression … not wanting to be too anything so to, kind of, just dampen my [gender] presentation.*

While the unfolding dynamics can be explained in psychoanalytic terms implicating projection and projective identification it can be argued that the phenomenon of the anti-analytic third has emerged which can embroil the therapist in a stalemate or impasse. The aforementioned dilemma requires of Ruby an internal struggle with self-regulation and with individual feelings of shame and guilt issuing from her female gender expression and an inhibiting sense that she is transgressing. In order to reclaim those split-off parts of herself, the therapist must confront the extent to which her cis-gendered guilt has psychically crippled her by acknowledging the unconscious, potentially destructive underbelly of such guilt (Straker, 2007). The excerpt indicates how the therapist is striving to stay present and attuned, albeit in an unconsciously experienced split involving dissociated self-states and fluctuating identifications. There is a conflictual wish to be out of contact with the patient when tension can no longer be sustained, yet a paradoxical desire to remain in contact.

Straker (2007) posits that unbearable tensions between moralities, tensions which escalate to a point where different selves become dissociated and split apart, can reach a tipping point when one becomes personally embroiled in a political sphere which one has been largely shielded from or chose to ignore; essentially, where there has been a cocooning of the private self from the social self. A theory that embraces a multiplicity of selves may accommodate to this tension. This crisis in subjectivity does necessitate deep self-reflection and a subject-to-subject encounter between therapist and patient, where both can authentically revisit and constructively address their incontrovertible differences, in a *graduated* and *judicious* manner which transcends the altruistic desire to heal and be a source of salvation for the other. Perhaps the therapist in the above excerpt must, during the course of supervision, come to relinquish her unconscious belief that all that is good is located in the patient while all that is bad resides in the therapist or in discursive practices. A subject to subject encounter is no mean feat and has to be approached in a very thoughtful way but a generative dialogue with a creative analytic third should be encouraged.

According to Straker (2006), insertion into noxious social discourses, which have been inexorably imbibed, is damaging to both the socially constructed subjugated group and

the socially constructed dominant group. However, the damage is less recognized and more pronounced for the latter group whose capacity for full humanity and absolute recognition of the other is compromised. The therapists alluded to their experiences, when working with trans-patients, of confronting the destructiveness of their own performativity and the associated infantile wishes that may have become bound up with it including envy and aggression. Klein (1961) asserts that the move to reparation can only ensue when therapists come to recognize their destructive impulses and/or their role in the performativity of power relations. When the embodied consequences, from being inserted into a shared noxious discourse or relational matrix, resulted in unconscious destructive enactments, recognition of such instantiations were consciously occluded for many of the therapists interviewed.

Straker (2006) ascribes therapeutic failures of recognition to an operative and noxious in-vivo transgenerational transmission of diminishment which floods the therapist by evoking attendant feelings of shame and guilt occasioned by a necessary moral judgment passed upon the self. For example, various therapists made explicit mention of the sustaining performative power of their cis-gendered identity as well as lamenting how noxious and homophobic social discourses have pervaded the field of psychoanalysis for too long. When the therapists described a sense of being complicit, or inculpated with majoritarian social discourses, it appeared to evoke self-states of shame and guilt.

It can be posited that, in the prior excerpts, the maintenance of particular power relations was manifested through the palpable presence of a noxious pregiven third, moments where the therapists' capacities for mentalization and/or containment are suspended and therapists are rendered numb, mindless or overwhelmed. Straker (2006) claims that in such circumstances, more experience-distant concepts and theories, referred to as pregiven thirds of theory (Britton, 1997), can come to the therapist's rescue, liberating them from potential impasses in order to set free the reverie required to generate the creative analytic third of which Ogden (2018) speaks. It is not always guaranteed that the pregiven thirds, of theory and concepts, will facilitate the therapeutic process; however, subscribing to the value of psychoanalysis is more likely to restore thought than to hinder or constrain it.

It is in arriving at a true analytic third that the analytic dyad can succeed in creating or reinventing itself anew in the analytic space. The thwarting of this analytic third, whilst in the midst of social discourses which act to inhibit and destroy thought, depends on Suchet's dedication to the relational principle that "the analyst needs to change"

(Goldner, 2011, p. 23). This reinforces Straker's idea that when you change the countertransference, you change the patient.

4.7 Therapists' Experiences of Embodiment

The embodied dimension of therapeutic work, including the intersection of body and mind, is often very difficult to articulate and to monitor in the clinical situation. Saketopoulou (2014), in tackling embodiment in the clinical setting, cites Dimen (1998) who asserts that the body constitutes a "site of confusion" (Saketopoulou, 2014, p. 827). During the interviews the theme of embodiment emerged for each therapist, and each concurred with Dimen's pithy observation, and raised significant points about their experiences regarding the nature of embodiment and the phenomenon of two bodies intersecting in the analytic setting. Some of the therapists acknowledged challenges in attempting to make sense of their patient's non-verbally expressed internal worlds and such complexities are further compounded by temporal considerations given the patient's desire to expedite the process of transition.

Therapists' ability to process clients' psychic experiences seemed to be especially undermined in patients whose implicit mode of communication is, primarily, through their bodies. Therapists who demonstrated a capacity to mentalize experience and who were receptive to their patients' experiences of embodiment were better positioned to make sense of their patients' nonverbally expressed internal worlds.

The following section underscores how the quality of the embodied experience between patient and analyst is vital and how the analyst's body is a central feature of the intersubjective matrix and not merely the locus of somatic countertransference. This section will explore specific dilemmas in relation to embodiment that the therapists explored and how they might be theoretically understood (Hartung & Steinbrecher, 2018; Lemma, 2020; Saketopoulou, 2014; Silverman, 2015).

4.7.1 The 'Loaded' Body

The following excerpts encapsulate the destabilizing or unnerving feelings of uncertainty, which several therapists gave expression to, when considering their own bodies and those of their patients in the treatment setting. In the first extract, Justin discusses his sense of

discomfort when tackling embodied experiences, in general, within the therapeutic setting:

> *I think, often, there's an awkwardness around bodies - actually, just how much we can focus on a person's body. And, I suppose, an awareness around - obviously, I think myself and the client also needing to understand the focus on the importance of the body and the distress that the body can create but sometimes also feeling quite conflicted on how much can we focus on a person's body. And obviously, knowing what causes them dysphoria, understanding what the triggers are, understanding what could be contributing to that - is it purely gender dysphoria or are there other things associated with their body? So I think there's often a conflict around just how much do we get into a person's body?*

It was especially striking and noteworthy that two of the therapists, Justin and Jane, each employed the term 'loaded' when reflecting upon the process of confronting the material body in the therapeutic setting. In the following excerpt Justin remarks:

> *But what does it mean to get into the body? [..] I think that also it often feels quite loaded, but slowly starts to open up as a person does become more comfortable in their body. But I think it is quite a struggle to get into that. [..] I think they often feel a lot more - and these are generalizations - but often I would feel more, you know, it would feel more vulnerable in a way to get into the body; where often, as people transition over time, there often is a bit more freedom to play with the body or talk about the body. For example, when someone started on hormones, often they are just feeling a lot more comfortable.*

He expounds upon his thoughts about the body in the treatment setting:

> *Often it's very easy to slip into a headspace or avoid bodies or not work with bodies as much as we should. So, in [..] a broader sense, and sometimes it can feel more controversial for trans-clients, in a way, to get into the body and focus on the body, be it their body or my body. I think it does feel or it can feel more loaded. [..] I suppose, early on, often for many people, it feels like it's very easy to feel very dysphoric and very overwhelmed by gender and almost needing to tread very narrow lines in their bodies and in themselves. And I think that often the therapy space can become part of that.*

It is important to reflect, through a lens of mentalization, on the possible reasons why therapists may be resistant to immersing themselves in this analytic endeavor or unable to hold the patient's body in mind. We draw again from an excerpt in which Simon, in examining an instance where his trans-female patient was disclosing an intimate sexual encounter with her partner, acknowledges how a crucial aspect of the patient's narrative and a specific body part were obviated by the analytic dyad:

> *But by her not mentioning her penis and by her not mentioning her erection [..] it felt like there was an entire part of her body that was missing from it and I also couldn't then access the part that she was talking about. It was an inability to connect to the feeling of [..] which I think was interesting to me; that stood out to me. I remember thinking afterwards 'I don't really know what to do with this' because I hadn't … she hadn't and I hadn't necessarily spoken about the elephant in the room, which is that, likely, her and her partner both had erections; I'm assuming. I don't know [..] but we never spoke about it [..] I wonder, thinking back on it, whether or not there was some shame or guilt in me around having an appendage, or whether there was a projection of [..] her own shame about it or discomfort with it.*

Such clinical material illustrates themes of dissociation, abandonment and acknowledgment; it also re-emphasizes the relational psychoanalytic stance - that an analyst's awareness of possible failures in recognition owing to a prospective re-opening of painful psychic wounds can unwittingly potentiate an internal struggle with self-regulation, with the analyst's own feelings of shame and guilt (Benjamin, 2009). Such self-states involving psychic pain may also lay bare the workings of the psyche within the Lacanian register of the Real concerning trauma, where certain experiences of exile and marginality are beyond words and constitute "an excess, the beyond of words" and which cannot yet find representation in the Symbolic. (Straker, 2018, p. 265). This can have implications for therapists' attunement to somatic countertransference. Notwithstanding the fact that the experiences of patients, trapped in their bodies, can only be partially symbolized, similarly, therapists, in a parallel process, can be caught in their own experiences which cannot be fully captured in words and result in experiences that leave an inchoate, unintelligible residue (Straker, 2018).

This could be an instance of a dissociative stance of self-protection enacted by both therapist and patient, according to Benjamin (2022). She argues that failure by the client to receive recognition of their needs from the therapist, or acknowledgement of experienced trauma, through the enactment of the 'Failed Witness' position can constitute

a severe psychological threat. Paradoxically, recognition in the form of acknowledgement of individual and/or social injury is not counter-therapeutic and functions to uphold a requisite moral third of solidarity and universal need fulfillment. She espouses clinical processes which entail acts of recognition or witnessing and which, in the process, serve a reparative function of validating social and/or individual injustices, and demystifying a prior negation of the other's humanity. As uncomfortable as it is for therapists to implicate themselves in injurious social structures of domination and to momentarily align with the position of the perpetrator such a stance of recognition is vital for the mind of the Other to recover coherence and agency (Benjamin, 2022).

Hansbury and Saketopoulou (2022) argue that the trans-body is notably desexualized in metapsychology and the consulting room, comparative to its hyper-sexualized quality in the social realm. Notwithstanding their claim, one may propound in the above instance that the penis, as an indigestible, non-integrated part-object or concrete representation of this patient's psychic skin, needed to be dissociated and rendered unavailable to analytic engagement and reverie. It could be interpreted that the therapist has been unconsciously recruited to enact that which the patient cannot bear to think or to mourn because the bodily discrepancy of corporeal reality makes excessive demands on one's capacity to think coherently. One may conclude that the therapist, in failing to address this episode of body dysphoria, seeks to work within the client's gendered experience. Or perhaps it may represent a form of dualistic opposition and a bid to delink the sexed body from gendered experience (Saketopoulou, 2014a).

In instances where the anguished, subjective experiences of such modes of being cannot be shared and where the analytic dyad cannot come together in aliveness, Grossmark (2018), in employing Kohut's (1974) term, suggests that the 'leading edge', or growth-promoting dimension of the transference, is mutual engagement through a shared process of mentalization. He proposes creative interventions, as explicated by Ferro, Lombardi, and others, which involve the analyst unobtrusively partnering with the client and conveying understanding of the ongoing experience in terms of the patient's internal world; when the analyst can be embedded within unfolding enactments and not outside of them the patient may begin to inhabit his or her own experience and discriminate self from other (Grossmark, 2018; Lombardi, 2008).

Saketopoulou (2014a) argues that the dissociated body part needs to become thinkable so that anatomied gender can become digestible and suggests that such enactments may be conscious or unconscious invitations to the therapist to name what a patient cannot bear

to verbalize. In tracking and exploring the developmental implications of one's natal body not becoming sufficiently mentalized, Saketopoulou underscores, as a crucial step in the process of psychologically healthy transition, the importance of facilitating transgender patients, whose bodies are a source of suffering, in a process which enables them to psychically represent their pain and obviate further experiences of misrecognition. The analytic task for the abovementioned therapist is to allow language and symbolism to enter such knotted psychic spaces in order to help the patient delink gender and body and to disturb the fixed relationship between the materiality of the body and gendered experience (Saketopoulou, 2014a).

Therapists variously described the bodies of their patients as being noisy, quiet, loud, fragile, pained, hated, neglected and/or denied, and perceived that the body, as the material of gender and the most primitive form of self-representation, represents individuals' unique gendered experiences and gendered presentations. Given that atypical or unstable genders tend to evoke psychic pain, stir up tremendous anxiety and activate defensive operations, it is little wonder that it arouses states of apprehension in the therapist. Another therapist, Jane, conveyed this when she stated:

> *I haven't had that many trans-patients, but I have had certainly….the biggest experience I've had with people feeling not themselves in their bodies or struggling with coming to terms with their body have been my trans-patients.*

Jane adds the following:

> *So [..] I find it makes me want to do things with my body, like minimize it. So I speak with my hands a lot; I'll find that with patients who are quite acutely gender dysphoric and quite aware of my body [..] I almost want to make sure my hands are quite quiet and I'm not really drawing attention to myself.*

It is probable that, for some gender-variant patients, the body has been extensively modified through a range of extreme interventions, including scarification, which may explain therapists' stance of restraint in relation to the body; for example, one may recall Rachel's experience of working with a 'nullo' patient who deleteriously modified his body. The acquisition and safeguarding of a cohesive and immutable gender can frequently entail attending to various psychic wounds through the exploration of gendered boundaries or past experiences of significant gender trauma. Jane discussed her

experiences of working with traumatized patients' bodies who have displayed an evident struggle to connect with their bodies or to name specific body parts:

> *I mean, you could look at it in a very, kind of, symbolic psychoanalytic way where I think the naming of it is actually quite violent or quite threatening. And, I mean, a lot of my patients have had traumatic sexual experiences; so, often, even though that's not the reason that they have gender dysphoria, necessarily, it does play a role. So sometimes when they're referring to their own genitals, there's a kind of disgust at remembering maybe an abuse with similar genitals before. So I find sometimes it's like linking with trauma, that, kind of, compounding trauma. That brings it up for them. And that's part of the not naming.*

> *I find when patients do use the names, it's almost used like they're swearing. You know, like, I have patients who will use a swear word very occasionally and it's for emphasis. I find with my trans-patients, that's often how the genitalia are referred to as well - that if you're going to talk about it, you're going to talk about it in the context of hating that part of your body or somebody else being disgusted that you still have that part of your body - when you look like a woman - so it becomes quite a violent use when it is named.*

This example invokes Silverman's notion of the body and mind as prohibitive "sites of danger" for clients who have disavowed traumatic experiences and who may have been unable to process and thereby transform unbearable psychic experiences (Silverman, 2015, p. 53). It can also be posited that unresolved intergenerational trauma, which is expelled into the child, can manifest, by proxy, in others' bodies. This may also account for therapists' experiences of bodily discomfort in instances where their bodies become the receptacle for intrusive, unconscious projections from the other (Lemma, 2018).

Working with bodies can also involve coming into contact with subjective experiences of gender anguish when entering into a liberating yet distressing process of mourning with respect to unrealized gender idealities. For many trans-patients exploring their gendered boundaries can be contingent on necessary psychic amputations which can carry a foreboding sense of psychic annihilation or near-catastrophe (Saketopoulou, 2014). Simon remarks upon his experiences:

> *So, I have other trans-patients where they don't really talk much about their bodies, it almost seems like they've forgotten their body, they've either left* [the bodies] *behind or they live in a space that almost starts to feel schizoid in the sense that it's like, you know, I'm so in my head that I don't have a body.*

Accordingly, therapists experienced a parallel process of foreboding affect when drawing attention to patients' bodies. In the following passage Simon conveys a similar state of tension or conflict:

> *But, fundamentally, for me, what it does is it makes me think about the anxieties I have personally as a therapist, which is OK. So if this person is coming with a body dysmorphic question and they are trans [..] Can I talk about the body? Can it be something ... Can the body be in the room? Or is that somehow off limits? Because, of course with a trans-person, it's the one thing that they cannot just magically wish that the world would not see. That's generally the struggle.*

4.7.2 The Body that 'Passes'

Some therapists emphasized a singular focus or preoccupation with the ability of the body to 'pass'. In the following excerpt Richard opens up about his own sense of embodiment and how it seamlessly insinuates itself into the treatment setting in the form of a keen sense of self-exposure:

> *So I'm very aware that trans-people, some of them may be engaged with internal struggles about passing and appearing to be convincing as a man or convincing as a woman. I think that evokes in me a kind of a debate about what does it mean to be convincing? Am I convincing as a man in this encounter? So there is a lot of internal questioning going on about what is a good enough body in terms of your gender presentation.*
>
> *And I think with some of the trans-men clients I have an awareness of do they look like a man to me? I mean, intellectually, I've crossed over in terms of being able to see and accept their identification and I use the right pronouns to talk about them as a man. But I think there's a little bit in me that is saying 'but to me, you don't read as a man'. I think that that's my own judgment, my own stuff that I've grappled with - what does it mean to read as a man, what is adequate?*

In this excerpt Richard expresses his own ambivalence towards the body as barometer of culturally acceptable cross-gender expression and alludes to the transgressive power of gender-crossing in disturbing the normative gender order and in surpassing strict dualisms (Amir, 2022; Glocer-Fiorini, 2022; Hansbury & Saketopoulou, 2022).

In this passage Justin reflects upon his initial thinking process around the bodies of clients:

> *I think there's definitely awareness of the client's body, just how masculine or feminine they are. It's difficult because I think that there are automatic thoughts around 'Is this person going to pass? Do they look masculine or feminine?' I think there are also initial judgments around 'wow, well they are very attractive in themselves just as they are but they still want to change themselves??!!'; there's a lot of those initial thoughts. But I think that there is also a lot of tension around trying to be careful of discourses around passing or putting expectations on how this body should be or pushing bodies in a certain direction.*

The extract captures a degree of Justin's potential antinomy and may also constitute the phenomenon of the anti-analytic third. Justin openly acknowledges his reluctance to subjugate patients, by adhering to social injunctions wherein bodies must somehow align or correspond with gender definitions based solely on visible anatomical genitalia. Notwithstanding an acknowledgement that embodiment should not be solely mediated through discursive practices and his repudiation of entrenched, cis-normative practices of gendered fixity he also betrays a tendency, albeit disavowed, to collude with, inherently biased, bifurcated and categorical modes of hegemonic thinking in contemplating trans-identities and trans-bodies. Shipman and Martin (2017) also foreground how the dominant discourses of a two-gender binary system can be inadvertently upheld in the therapy room by exerting pressure on therapists and patients to choose normative modes of gender expression/identity.

4.7.3 The Dissociated Body

Simon recalls a trans-female client who, during a session, was discussing an intimate sexual experience with her trans-female partner:

> *And being a very important, very intimate encounter, what I was aware of is that … she was not saying to me that it was a difficult, awkward encounter in some way, but by her not mentioning her penis and by her not mentioning her erection or not erection or her arousal in that regard - it felt like there was an entire part of her body that was missing from it and I also couldn't then access the part that she was talking about. So she's telling me, on the one hand, what an intimate and wonderful*

> *experience this was and on the other hand, there was this disjunct. It was an inability to connect to the feeling of it, which I think was interesting to me; that stood out to me. I remember thinking afterwards 'I don't really know what to do with this' because I hadn't, she hadn't and I hadn't necessarily spoken about the elephant in the room, which is that, likely, her and her partner both had erections, I'm assuming. I don't know. You know, it's an assumption, but we never spoke about it.*

The therapist acknowledges challenges, even in the crucial period of 'afterwardsness' or après-coup, to interpret or construct meaning about this particular experience, suggesting that dissociative defenses function in both the patient and the therapist to keep disturbing content and affect from consciousness. The therapist, in the aftermath is able to name the unnamed in the session, however it is not clear whether this was taken back to the patient at a later point in the therapeutic process. It is possible that a parallel process occurred within the therapist, where he unconsciously captures the trans-experience of identifying with a mind of one gender whilst powerfully dissociating, in a complementary manner, from a body of the negated gender (Withers, 2015).

Simon elaborates further on this experience in the following extract:

> *And I wonder, thinking back on it, whether or not there was some shame or guilt in me around having an appendage or whether there was a projection of her own, her own shame about it or discomfort with it; because she has described to me in previous times how difficult it is for her when she gets an erection. She always used to describe it as a disjunct between her mind and her body [..] She would have moments where she would get an erection involuntarily as happens in a biologically male-gendered or male body. But the problem is that her mind would never allow her to experience any joy [..].*
>
> *So the body could be aroused but [..] she just couldn't find the joy in it. So I wonder if, in that talking about her sexual experience, I wondered afterwards whether or not it was somehow that my sexual experience was going to be in some way threatening as if either I'd taken on something of her experience, like it was a transference in some way or it was a projective identification on my part around like 'this is something that is not okay. It has to be felt as awkward and strange' or whether or not I was afraid of going there because I was afraid, perhaps of, ruining her good experience with this unwanted penis.*

One could also propose that a process of dissociation may have evolved as a result of the patient's impaired capacity to fully or partially integrate adverse experiences which, in certain contexts, can support adaptation. Such implied adaptive limitations may have set in train a dissociative act of separating; this state or mode of being separated is regarded

in psychology and psychiatry as a detachment of the mind from the emotional state or from the body and is rooted in the Cartesian notion of the mind and body split. Additionally, past traumatic experiences can often be identified by the loss of a train of association, thus signaling to a disjunction of the inner logic of the psyche (Gordon, 2013, Gozlan, 2022). Quinodoz (2002) also introduced the concept of 'heterogeneity' and specifically denoted heterogeneous patients, individuals who perceive themselves as fragmented, and who fear a disjunct whereupon an "inner contradiction might lead to the loss of their sense of internal cohesion" (Quinodoz 2002, p. 784).

In the abovementioned scenario the notion of a *dissociative bond* between therapist and patient may also be manifesting. Such a bond, elusive in nature and confined to unspoken terms, holds at its core an understanding and shared detachment from the self, a psychic void or absence (Gordon, 2013). It has been proposed that such a bond of dissociation creates a potential or transitional space that may not lead to full integration of dissociated knowledge yet bestows a transformative, 'coming-into-being', healing space for the purposes of gradual creativity and self-discovery. This mutually co-constructed bond, a psychic trap of unspoken understanding, seems to be grounded on a delicate balance between protective dissociation and a conflictual need to recognize yet maintain distance from the putative trauma (Gordon, 2013).

The psyche of both parties in the dyad was likely 'seduced into the mind' as conceptualized by Winnicott in instances where the infant is too immature to deal with a trauma or environmental deficiency. Notwithstanding the psychoanalytic interpretation, it was imperative for Simon to regain a sense of balance and a capacity to discern what was transpiring and been potentially co-created in the clinical setting. After all the field of the treatment itself can embody, incarnate, and vivify these non-represented and unformulated total situations. The patient's silence indeed may be functioning as an expression of despair and a desire to share the hurt in the unconscious, without having to translate it into the conscious realm of words and thoughts, so enactive witnessing of warded-off, dissociated self-states is advocated over impinging interpretations (Gordon, 2013; Grossmark, 2018).

However, the original feelings which have aroused dissociation must be confronted if the mind is to recover original psychosomatic integrity with that body. Thus, gaining a foothold, by deferring to an appropriate theoretical understanding, would lend itself to facilitating a recovery process which evokes healing and permits the emergence of a creative testifying self. In such a process dissociated knowledge can be *judiciously* and

imperceptibly reintroduced into awareness, and split-off parts of the psyche can be opportunely summoned to appear.

With respect to the prior example Saketopoulou (2014) asserts that both therapist and patient must come into contact with the psychic pain that is unique to trans-embodiment, without finding oneself experiencing psychic annihilation in the process. She explains that by exploring gendered boundaries, in graduated, manageable doses, Simon can assist the patient to bear the pain by registering, appreciating and eventually mentalizing by exploring gendered boundaries the fact that gendered boundaries are the site of psychic near-catastrophe for the latter.

4.7.4 The Scrutinised Body

Several therapists described instances of feeling intrusively scrutinised by certain patients and in certain contexts experiencing an air of either idealization or denigration from their patients towards them which arouses a sense of discomposure in the therapist. Simon remarked:

> *I think that's why sometimes my body itself, just my body, just the fact that I sit in the room and I have a male or a masculine body or whatever, however somebody might label it or perceive it, makes me feel like I can't always necessarily relax fully into myself, because what if my body is threatening?*

Therapists also reported a distinct sense of some patients being envious or rigidly preoccupied with the aesthetic of the therapist, - almost evincing a desire to join or merge in oneness with the therapist or, conversely, to devalue them. In the next excerpt Linda describes her uncomfortable experiences of feeling somewhat colonized when working with a gender non-binary patient, assigned female at birth, who has eschewed her femininity and her natal body and is ostensibly struggling to tolerate difference with Linda:

> *Their association around being very feminine is something about the material, the superficial, self-obsessed, preoccupied with appearance, [and] vanity. And so I noticed over time that when I am…. when I'm dressed in a way that they would identify as more feminine or [..] more dressed up or smart, or maybe I'm wearing more accessories, or potentially if I were to be seen to have put more effort in I become aligned*

with that stereotype, which is very far removed from what they are comfortable with, and [..] what they disavow. Then they would be more likely to ….would be more difficult to feel that there's a good sense of rapport, joining, in that session because I become too far from what they can understand for them to imagine that we could have a shared experience - if I come in and I'm wearing cool sneakers and jeans, and I look a little bit more casual [then] *they seem to relax into it. There might even be an identification where they could even imagine wearing what I'm wearing and then I'm suddenly more relatable. I don't need to be attacked.*

Linda proceeds to discuss another experience of working with a trans-female client where a distinct desire by the client for a form of mutuality or symmetry with the therapist is discerned:

Her body is very different to mine, but. I almost wonder if she doesn't try to mimic some of the ways that I represent myself; [..] It might link to some of what we spoke about earlier, about coveting something, but almost like, 'you're a female. This is maybe how I could be a female'. And almost in some ways mimic that or checks that out. But I'm aware of how I dress when I see this person [..] And this individual will seemingly take note of me more if I'm dressed in a way that's more aligned with the way they were dressed [and] I think responds to me differently.

Ralph also contributed the following remark:

So I've definitely seen, for example, with my trans-masculine clients, my beard often being something that …. So, if I change; either, they will comment on my beard … and on the surface, they will say something like 'I really like your beard. I like the way it looks and I'm hoping that with testosterone that my beard growth would …..'. But in the session, feeling that this is more than just complimenting my beard and saying that that's a beard that they would want, that they're definitely sensing that my beard somehow was symbolically representing some kind of ideal towards masculinity.

I do remember there were times when I just shaved it off or trimmed it really low, and clients would comment on that. And there would be almost this kind of meta communication of [..] almost like I was, I was reducing my masculinity in some way …. enough for them to note it and want to comment on it. And the undercurrent is like, 'I don't even have the choice yet to do that and you can shave it, you can have it, [..] And it's almost like

you're in this privileged place having your masculinity; I don't yet'. So, that, [..] I've seen come through with trans-clients.

Lemma (2020) would argue that, in such instances, the embodied self of the client can be experienced and coveted through sensual apprehensions of the therapist's physicality, and that this constitutes both a vital link to and identification with aspects of the analyst's body. In the same way that the development of the child's capacity to mentalize and reflect is indicative of the child's development and acquisition of a mind separate from the mind of the other, and given that mentalization occurs in the body as well as the mind, one could also argue that a bodily process of differentiation may not have been achieved by the patient. The above-mentioned therapists' experiences may signal a formative inability by the child to securely elaborate on their own bodily subjectivity and initiative which is belatedly, and with varying degrees of conflict, being negotiated with the therapist. In a parallel process the therapist, in the manner of the child who onerously incorporated an invasive object, is likely feeling unstable, depleted or stripped of personal meaning and haunted by unidentifiable, foreign bodily perceptions to the same extent that the child once was colonized (Silverman, 2015).

Whilst Linda alludes specifically to a mimetic tendency by the patient and an experience of being 'done to', this quest for symmetry by the client may also be understood as the latter's desire to achieve sameness as a means of offsetting original destabilizing feelings of difference and disjunction with an unequal other. This position of Thirdness, as promoted by Benjamin (2021), purposefully negotiates difference and is conducive to cultivating a distinct and separate I-Thou relationship. This position can be achieved when the therapist can allow themselves to be vulnerable to the other's impact and through holding the tension of recognition between difference and sameness, taking the other to be a separate but equivalent center of initiative and consciousness with whom feelings and intentions can be shared - a 'doing with' the other as opposed to feeling 'done to' by the other (Benjamin, 2021). The abovementioned relational dynamics may also be understood as the appearance of 'identificatory love' in the transference, a term coined by Benjamin (2013) to describe a homoerotic desire or longing by the patient for recognition and a love of what is seen as or wished to be ''like''; this forms the sense of oneself as a subject of desire. Benjamin (2013) argues that being recognized in one's loving desire to be like the other is as crucial as being safely attached to the source of goodness and that missing the homoerotic identificatory needs in the transference can be crippling and withering. Such scenarios also correspond with Coren's (2015) suggestion that a space needs to emerge in which to recognize and appreciate the otherness in one's

self and the otherness in another so that the analytic dyad can learn to tolerate the tension that arises when trying to honor the other's subjectivity.

In this following passage Justin recalls a feeling of being held captive by his trans-patient:

> *I think that there was something about the body and that it felt very important for this client, that we both needed to be quite normative or that we almost needed to sanitize or - there's probably a better word than that - but kind of erase our bodies - our bodies weren't about queerness but needed to be normative. And I think particularly for her body, it needs to be super normative because that's going to be the way that she would be accepted one day in a relationship and have a family, and almost me becoming an extension of that. I think, me changing my body, I think then that that obviously pushed up against that.*

Such perceptions align with the position of Lemma (2020) who concluded that patients, who may have experienced a deficit - in the form of an early under-cathexis of the body self - will attempt to form an "aesthetic link" with the analyst. The author posited that the analysand, in apprehending by the senses (aesthetic) a feature of the analyst's physicality, will use it to establish a connection (link) with a wished-for, yet heretofore unrealized, embodied self, a body-of-hope. Lemma conceives of the therapist, who inhabits the role of aesthetic object, as embodied emotional scaffolding toward an anticipated or wished for experience of the self; this is rooted in a body that is perceived as alive or libidinally cathected and which can be both desired and desirous and presents an opportunity to establish aesthetic reciprocity. Equally patients can denigrate the aesthetic link when an aesthetic conflict or an unpalatable asymmetry is experienced.

It is possible that the trans-female patient, in the preceding excerpt, established a narcissistic identification or developmentally necessary idealization with the body of the therapist, one which was not experienced in the context of the primary homosexual relationship with the mother. Lemma (2020) would argue that, in the abovementioned extract, the patient needed the therapist to be a body double that can resonate with the patient's embodied experience, and eventually reflect it back and, in the process, name it for the patient. This notion of an aesthetic link corresponds with Bollas' notion of a transformational object (Bollas, 1979) which Justin alluded to in the following excerpt:

> *From a client's perspective, initially, I think that often there's a lot of curiosity around my body. I suppose that I often assume that my sexual*

orientation or gender identity is quite obvious, which is actually not the case. I think I have sometimes been seen as trans and sometimes I've been seen as gay, sometimes I'm seen as straight. So I think sometimes that is quite interesting what the client could put on to me.

In this extract Justin considers the impact of the idiosyncrasies of his embodiment on the patient and how the latter may relate to the analyst's embodiment and invest the therapist's body with personal meanings; this corresponds with Merleau-Ponty's formulation of the body as both "an object for others and a subject for myself," (Saketopoulou, 2014, p. 828). Lemma (2020) would further claim that physical markers of the therapist's "otherness", through appearance, can be used by patients temporarily in order to play with a different version of themselves in a body that has been libidinally cathected to that of the therapist. In the three previous examples it is the therapists' calm receptiveness to the patients' bodies, along with a tolerance of the latter's curiosity towards the therapists' bodies, which created the opportunity for a qualitatively different experience of aesthetic sharing for both patients. These implicit interventions, despite placing a focus on the analyst's own body cathexis, did not lead to collusion or enactments. It is important to acknowledge that in the therapists' accounts the notion of the aesthetic link did not extend to the physical space of the consulting room as propounded by Lemma (2020).

4.7.5 The Neglected Body

Several therapists drew attention to the fact that the body does not receive the attention that it should be afforded in sessions. In the next extract Simon states that he tends to foreground the mind over the body and he indicates, somewhat obliquely, that a strict dualistic opposition of body and mind not only compromises the continuity and unity of the subject but also the insights acquired in relation to the body:

But I'd say that, for the most part, it's probably more a background process, not something I consciously think to look out for as much as I would, for instance, think to look out for words that are about their relationships or words that are about their emotions. I don't think I consciously hold in mind as much thinking about, right, how is the patient physically looking? But I do think that there is so much communication that does happen through the body; like that I can definitely say. Trans-patients or cis-gendered patients, actually, there's always something about

> *the body that's telling you something. I do believe that; it's just I don't think I always remember to hold it in mind as much as I should.*

From an epistemological point of view, it may be more beneficial to adopt an alternative way of thinking that surpasses strict dualisms and affords greater consideration to the body rather than valorizing or overestimating cerebral intelligence. Is there a likelihood that the issue of "excitement," as in the notion of excitation and the body's inherent excitability contributes to failures in self-regulation and the therapist's need to split off and dissociate the body from awareness? This idea may also pertain to Lacan's concept of 'jouissance' if one were to consider the body as being imbued with a certain mix of pain and pleasure.

Ruby stated that more training is required with respect to the body in the clinical setting:

> *I'm very aware that sometimes I feel like I'm from, you know, my chin up. That is what's present in the room and that's what's acknowledged and that's what's engaged. But I definitely think it would be really useful to have more training, for therapists to be able to engage and be present to the experiences of the body and the visceral and somatic responses that occur in the work.*

Justin agreed that therapists may not possess a relevant competence in dealing with the body in treatment:

> *I realize, with a lot of colleagues* [being in agreement], *that, often as therapists, we do lack focus on the body and I think there's a lot of work pushing for that. So I think there's probably a general sense around what does it mean to get the body into the room and to use our bodies and use our clients bodies.*

Justin did not stipulate that training be geared towards the transgendered body. According to Hansbury and Saketopoulou (2022) analysts are especially anxious about the trans-body and posit that it is because the body is perceived as holding the final verdict on gender.

Ralph asserts a conviction that it is his role as therapist to confront the body and to initiate a process of exploration over the course of treatment and he imputed patients' resistance to doing so to shameful feelings.

> *I think it's my role to do that because [..] so much stuff of our bodies and sexuality is shrouded in shame. And so [..] sometimes I think I'm the advocate for my clients' bodies and sexualities and genitals - that I'm*

often the person, that the first time …. the voice, that gives them permission – 'you need to talk about this. We can talk about this. It is good to talk about this. It is necessary to talk about this' - and when they hear that, it often leads into good …

The abovementioned passages which particularly allude to therapists feeling an inchoate sense of being coerced or scrutinized, may speak to one of Ringstrom's (2003) ideas with regards to enactments in the treatment setting. Whilst acknowledging that enactments may appear to bear verisimilitude to contemporary relational theories about projective identification, he claims that enactments go one step further. He argues that the point of the patient unconsciously coercing the analyst into identifying with some aspect of the patient is more about *flushing out* something about the analyst's authentic identity than about understanding split-off, disavowed aspects of the patient per se. Ringstrom (2003) posits that it is only in this manner that the analyst is ultimately found not to be a repetition of the historically dreaded other but can evince that they are a new presence, with new ideas heretofore unimaginable to either party (Ringstrom, 2003). It is likely that many gender-variant patients have experienced situations of noninvolvement or negation of their bodies and minds with a caregiver who could not tolerate situations involving too much affectivity situations. Ringstrom (2003) hypothesizes, that a patient's call for involvement with the therapist, whether relating through the mind or soma, is an actual plea. Such pleas can be extraordinarily challenging for therapists since they embody contradictory elements and are frequently embedded in a complex process that obfuscates or wards off that desired connection which may have been previously denied or prohibited.

4.8 Experiences of Treating Gender Nonconforming Children and Adolescents

New medical advancements and options for transitioning, in addition to an increasing array of gender representations, have contributed to breaking down barriers and opening up liberating possibilities for today's gender diverse youth and these have gained widespread backing. Conversely, there is a profoundly palpable anxiety which continues to impact therapists and to pervade contentious debates; this is manifested through recurrent, baffling metaphors of mutilation, amputation, contagion, disrupted development, rupture of time, and lost childhood, among others (Evzonas, 2022).

Accordingly, many therapists acknowledged heightened and accentuated levels of concern when working with a rather vocal and clamorous youth demographic, who increasingly demand recognition, as they embark on a process of medical and surgical transitioning.

Andrew Solomon, author of 'Far from the Tree', queried whether the transgender phenomenon is either an immutable imperative or a transient neurosis for gender nonconforming youth; many therapists hold that the benefit of time is fundamental in order to determine an answer to Solomon's far-reaching abstraction. Therapists' concerns were variously ascribed to issues surrounding ethical protocols, the irreversible nature of specific procedures and the element of social contagion. For some of the therapists interviewed, the onerous challenges faced when treating this particular population inexorably push against more traditional theories of gender, challenge conservative understandings of sexual identity and essentially amount to Hobson's choice.

Rapidly evolving social and cultural change can have an unbinding effect upon the intrapsychic domain, which can impact therapists as well as the youth demographic, especially with the intersectional interweaving of gender and age. This section examines the problems and psychoanalytic dilemmas inherent in the treatment of gender-diverse children and teenagers that emerged as a theme in the data, and elucidates the quandaries which therapists inevitably face in the midst of an activist milieu. This section also underscores the hotbed of associated anxieties in the field and the concurrent impact of the family system's involvement in the therapeutic process. Although the perspectives of some therapists do vary, for the most part, the experiences of therapists are consistent and aligned.

On a more positive note, Ruby articulated her subjective feelings of admiration for adolescents who have recourse to a richer array of gender identities for the purposes of constructing and crafting more authentic gender and sexual subjectivities. She also acknowledged feelings of envy in the mix:

> *Yeah, I think particularly with the teenagers, I found myself feeling envious of the freedom that they have. Thinking about growing up in the eighties in South Africa and how incredibly repressed and oppressed we were. [..] I had my own kind of emerging as a gay woman, which felt abhorrent and it was a crime, it was still illegal. And I suppose what sometimes is evoked for me is a sense of, Oh God, this is incredible; listen to how you can speak about this with one another. Look how open you are.*

> *Look how amazing and relatively easy this is, to address some of these things. Obviously not completely easy, but it was inconceivable for me as a teenager.*
>
> *And I suppose there's a part of me that thinks, Oh, it's incredible. You know that you are so self-aware, that you have this confidence, that you can kind of speak your truth [..] It's not pride because that feels a bit patronizing. It's very satisfying. [..] I'm so impressed at a lot of these young people at how self-aware they are, how awake they are, how connected they are to themselves.*

Rabain (2021) posits that therapists tend to be either fascinated or frightened by transness. In this excerpt the therapist discloses her comparative struggles, in the past, to craft a viable subjective reality and to experience a developmental pathway, which included freedom of gender expression, in a sociocultural era where nondiscrimination policies against homosexuality had not yet been adopted. She acknowledged her envious feelings that young people are free to explore the fluid and ambiguous aspects of their gender identity, independent of constraints, inhibitions and policing of their gender experience. She contrasted her gendered experience which appeared to preclude openness, curiosity, and exploration.

The therapist, Ruby, elaborated further:

> *But there's also something that I observe, which is particularly with teenagers because I work predominantly with teenagers. But this awareness and connection to themselves and their identity as it emerges and their bodies and their relationship to their bodies, there's a sophistication which was completely absent at that age … when I was their age. So I think there is something quite evocative for me. You know, the fact that they have organizations, alliances at school, that these are discussed, teachers are called out or people are called out and kids are wearing badges [..] it's something that is recognized and to varying degrees accepted.*

On the basis of the therapist's personal account her psychic reality during childhood appears to have been less privileged than the current generation; as such, her account may reflect myriad facets of the therapist's internal world and may inform a distinct organization of the unfolding transference-countertransference dialogue with her patients. From a psychoanalytic perspective, it would be important for a therapist, when treating this particular population, to explore in supervision, any emergent identifications especially in relation to gender identity and gender ideals. It is also noteworthy that

psychoanalytic literature has posited that analysts can frequently harbour a fantasy that the trans-patient "gets to have it all, that trans individuals are trying to inhabit both genders, and that their very trans-ness marks their unwillingness to relinquish and/or inability to mourn" (Hansbury & Saketopoulou, 2022, p. 232). As noted in prior sections a sense of discombobulation or even transphilic biases can emerge in cis-analysts or trans-analysts when engaging with the polymorphous nature of a patient's fluid sexuality and gender.

Several therapists explained how family system dynamics and porous boundary issues can adversely impede the process of therapy. Mary remarked in an ambiguous manner:

> *I don't work with children under 18. I find it very difficult to work with parents through their child* [therapist laughs]. *It's absolutely triggering because, as a mental health care provider, I also believe that our role is to advocate for our clients, where necessary.*

The therapist supported the establishment of a more hermetic boundary between parents and their children's privacy. The following therapist, Ruby, also explained the challenges to the therapeutic process when the family exists on the periphery of the analytic space with outsized and unrealistic expectations of the therapist:

> *A lot of the clients that I've worked with, who identify as trans or gender divergent, have been teenagers, [..] 80%, 85%, and I guess [..] it comes with immense tension. It's hugely controversial. [..] I have some parents who are absolutely resistant* – [and who] *use their power to yank their child out of therapy because they don't get a sense that you are going to do…. I don't know… conversion therapy. I don't know what the phantasy is, that they don't …. they're not comfortable with what they perceive as you supporting or enabling their* [child's] *transition. So I have found it to be incredibly difficult.*

A third therapist, Ralph, also discussed how injunctions or protests by the family, whether muted or more vociferous, can stymy therapeutic progress and give rise to a distinct form of anxiety:

> *I think with issues around gender identity and a wish to transition, and a wish to have hormone therapy endorsed or surgery endorsed, there's a lot more involvement of parents and understandably so. They're very anxious that what they perceive as their teen child ….* [that] *their teenager is being quite impulsive or is being influenced by peers. So I find that there's a lot more, in some cases, a lot more involvement, by the parents and*

> *sometimes a bit of treading on the space, on the psychotherapy space that, usually* [typically and under normal circumstances], *feels quite safeguarded, quite boundaried.*

Rabain (2021) asserts that parents, especially from enmeshed or incestuous family systems, are likely to "over-cathect" the pubescent body of their child, which they consider is not being cathected enough by the latter. The parent's tendency to engage in a compensatory process of talking extensively about the bodies that their children persist in hiding may explain parents' fixations with the therapist and the coinciding therapeutic process. Such efforts may be understood as a form of overcompensating for the child's rejection of their genitals by displacing onto the beleaguered therapists. It is important to also consider the complex interplay of intergenerational envies, rivalries and projections that unfold in families and intergenerational constellations after a child transitions (Harris, 2022).

The author also refers to Lacan's concept of "the subject supposed to know" which may explain why parents, oftentimes anxious and desperate, seek out and cathect therapists as benevolent and competent parental imagos; they may endow these therapists with unrealistic expectations and co-opt them, out of necessity, to do their bidding. Several of the therapists admitted to an accrued sense of felt pressure which specifically results from parents' exhortations to therapists to either essentialize their offspring's gender or to facilitate a preemptive stalling of irreversible surgical interventions which can irredeemably harm their child (Rabain, 2021).

Ideally, the burden on therapists could be eased through the pioneering of multifamily groups, as advocated by Rabain (2021). Such groups would enable parents, in a mono-generational setting exclusive to parents, to privately discuss and abreact their anxious feelings surrounding their child's emerging puberty. Intergenerational gatherings of parents and adolescents would also allow for the interplay of identifications and counter-identifications among binary and non-binary participants from multiple families and would permit participants to redirect the libido to substitute objects of cathexis (Rabain, 2021).

Mary countered the claim that maladaptive dynamics within a family system is centrally at the root of gender dissonance and a youth's desire to transition gender:

> *But having said that, I've also had individuals where they, their families have just been - I almost want to say Brady Bunch perfect. It's the kind of stuff you see on TV, and I almost find myself going, 'Oh, I'm missing something, it's going to be this perfect? Nobody has this perfect of a childhood'.*

Each of the abovementioned therapists alluded to regulatory anxiety in their own countertransference although they did not explicitly elaborate upon how the extended family culture contaminates the therapeutic process. When there exists a disturbed family system the therapist has to contend with further layers of complexity; for example, in instances where the intolerance and pathologizing of homosexuality within a family system results in an inexorable press towards transitioning medically/surgically (Harris, 2022).

Several therapists, supporting the views of writers, such as David Bell (2020) and Lisa Littman (2018), discussed the viral nature of social contagion within the activist community by referring to this latter-day cultural phenomenon of sudden or rapid onset gender dysphoria (ROGD); this phenomenon concerns children who had hitherto given no indication of significant gender dissatisfaction and abruptly come to a decision to shift gender identifications to cross-gendered manifestations. The following therapist, Mary, argues that the proliferation of online content on the internet and social media exerts a tremendous pressure on clinicians and patients alike, and is a major determining force in youths' desire to undergo cross- gender transition. She claims that the modern technosphere occupies a causal position for the explosion in numbers of natal boys and girls wishing to undergo medical/surgical transition. Mary adumbrates her experiences in the state and private practice setting:

> *Sometimes what we find happening, if you work in psychiatric units - so it's kind of a known thing. [..] When people come into spaces like that, they're vulnerable. They've been through trauma. They're not in the best of spaces [..] sometimes there's a lot of pathology or diagnoses or whatever that comes with it. [..] because sometimes you almost have a little bit of a spread - of a thing that happens where one person comes in with something and then, before you know it, everybody now has that - where it's almost like - it's a little bit of a contagious thing that happens in that closed system of a [..] psychiatric unit or a clinic setting.*

She elaborates upon the role of the activist milieu in propagating this collective and ill-conceived desire amongst young South Africans to transition gender:

> *This local community of trans and gender* [diverse] *individuals - and you just see as they come through my door, I'm hearing the same things being mentioned [..] and I don't seem to see that as much with individuals who are on their own trajectory and who are not that connected with that community. There is something that seems to happen [..] a cross-contagion [..] You start to hear very similar stories and then it's kind of tough for me as a psychologist then … to really sometimes sift through what is the actual presentation for this person and what is stuff that is, somehow almost by word of mouth.*

Mary backs up prior claims made by Bell (2020) who suggested, somewhat audaciously, that some children are being coerced or indoctrinated by persuasive peers or parents for the purposes of producing plausible, but inauthentic, narratives which will undoubtedly secure a referral for medical treatment.

Mary outlines a similarly 'unhealthy dynamic' within the trans-activist community and a growing trend towards gender pluralism, fueled by sociocultural issues which adversely problematize the gendering process:

> *Look, I think it's an extra issue that we have with the younger generations [..] I used to work with children and with teenagers, [However] I [..] now catch them 18 years and older. I still see that, with the younger generations, [..] coupled with really loving a label. I get the sense that it's almost 'we've got to be able to label ourselves, [..] 'I want to know what my label is', [..] it was one of the reasons why I actually stopped working with teenagers because [..] it was so difficult to work with this thing where you are constantly up against the social media technology, the onslaught of information [..]*

This may be an example of culture entering the clinic wherein a noxious social discourse manifests and is "performed" in the room (Straker, 2006). Mary feels overpowered by aversive affects and indirectly alludes to an inner tension or split around, either, colluding and joining with the patient, and/or submitting to patients and disrupting the therapeutic process. Mary continues:

> *It is that stage of identity formation and finding yourself and all of that. So in some sense, it's developmentally appropriate, but it's been heightened so much by this access to social media, internet information. There's a*

> *drive for a label [..] I think sometimes you almost feel like somebody is disappointed and they really don't like what you're telling them [..] It's almost like 'you don't know what you're talking about' - it really goes into that space of 'how dare you define my identity or define who I am because I know this is who I am'.*

This speaks to Pontalis's (1998) notion that we are at the mercy of a radical unconscious that both resists control by consciousness and exceeds it. For both therapist and patient, what has come from outside is now experienced as within, and is being performed within the analytic space (Straker, 2006). Altman (2000) enjoins therapists to move from a two-person to a three-person psychology by considering contextual factors such as race, class and gender to be a third person in the room. It is important to be aware of its performativity in the room which can open up possibilities for transformation. Straker (2006) would argue that recognition is occluded when two individuals who have been inserted into a shared noxious discourse "come to embody its consequences in an unconscious destructive enactment" (Straker, 2006, p. 744). Mary concludes her thoughts:

> *And there's something for me of - I want to voice this bit carefully, because [..] it's something that's been mulling in my head but I don't want it to come across in a bad way - [..] Sometimes it seems to be that they can be a little bit of a [..] and I almost want to say unhealthy dynamic, sometimes that can happen in the community, and I say that so carefully.*

In the above excerpt Mary has conveyed how overwhelming it can be for therapists considering the rigidity and vehemence of the advocacy onslaught. In these circumstances the impact upon the therapist's capacity to mentalize becomes problematic and reflects the disorganizing presence of a noxious social discourse. This is encapsulated in the notion of the anti-analytic third (Straker, 2006).

While Saketopoulou (2022) widely embraces how trans-youth are seeking to disorder the world by bringing new gender possibilities into being and, in the process, unseating the very principles by which the body and gender are lived, other therapists held an opposing perspective and were more split and mistrustful over the capacity of a minoritized subject to discern between need and wish (Bell, 2020, p. 1034).

According to Gozlan (2022) many adults, including therapists who are putatively acting *in loco parentis*, struggle to consider pre-pubescent and pubescent children as complex beings who, like adults, are fallible and capable of making bad decisions which may cross

the Rubicon. The therapist's preoccupation with the possible ruptures which transitioning can engender, with respect to developmental continuity, appear to be compounded by anxieties and concerns over a minor's capacity to ratiocinate and project into their own future, as a means of evaluating or predetermining irrevocable disruptions to development and the possibility of regret. Conversely, the risk inherent, in a therapist's unconscious desire to orient concretely towards achieving a completely satisfactory outcome for this young and vulnerable demographic, is to sustain a rigidly dogmatic viewpoint on what is occurring with the transitioning patient and to forfeit an attitude of open inquiry receptive curiosity (Saketopoulou, 2022).

There are a host of counter-arguments which complexify this conundrum for therapists; some proffer and endorse alternate options, more alterable or modifiable solutions, such as a protracted social gender transition as well as aligning with wait-and-see ideologies (Edwards-Leeper & Leibowitz, 2016). These alternatives can eliminate more drastic interventions or, at least, retard the decision-making lead time in order that more adaptive ways can emerge in which minors can express their gender ambiguity. Bell (2020) claims that there is empirical evidence which demonstrates that a substantial percentage of children will desist, rather than persist, in their same gender identification, and may even gradually emerge as gay or lesbian, if an intervention is not otherwise offered; he bolsters his argument by arguing that the hastening of medical and surgical interventions amounts to conversion therapy, originally designated as a homophobic intervention and justly impugned. However, Gozlan (2021) contests an approach which reduces or obviates this complex dilemma of transition, by arguing that what is tragically foreclosed is the subject's personhood and/or the various idiosyncratic, creative solutions which can be imagined and animated by one's gender. Considering the dearth of rigorous, longitudinal research it is understandable that therapists struggle to hold such tension.

Ruby drew attention to the fact that despite teenagers having access to communities of like-minded people there are many who confine themselves to socializing online and cultivating relationships with people from far-flung destinations.

> *It's difficult sometimes to deal with … when there's younger clients, or clients who are being cared for by their parents … those dynamics, I think, are more difficult for me to deal with than with cis-clients [..] They're very knowledgeable about different gender identities, dysphoria, people's*

different experiences of dysphoria, pronoun use [..] because they find a lot of support online.

These clients also talk of their very best friends, living in far-away places, because these are the people that they have most contact with [..] they do come with a lot of social knowledge.

Ruby also asserted, in the following extract, that atypically gendered youth are predisposed towards tendentious claims over verifiable facts. Their finding is that patients are malleable and impressionable and may not, in actuality, identify as cross-gender despite an overt and inflexible gender presentation that claims otherwise:

We can't then divorce this thing [..] from the times in which the current generations are growing up - millennials, Gen X, all of these ones where technology access to information - and I put that in inverted commas - because information and facts aren't necessarily the same thing [..]half of it is fake news, half of it is not fact checked, half of it is Wikipedia [..] One would stumble upon something online and people would start googling it. [..] they're coming in with 'Oh, this is what I've experienced. This is what I've googled. This is what I found. I relate to that. I have figured out'. [It's] almost as if they come in with their diagnosis [..] 'I have found what is wrong with me. This is what's wrong with me [..] And I think that's how I started to pick up some things happening … that it's either contagious between members of the community or it's because, like I say, that they also have the access, obviously to the internet.

Clinicians such as Saketopoulou (2011, 2014, 2014a, 2020, 2020a, 2022) would posit that the therapists in question are preserving a prescriptive or normative gender order by employing restrictively normative conceptions of sexual and gendered life. Hansbury (2017) and Barkai (2017) might argue that the abovementioned therapists are adopting a non-neutral stance where the desired goal is same-gendered identification with appropriate gender-role behaviour

As previously discussed there can be a tremendous pressure within health institutions to close down any discussions which seek to identify predisposing or precipitating factors in lieu of a stance which unquestioningly accepts and endorses the child's perspective or demand for 'closure' (frequently supported by the family). According to one of the therapists it can take considerable sensitivity, tact and skill to manage children and families in such a manner so that thinking spaces can be opened up. One therapist lamented the fact that there can be such a marked reluctance to maintain an enquiring

stance in relation to gender re-assignment and alluded to a prohibitive climate which valorizes 'an affirmative agenda', itself a cause of serious damage according to some. Edwards-Leeber and Leibowitz (2016) refer to a framework known as 'Affirmative care with transgender and gender nonconforming (TGNC) children and adolescents' under which many mental health clinicians practice. Authors such as Bell argue that physicians would not affirm the views of an anorexic child who maintains that their dangerously low body weight is normal.

Ruby expressed a distinct sense of ambivalence about the current trend:

> *I think there's a lot that all of us professionals still need to understand and figure out in terms of, particularly, this incredible wave that we're seeing. It's almost like there's something in the zeitgeist. You know, there's so many things that we're trying to make sense of that are culminating in a massive increase in referrals of young people who are identifying as trans. So I think it's very exciting, at times incredibly nerve wracking, complex.*

Bell (2020) states that it is not the role or duty of a physician or psychologist to champion one solution over another but rather maintain a position of interest, curiosity or doubt. Yet he insists that one needs to be persuaded, before embarking on a course that will irreversibly damage the body of a prepubescent or pubescent youth, considering the under-developed capacity of an overwhelmed minor to remain thoughtful and self-aware in the process. He opines that reneging on such a stance is inherently damaging and essentially undermines reality-testing for both the youth and their family. One of the therapists echoed the stance of the psychoanalyst Tom Main who sagely remarked that the job of the psychiatrist is often to "not just do something but stand there".

> *As far as Diane Ehrensaft's whole thing about the gender child* [The Gender Creative Child – by Diane Ehrensaft]- *is that as therapists, in line with the Winncottian model. I think in order to do the holding, you don't actually necessarily need to be the expert. You don't necessarily need to know what's happening or where the person is going, but it is creating a safe environment for them to be able to explore and for their true self to emerge and their true gendered self to emerge.*

Some therapists claimed, paradoxically, that teenagers, armed with an indisputable air of confidence yet malleable by their peers, tend to exhibit a recalcitrant attitude in therapy and demonstrate a resistance to sufficiently engaging in the therapeutic process. In this excerpt Ruby discusses similar clients:

No, just impatience, like 'why do you want to go there? I don't know who that kid is' or they speak a bit disparagingly, unlovingly about that, that former self, their previous self. I don't experience hostility, but a sense of like, 'what's the point, that isn't truly .... that's not the real me. So why are we spending time thinking about that' [..] I find that with teenagers ... with other clients, there's more of a capacity, older clients, adults, a capacity to see the bigger picture and to look across and to appraise all the different developmental phases rather than there being a split.

[..] but almost as if the person humoured me a little bit. I don't know if this amounts to a form of resistance, but maybe didn't engage so deeply because it was almost as if they were saying, 'look, this is just something we have to do to get over with, I'm not going to give you more than the minimum'.

Saketopoulou (2022) acknowledges that some patients struggle to use the analytic space offered but counters the prior therapist's claims, asserting that it is the therapist's responsibility to sufficiently engage trans-patients and not the remit of the patient; she also posits that the reason patients defect from therapy or fail to engage with mental health services is due to therapists' fixed belief systems and their clinically dogmatic preoccupation with establishing whether a surgical intervention should be viable or not.

4.9 The Role of Supervision

As discussed in the previous section, therapists cited instances where they struggled to think or to make meaning of the interpersonal dynamic as it was unfolding within the analytic dyad, and in the immediacy of the here-and-now. Considering the paucity of studies pertaining to the complex dynamics of gender subjectivity as well as the intersectional interweaving of gender identity, systems of power and culture it can be argued that the therapist would benefit from the presence of a third mind. It is important to acknowledge how much the transferential situation can be concomitantly influenced by pre-transferential bias and/or theoretical countertransference, which inadvertently compromises the analytic space, namely, the introjection of existing psychopathological, methodological, and technical references (Evzonas, 2021a). This section will explore the crucial role of supervision when working with gender non-binary patients and will reflect upon some therapists' experiences of bringing their physical bodies into their own individual therapeutic space.

It is arguable, on the basis of therapists' accounts, that they, as a collective, are not making optimal use of the space of supervision, which can be indispensable as a mode of recasting or reframing moments of impasse, disentangling relational knots and/or revealing therapist blind-spots. According to Guyomard (2011) "It is always in the aftermath of a prior involvement, conscious or unconscious, to which the countertransference appears as a repercussion" (p. 46). Consequently, supervision can afford the therapist a vital opportunity, in the aftermath, to retrospectively come to grips with that which has transpired within the analytic dyad. Given the intensity of the anxieties evoked by this work, as discussed above, it was surprising that supervision did not feature more regularly in the therapist narratives.

A salient finding, which each therapist gave expression to, was a preponderance of focus and attention, in traditional therapy education and training programmes, to the mind over body. Therapists did not issue the same charges with respect to the field of trans-subjectivities, despite alluding to a dearth of competency when treating this niche client base and implying a distinct need to focus on transgender competency development in order to address these disparities in training.

In the following excerpts some of the therapists discuss the extent to which they make use of the supervision space. In the first extract, Dolores, who does not attend supervision, discloses that she does not document or register her own internal process in her process notes:

> *In my notes, that I document, as I said, this model that I work with …. I only work on the unconscious level. So [..] I'm recording, verbatim, the way they* [the clients] *tell the story, the way they process it and the insight. So [..] I do my own thing separate, but that I don't document.*

Dolores indicated, on numerous occasions, that she is ideologically committed to her own way of working in which she 'heals' herself without making use of supervision spaces. One may posit that Dolores can potentially be susceptible or prone to non-reflective splits which obliterate a capacity for a deeper self-awareness, an awareness which can safeguard against more myopic modes of thinking and interpreting. By Dolores exploring in supervision a counter-therapeutic proclivity to dissociate in the countertransference, especially when in the grip of the drives, a process of working-through in the countertransference can be galvanized, which can ultimately redound to the benefit of both therapist and patient (Hartung & Steinbrecher, 2018).

Evzonas (2021b) highlighted the inseparability between clinical praxis and theory in the countertransference. It can be further argued that therapists are also inseparable from their patients in the therapeutic process and that the penetrated projections of the latter can elusively link up with highly archaic parts of the analyst's inner objects, including archaic somatic elements, which have not, heretofore, been affectively worked through. Despite an avowed desire by a therapist to erase their subjectivity and assume the role of observer rather than participant, the patient and therapist both *have to* approach the unbearable and prepare to be confronted with it. A potential contact between a patient's projective identification and archaic objects within the analyst, and their damaged infantile self, can be liberated in the countertransference. Accordingly, there is a necessity for supervision, as a means of assisting the analyst to disentangle colliding object relations and further explore intricate complexes and various forms of internal resistance. One may conjecture that the abovementioned therapist may profit from supervision.

Most of the therapists did not explicitly discuss supervision despite recalling specific challenges and obstacles in their work with gender non-binary patients. In this extract Jane discussed what support they avail of when working with trans-patients:

> *So it's a mix of supervision and reading, I guess, and then peer-to-peer supervision as well. So talking to other professionals, we are working with similar issues. Yeah, but I think it probably was that mix.*

Similarly, Linda acknowledged the lack of emphasis on the body, for individual therapists and within group work, but noted that strong countertransference was taken to supervision:

> *I don't think it's* [the body] *that present in training [..] In fact, even in the groups, I don't think we often speak about our own experiences of our body at all. Interestingly, I mean, if I feel something strongly in the countertransference, generally with patients, I will take it to supervision. So whether it was felt in the body or in, you know, an emotional response or a thought or whatever it might be, I would take it to supervision like anything else. But it isn't very present.*

The therapists' bodies and somatic reactions were generally fairly unconsidered, as evidenced by the themes discussed above. However, several of the therapists acknowledged that paying more attention to their own bodies may be useful. Justin remarks:

> *I wouldn't keep that level of in-depth notes, but I think if I was presenting a case to colleagues or discussing a case in a reading group or something like that, then I think I probably would note these things. But it'd probably be more of an internal note. I wouldn't actually jot those things down [..] I had a reading group last week, one of my gender groups, and we were talking a lot about this actually - how easy it is to neglect the body and forget about the body.*

Another therapist, Ruby, added:

> *And I think those really important sources of information are an important therapeutic material to engage with [..] So I think it's something I definitely think we should do more. I think it's something we don't do as naturally or I think we, kind of, really need to be pushed, pushed more on doing.*

As mentioned by one of the therapists previously, who stated that she does not keep notes on her countertransference responses, the notion that therapists would not keep notes or write down their own somatic reactions reemerged. While there was a sense that more consideration of these aspects of treatment would be useful, there is a sense that it doesn't come 'as naturally' and therapists would need 'to be pushed'. This wariness is notable and may be attributable to therapists' desire to dissociate from these 'loaded' bodies and neglect that which is the focus of such scrutiny.

It can be suggested that supervision would assist therapists to increase their competencies in working with transgender populations and facilitate the exploration of critical issues for this marginalized and diverse population, living in a systematically oppressive society with rigid norms and expectations.

Therapists variously spoke to the complex domains of intersectionality including power, gender and diversity. Two therapists recalled their experiences as novice therapists and acknowledged periods of feeling overwhelmed and wholly ill-equipped due to a perceived lack of erudition. These therapists expressed an attendant desire to broaden their theoretical knowledge base and to acquire a specialized skillset with which to enhance their technical competencies within the clinical setting. Simon noted:

> *It was a really, really difficult experience for a beginning therapist because again, it was really early on. That* [a patient abruptly identifying as trans and asking for a written endorsement by the therapist for the purposes of medical intervention] *has, forever, I think, made*

> *me wary about somebody who comes to me and says - and I have had people come to me that I've turned away - people that I have subsequently said, 'I'm sorry, this is not something I can do or that I can help you with'.*

In this excerpt Simon also underscores the primacy, for the therapist, of engaging in supervision and personal therapy, as well as advocating for the production of generative knowledge in order to develop more perceptive levels of somatic awareness:

> *I feel like my body is one of those things that I haven't yet folded out fully. I don't have access to all the tools that might be available [..] and so I'm trying to unfold that. But, in terms of, generally, whether I feel therapists should be more aware or could be more aware of it – absolutely!*
>
> *I think from the experiences I've had with supervisors, with my own analysis, with other colleagues, I think those who can use the body, I believe, are fundamentally more effective than those who are less aware of or less attuned to it or don't believe it has as much value. And the reason I say that is actually more from my own experience of my own analysis, which is that there are certain things I know that I would never have reached in myself had I not had somebody pay attention to my body.*

Dalton et al. (2022) go further by claiming that supervisors need to ethically ensure the transgender competencies of their supervisees when treating and catering for a comparatively underserved community who face gender identity-based discrimination. One of the therapists, in indicating how various systems of oppression can interlock, cited an instance of race and gender intersecting in the treatment setting and could acknowledge the inherent struggles when engaging with clients who may hold multiple identities and minority statuses:

> *It's very distinct. Some people, you know, a black patient who comes from an African background* [where] *culturally men are more powerful, potent, seen - as a child being the youngest* [and] *not seen;* [then] *suddenly, as a male, as potent, recognized, seen,* [this] *can do things, can be powerful [..] I think that it's not specific, I've never found one model that we can fit everybody into, I think that's problematic.*

Despite drawing attention to the intricacies when dealing with intersectional identities, very few therapists, unless prompted, conveyed the necessity of supervision or a thinking space for the body and issues of gender. However, the process of the interviews undertaken for this study revealed that a space for thinking about the body (both the

patient's and the therapist's) has potential to increase therapists' critical consciousness or awareness of the corporeal body and play with potential meanings. In the excerpt below the therapist commented on how the interview had foregrounded the importance of the body in this work:

> *I think there should be, you know, now that you are bringing it to my mind and I'm thinking about it, it does seem like it's quite a significant aspect of the therapy, and one has to be aware of what's going on with your own body and with yourself as well and how your own thoughts, I suppose, of your body, your relationship with your body, all of that. So I think that's going to be very important in terms of future learning and development; absolutely.*

In the following extract, Jane, during the course of the interview, managed to establish a positive correlation between the authenticity or congruence of her gender presentation and the quality of attunement to her somaesthetic perceptions:

> *I hadn't actually thought about that. But now that you mention that, I'm thinking about how I often am … I think I'm more aware of how I dress as well and almost how my gender is being expressed. I think I've felt almost an urge to be more androgynous at times, more gender neutral, almost. [..] And if I think about it that day, I felt more aware, I think, of my body because it was more … I was more obviously displaying my gender and my privilege, like you're saying. So I'm just putting that together, now that I think, that might have been why my body felt more present that day.*

In this section Nicky demonstrated how processes of psychic elaboration can potentially be facilitated or deepened with the benefit of time and space:

> *There are certain patients - quite interesting; what you're saying made me wonder about this, - where they don't want to speak about anything outside of what's happening in their present day, and I wonder if it's because what's happening now is aligned with their gender as it's felt now. And what happened in the past is, you know, those memories are related to the body that they want to separate from or the identity they want to separate from. They'd have to have memories of themselves as a man, memories of themselves, as a woman. That's quite a painful thing for them.*

It cannot be ascertained from the previous excerpts whether there were potential constraints on both analysts' freedom to think and dream their patients as the work of

their therapy progressed. Notwithstanding the fact, and considering that there can be new and uncharted fantasies, and countertransferential reactions continually emerging in analytic work with trans-patients, one may cogently argue that the aftermath is *crucially* important for the therapist to retrospectively arrive at more informed understandings and formulations.

It can also be observed in the prior excerpts that 'afterwardsness' and post-hoc working-through are essential to managing countertransference. Evzonas (2021a) even argues that some questions can *only* be answered in the après-coup and that therapeutic insight may be acquired piecemeal or in a non-linear graduated manner facilitated by a thinking space. Dalton et al. (2022) also writes about how gender organizes the supervisory process as well as the therapeutic process and what transpires in the former can be utilized as an isomorphic process in the latter (Dalton et al., 2022).

In the following extract Jane reveals how the après-coup of supervision elicited an increased countertransferential knowingness and contributed to some deeper insights into the patient's psychic structure:

> *So I mean, I'm working with the supervisor now. I find him quite interesting. [..] And I think he's been quite interesting in thinking about a particular theory from Laplanche. [..] Basically, he talks about, in the attachment context, there being messages transferred, and he talks about two specific ways that messages are transferred from the primary caregiver to the infant; one is through intromission, which is basically, like, insertion into the infants. [..]He* [My supervisor] *and I have been thinking about how does that play out? Does it play out in a .....? I'm imagining the mother changing the diaper or the nappy and having that brief period of disgust at, maybe, her infant's penis and wondering what message is, in that instant, being transmitted to the infant? And what are they then learning to associate ... that their genitalia is maybe disgusting to their mother or not preferred and if that's being carried through, I think I could see a link there with how somebody starts to kind of take on that message.*

While Jane is able to appreciate the benefits of supervision when working with a gender non-variant population, it can be generally difficult for therapists, including those interviewed, to explore their own complexes and internal resistances which have been evoked by the patients' transference. There can be a fear of scrutiny or judgement by supervisors or an unconscious fear of the zeitgeist – the phenomenon of the anti-analytic

third. When working with trans-patients there is the likelihood that the patient's painful relationships with their own body integrity and continuity of being can be revived in the therapist, as a result of their own pubertal upheavals, wherein they can become locked into identification with their patients (Aron, 2006).

Several therapists discussed the evolving nature of the therapeutic alliance based on patients' stages of transition but did not explore the fine-grained nature of such shifts. Engaging in supervision would afford therapists the opportunity to explore and bring to conscious awareness, precisely how the shifting social locations and world-views of both therapist and client can unduly impact the therapeutic process. Some therapists recounted their experiences when their clients' physically transitioned and how they typically negotiate altered physical appearances. However none of the therapists explored the more nuanced implications when a client shifts from one social location to another, as a result of medical and/or surgical transition, (for example, from being perceived as male to being perceived as female) and how it is replicated inside the therapy room. Shipman and Martin (2017) posit that the therapist needs to be sensitively attuned to the concomitant shifts in gendered interactions in the wake of gender transition; these may include a revision of gestures and cultural rules pertaining to physical touch and bodily proximity.

The therapists in this participant group appeared not to foreground the broader implications for the treatment setting when a client transitions medically/surgically. While this may be reflective of a broader neglect of the body in psychoanalytic theory and technique, it may also be defensive, given the powerful anxieties that are evoked, as discussed above. Supervision may offer a thinking space in which to contain these anxieties and open up thinking in order to elaborate upon altered power differentials and gender expectations.

The therapist–supervisor relationship, an isomorphic process of the client–therapist relationship, can proactively assist the therapist with navigating the vicissitudes of a treatment centered upon a prospective transition. Therapists implicitly communicated the countertransferential, unthinkable anxieties which unwittingly manifest as a result of overdetermined causes and subject to the internal life of the therapist. Given that so much cannot be determined in real time and can only be understood by therapists as afterwardsness, discerned in the après-coup, it is imperative that therapists have a thinking space to reflect retrospectively and metabolize that which was unrepresentable. It is noteworthy that there is presently a paucity of a clinical framework including guidelines with regard to cis-supervisors working with trans-identified therapists.

4.10 Essential Enactments

On the basis of the information provided by the therapists interviewed it may be possible to contrast distinct approaches adopted by several therapists and to make some inferences. Notwithstanding the somewhat inconclusive nature of such inferences, given that the reader has only been privy to selected aspects of the therapeutic process, it is useful to contrast the distinct approaches and to identify barriers or obstacles which disrupt or impede the process. Drawing sharp distinctions between the different approaches assumed by therapists was not the central aim of the research but yet has emerged as a theme considering the fact of qualitatively distinct outcomes and the degree of therapeutic yield for both therapist and client.

Several of the therapists explicitly conveyed, over the course of the interviews, an express desire not to impose on their gender-dysphoric patients and unwittingly trigger enactments. However, according to Ringstrom (2005) enactments are ubiquitous and, paradoxically, fruitful ways of examining 'minipsychodramas'. He suggested that employing principles pertaining to improvisation as a mode of play can potentially set the stage for a different story to be told, one in which constricted scripts which reflect unique and unconscious organizing principles can be explored and revised (Ringstrom, 2010). Ringstrom (2005) warns how powerfully urgent enactments can devolve into impenetrable, rigid impasses if an improvisational attitude is not cultivated by the therapist. In the following excerpt, one of the therapists, Justin, in professing a sense of the unknown, demonstrates how he gently and with judicious forethought improvises with his patient when he acknowledges his soporific countertransferential state:

> *I think the sleepiness …. I think that's something I've got used to in the past when it becomes really hard to unpack something or to get into something. I think clients, especially when there's been very, very strong dysphoria, I think that's been quite difficult to …. So then using the somatic stuff actually saying, you know, 'this feels very stuck' or 'this feels dangerous to get into' or 'it feels like we have to shut down' or 'it feels almost as if I'm trying to create clarity by thinking about things, but actually that clarity could be dangerous or seeing your body in focus or seeing your trans-ness in focus'. I think definitely that that has been something that I think definitely has been used in the room [..] actually when we start feeling sleepy, when we are feeling disconnected or dissociated in a way. I think almost talking about it, actually putting that into language and articulating it. I think that has been useful for making meaning.*

Ringstrom conceives of the therapist and patient as two actors participating in a succession of scenes in which therapists are required to ask themselves what will facilitate the development of a scene, and what will foreclose or shut it down. He conceptualized this manner of thinking as a 'relational ethic' which constitutes a series of questions that the therapist and, over time, the patient can both entertain (Ringstrom, 2005, 2007, 2010). In the abovementioned passage Justin deftly demonstrates this technique through posing, in an appropriately paced and delicate manner, such a series of questions in which to engage his patient. This set of germane questions primarily serves to track improvisation and determine whether Justin and his client are opening or closing, vitalizing or deadening, connecting or avoiding, focusing or muddying, liberating or constraining, playfully exploring or just fooling around, affirming or annihilating, recognizing or misconstruing, fencing or going for the jugular (Mitchell, 1997; Ringstom, 2010). Ringstrom (2010) clarifies that the relational ethic is not merely the practice of adopting a reflective position of what has just transpired between therapist and patient but is, rather, a more moment-to-moment form of evenly-hovering mutual attentiveness, an approach that he distinguishes from the classical psychoanalytic ethic which constitutes the three pillars of abstinence, neutrality, and anonymity.

In the following passage Jane recalls a recent similar experience of improvisation with a young trans-male patient in which they managed to symbolically join or twin with each other and to engage in a mutual experience of sameness within difference:

> *And that's* [experimenting with her appearance] *been part of my own gender journey and sexuality journey in my own personal life. But I found that cutting my hair even shorter has been definitely noticed, that people have picked up on it. And especially, like, I had one…. this week, it was quite a sweet experience. I was with a 17 year old trans-boy and he was just so excited that we had the same haircut. And it was an interesting moment because I think for him it was possibly seeing somebody who is … I don't know how to put this into words … but that is in the body that he has maybe rejected or the gender he has rejected because he was assigned female at birth obviously - but that there was still this coming together of both of us from different gender identities and just enjoying the same hair. And I felt like it was actually quite an interesting bonding moment as opposed to it being kind of weird. I think he was very, very interested and he wanted to talk about it.*

In this example Jane appears to have successfully created an analytic play space within the treatment by engaging in a playful to-and-fro, and the kaleidoscopic nature of these intimate, co-constructed self-states appears, in the process, to have roused and enlivened a bi-directional associational process with her young client. According to Benjamin (1990), during the therapeutic process, the endeavour of sharing the creative productions of fantasy alters the status of fantasy itself, moving it from inner reality to intersubjective communication. When a momentary balance between intrapsychic and intersubjective dimensions can be struck, as in the above examples, a sustained tension or rapid movement between the patient's experience of us as inner material and as the recognizing other can also be achieved. This analytic endeavor, which Ringstrom (2010) refers to as a Yes/And process or exchange, may have constructively facilitated both parties in entertaining the heretofore unimaginable, considering the constraints of each of their respective theories of mind (Ringstrom, 2010). Stern (2007) posits that potentiating improvisational moments, as demonstrated in the aforementioned passage, may have created ripe therapeutic 'moments of meeting' between Jane and her client. According to Ringstrom (2010) shifting into an improvisational mode most likely culminated or eventuated in the experiencing of 'posi-traums' for Jane and her client. These posi-traums are potentially conviction-altering moments that defy or transform existing personality organizations, thereby providing an experience of something positively unimaginable, such as initiating new convictions. According to Benjamin (2011) the experience between Jane and her client can be conceived of as a shared, mutually intelligible experience rooted in a collective fantasy which can potentially resignify problematic discursive practices.

As explored in previous sections of the research many of the therapists appeared to adopt the more classical ethic of neutrality and restraint, especially when harbouring a fear of inducing dysphoria or of provoking undesired or unsolicited enactment. From an improvisational perspective, according to authors such as Ringstrom (2010), Aron (2005) and Benjamin (2005) the three pillars risk constitute a class of yes-but negations that amplify the risk of undermining or inhibiting playful engagement between the two parties. In the following clinical vignette Linda discusses her work with two trans-female clients who she indicates occupy incompatible or dichotomous relational positions from her. She outlines the attendant struggles in their subsequent interactional processes and alludes to an overcompensating desire to accommodate to her patients by not disturbing their somewhat precarious mode of relatedness:

> *She cannot be this petite female she's always fantasized about - that cannot be changed, that becomes something painful. Likewise, with some of my female patients who really struggle with weight, one who she's obese, and she carries huge shame. She doesn't even want to talk about her body. It becomes very difficult for us to talk about my body in the room with her because it's so painful. [..] I don't feel good in my body when I'm with her. [..] when I'm in therapy sessions with her, I wish I could hide it because it is a site of pain for her. And I'm aware that I, and whether this is a good or bad thing one could question, but I am aware that I alter the way that I dress on certain days, depending on the patients that I'm seeing.*

At a later stage in the interview when clarification is sought by the interviewer about Linda's prior stated desire to protect a trans-female patient Linda, drawing attention to her heightened gender sensibilities, expresses concern that her gender-presentation can be unwittingly weaponized to an extent that it acts as a source of impingement for her patient:

> ***Interviewer:*** *And it's sometimes that the body is concealed, that it actually is too painful and there's almost shame around the body or* [maybe] *not shame, but just trying to protect the client?*
>
> ***Linda:*** *Yes. Or, myself,* [feeling] *like the one who's aggressive - more aggressive if I'm hyper feminine, I will be reluctant to wear a dress on the days I see that person.*

In the above example the personal and the political are intricately woven together and Linda appears to be confronted with the fluidity of power and powerlessness causing the analytic work to be in abeyance. It may indicate that Linda is in the grip of the fantasy that "Only one can live", as conceptualized by Benjamin (2022) to describe a mentality which unconsciously organizes the struggle for recognition and which adversely induces a dissociative stance of reflexive self-protection. This psychological form of self-protection, arising from fears which prevent acknowledgement of suffering and responsibility for social injuries, is connected to a widespread social imaginary of 'doer' and 'done to' (Benjamin, 2022). Additionally, in underscoring the visceral quality of marginality, Linda appears to be experiencing a sense of inhibition which forestalls improvisational play; such a wish or desire to inconspicuously retreat from dysphoric clients was similarly expressed by other therapists including Rachel, Ruby, Richard and Mary, amongst others. We may recall Ruby's account of wanting to conceal her gender also:

> *so I find myself [..] trying to just downplay a little bit, a sense of feeling some guilt or also wanting to downplay my… just wanting to neutralise or dampen my gender expression … not wanting to be too anything so to, kind of, just dampen my* [gender] *presentation.*

It can be posited, on the basis of a set of the therapists' accounts, that several therapists, fearing that breakdown and/or aggression could not be withstood or tolerated by their patients, may have gotten stuck in complementary twoness and engaged in submission to a persecutory, long-prevalent ideal of being an all giving, 'complete container' (Benjamin, 2018; Steiner 2006). Benjamin (2006, 2018), in subscribing to Ferenczi's original viewpoint, holds that not accepting the fact of inevitable enactments, in which patients' wounds are re-opened, can gradually lead to stalemates which vitiate the authenticity of both partners and preclude mutual recognition. Mutual recognition is preceded by the analyst accepting the necessity "of becoming involved in a process that is often outside our control and understanding" (Benjamin, 2004, p. 41). According to Bohleber (2013) analytical treatments not giving rise to any enactments might prevent true engagement with the patient from occurring. The author argues that successful outcomes cannot be reached in analysis unless the analyst becomes intentionally emotionally involved with the patient (Bohleber, 2013).

Benjamin (2006) would argue that adopting such an observational stance, the original psychoanalytic position, implies an internal monosubjective third which, however purportedly self-reflective, cannot adequately address breakdowns in recognition, and the reestablishment of the third as an intersubjective process; she may conceive of Linda and Ruby's approaches as more inefficacious modes of pseudomutuality as opposed to mutual recognition. According to the author analysts can benefit from working through their fears of blameworthiness, badness, and hurtfulness, given that such fears can potentially tie the dyadic system in knots and deleteriously turn self-reflexive functioning into self-flagellating and counterproductive 'bad analyst' perceptions . Benjamin (2006) states that the analyst must learn to distinguish true, differentiating, shared thirdness from a more perverse, alienated simulacrum of the third, which blocks real self-observation, despite its primary emphasis upon empathic and rhythmic attunement. She holds that the observing third can potentially contain the knowledge of breakdown or disruption, which can be perceived as a destructive outside force, a killer, threatening the treatment. She contests "the self-immolating ideal of recognizing the other, in a form that demands self-erasure, as if such abnegation were a proper form of amends", concluding that it can be

experienced as a barrier which leads to compliance, hopeless dejection, or hurt anger for the patient (Benjamin, 2006, p. 135).

The abovementioned experiences may also speak to Laplanche's idea of 'too muchness' or the excess. According to Benjamin and Atlas (2015) clinical work within the intersubjective space actually requires an ability to connect to traumatic failure in the intersubjective area of mutual regulation in order to gradually modulate a potentially destructive cycle, in which the too-muchness of excess leads to the fear on both partners' parts of repeating ruptures in the analytic relationship. The authors emphasize the imperative of working through the surfeit of terrors and desires, which may be attributable to early attachment experiences, as they emerge in the transference–countertransference. Gaining competence in the working-through of ruptures related to overstimulation will cultivate and develop an adaptive ability to hold excitement and stimulation without experiencing the too-much as intolerable.

Such clinical predicaments, involving therapists experiencing themselves as the 'do-er' or perpetrator (as narrated by Linda), may also speak to Rozmarin's (2011) assertion that ''the entire grid of meaning onto which we plot our subjective experience is anchored in collective discourse'' (p. 20). Capturing those clinical moments where mind and society meet, Benjamin (2011) posits that something can be lost or made more troublesome by the analytic dyad acknowledging the intensity of interpellation but, conversely, suggests that something can also be gained. It is possible that Linda and her client may have distinct challenges posed by interpellation that compel a kind of guilt and struggle for the therapist of a specific kind. The author outlines how interpellation can lead to a de-linking of individuals from their socio-political context (not limited to client but also including therapists) which can, consequently, impoverish the mind, activate dissociative dynamics and deny much needed linguistic signification to ordinary experiences which may rattle the social order. It is possible that such dynamics are relationally unfolding for Linda, and the other therapists, who may be experiencing the intensity of interpellation.

Guralnik (2011), in a clinical vignette, demonstrated how interpellation can frequently partner with dissociation, by tracking a mutual run-in involving her and her client with racial interpellation, situated at the nexus of class, ethnicity, money, and public power. Describing her contribution, as therapist, to an enactment where she drowned in her whiteness before her black client Guralnik (2011) acknowledges a mutual lapse into judgment by therapist and patient, as well as a shared lack of ability to understand each other's relation to a corrupt system. The author underscores that a loss of intelligibility to

oneself can occur, when the perception of oneself as Other has been introjected, and when patients have received an indigestible dose of hatred that imperceptibly evolves to self-hatred. Is it possible that Linda, in a parallel process, is also experiencing a loss of intelligibility or a not-me self-state, in that moment, which prompts a state of dissociation? Guralnik (2011) outlines the inherent struggles for the dyad to find synchrony and recreate a mini-universe in which laws prevail when the Other has been melancholically foreclosed into the world of the abject. But how can this melancholy be grappled with in psychoanalysis, when the therapist represents that from which the patient has been excluded, whilst the patient occupies a status that is created by the Othering action of a discourse? Benjamin (2011) insists that in such split constellation, whether pertaining to gender, race, sexual orientation and so forth, the client *needs* access to a specific part of the therapist which they may not even consciously desire or hope for. That part represents a framework for action, and for justice that involves a viable lawfulness, rather than the quest by a helpless victim for restitution through the acquisition of power.

Benjamin (2011) welcomes such moments of manifestation, as evidenced in Jane's excerpt, where issues of economics and power, law and lawfulness can be introduced into the smaller arena of the therapeutic relation so that these different realities can be negotiated in the arena of the Third. It is noteworthy that Guralnik (2011) and her client managed to regulate their relationship by creatively negotiating a deal that involved responsibility and agency on both sides, and in the process, restored lawfulness by setting up a moral Third and establishing a consensual reality. Benjamin (2011) asserts that the task of the therapist, which undoubtedly is difficult to execute, is to maintain, in the enactment, that most tenuous balance between representing both the perpetrator who can admit the crime and the one who witnesses the crime and its acknowledgment. She draws attention to a more specific, intense version of the larger dilemma wherein the therapist is required to act, as in the case of Linda, as the representative for that normative society, a society which *needs* to recognize and acknowledge what it has done to the Other and to identify with the intense pain of that Other. Linda's struggles with self-regulation owing to conscious feelings of shame and guilt may be attributable to her awareness of her failures in recognizing the hurt of the Other and potentially re-inflicting old wounds.

When the capacity for mutual recognition is developed a subject becomes able to recognize the other person's subjectivity and to develop a capacity for attunement and tolerance of difference (Benjamin, 1990). Given that the human mind is interactive rather than monadic, this imperative phase of discovering other minds and sharing inner worlds,

as espoused by intersubjective theory, not only facilitates differentiation but also enhances the felt connection with the other. According to Benjamin (1990) the ideal resolution of the paradox of recognition, from the standpoint of intersubjective theory, is for it to continue as a constant tension between recognizing the other and asserting the self. According to Benjamin (1990) no perfect environment can take the sting away from the encounter with otherness and that the clash of two wills is an inherent part of intersubjective relations. What matters is how these inevitable elements of negation are processed and Benjamin (1990) recommends that the inward movement of negating reality and producing fantasy should gradually be counterbalanced by an outward movement of recognizing. Loss of such a transition would invite a triumph of the external, a terrifying psychic vacuity, as well as an end to creativity itself (Benjamin, 1990).

According to Benjamin (2006, 2011) the dual role of any psychotherapist who unavoidably reactivates a patient's traumas and wounds, is of being a witness as well as being a representative of the perpetrator. She maintains that holding and sustaining both positions, by standing in that symbolic space between and witnessing, is a crucial part of invoking a moral or mutually recognizing Third, an analytic third which specifically acknowledges relational and social violations. Such therapeutic acts, which affirm and redress violations of expectancy, can ultimately become the basis for the client's experiencing of a 'lawful world', thereby permitting the injured one to reconstitute their sense of dignity and to take reparative actions through their own agency (Benjamin, 2006, 2011, 2022). In such circumstances therapists must not only perform the witness function but act as a double witness and do what the bystanders in the client's life could not do; the therapist must insist on some kind of law but also must not fail to recognize the injuries inflicted upon the oppressed or invalidated client. Recognizing the tension between what is intelligible, meaning-giving and resignifying versus what is oppressive and normative on the other that we struggle to bear in mind these amazing and complex depictions of therapeutic consciousness of the role of discourse in the lives of analysts and their patients.

According to Donald Winnicott (1971) the therapist must be able to play in order to be suitable to work. Susan Coates (1998) also suggests that "A true meeting of minds requires a small mis-meeting of the minds if the patient is to be recognized and met. It is this slight mis-meeting that allows a symbolic stance to occur and provides the creative spark" (Coates, 1998, p. 128). This creative spark is created in the potential or transitional space which *differences* create and can be achieved through the successful use of

improvisation. In the process therapist and patient can come to recognize something about each other and about themselves that otherwise would not be possible (Ringstrom, 2010). One may posit that Justin and Jane have managed to achieve this creative spark in their Yes/And exhanges. Conversely, it can be hypothesized that Linda and her patient may be missing out on opportunities to produce this creative spark given that the wish to evade or circumvent a potential mis-meeting of minds is considerable enough to preclude therapeutic creativity. It can also be argued that Linda and her patient are lapsing into unconsciously scripted versions of their engagement, or rather dissociative dis-engagement, a process referred to as mutual inductive identification, a process which ultimately prevents the generation of posi-traums and the untangling and illuminating of the dyad's enactments (Ringstrom, 2010)

Enactments are ubiquitous and virtually impossible not to engage in despite the best efforts of therapists and can be the staging grounds for reparative transference experiences. According to Ringstrom (2010) Yes/But enactments, the inverse of Yes/And exchanges, can shut down the play between therapist and patient rather than further it. It cannot be determined whether Linda's analytic stance in this instance has been inflected by her own personal gender development journey or by her professional training. Notwithstanding, the intensity of Linda's feelings of fear and aggression may gesture beyond the current context to earlier object relations. It can be posited that the aforementioned impasse may parallel the historic intersubjective space between caregiver and child, a space where the child's experience of over-closeness, as a result of the caregiver's unmediated physicality, may have evoked an experience of 'Das Ding' in which the caregiver embodies an internal object of horror. Additionally, having the other dependent on one's own mercy can also evoke and produce excruciating and complex affects and ugly feelings, which Linda, and other therapists, may have struggled to contain, at times.

Despite therapists' desires to evade specific interactions of a painful nature, certain collisions in the intersubjective space are ineluctable and can even prove fruitful. It is possible that Linda may come to represent 'objet a' for the client, the Lacanian lost object similar to the lost Kleinian breast, and, as such, will evoke an inevitable and powerful desire in the intersubjective space; this desire will put into motion an impossible and inexorable unconscious quest or fantasy for the recovery of this lost object, as a means of plugging a gap and a sense of powerlessness and lack experienced in the client's being, a gap which is inevitable as part of the human condition (Lacan, 1992; Straker, 2018). Given that the practice of psychoanalysis is predicated on the possibility of rewriting the

fate of the client and freeing them from repetitions – repetitions which implicate the drives - it can be argued that there is a therapeutic benefit to therapists, at once, acknowledging and engaging with the client's desire for satisfaction of the sexual and aggressive drives and their quest for jouissance in either aggression and power. When multiple states of exile and marginality, produced by everyday misattunements, have engendered profound feelings of powerlessness and dependency, the erstwhile powerless client may well harbour a desire to dominate and wield power against erstwhile powerful others. Instead of therapists submitting when experiencing foreboding self-states, or perceiving such collisions, between therapist and patient, as harbingers of deleterious treatment outcomes, such mutually fraught encounters can, paradoxically, introduce a redemptive and transformative note wherein the dyad survives. Such propitious outcomes can be achieved when therapists demonstrate a capacity to surrender so that the axis of power can be momentarily trumped by the axis of intimacy. In order for implicated subjects to give acknowledgement and to change in response to the other it requires a form of vulnerability, a surrender of self-protection, and awareness that therapeutic healing lies in surrendering to the inevitability of such confrontations as a process of rupture and repair (Benjamin, 2022; Ghent, 1990; Lacan, 1992; Straker, 2018).

According to Ringstrom (2005) given that the nature of the dyadic relationship is automatically organized on the basis of primitive modes of relating, the needed dimension of transference can disqualify or supplant the repeated dimension of the transference; in other words what is desired in, yearned for or sought from the other manages to be subverted or negated by what is dreaded from the other, including the other's perceiving one's badness, hatefulness and shamefulness. One may posit that Linda and her patient are embodying, and enacting precisely what each party dreads from the other which can potentially lead to impasses if that awareness cannot surface to the therapist's consciousness. It may be that patients are not always attempting to unconsciously coerce therapists into identifying with some disavowed aspect of the former but are attempting to flush out something about the analyst's *authentic* identity in order to prove that the therapist is not a repetition of the historically dreaded other (Ringstrom, 2010). Patients may be unconsciously attempting to engage the therapist in confronting the neglected body or in recognizing and acknowledging painful or coveted dimensions of sameness and difference which they are struggling to confront. It can be argued that some patients may have a tendency to relate to their gender or their bodies through a lens of deficiency where their overall conceptualisation of self is overweighted towards a deficit. Notwithstanding this proclivity, Mitchell employed particularly novel

methodological strategies and a more synthetic approach, referred to as 'clinical outbursts', in his efforts to resolve clinical and theoretical entanglements and to navigate clinical stalemates that therapists face. He recommended that therapists examine ostensibly unbridgeable polarities from a different level of abstraction in order to find a third alternative which reconciles the tension between incompatible relational positions and which dismantles the either-or mode of thinking (Aron, 2003).

This group of therapists variously spoke about the challenges in tolerating clinical dilemmas stimulated by the relational context. When dealing with therapeutic impasses Mitchell explains that therapists must learn to tolerate, sustain and identify entrapped states that are experienced in double-bind "damned if they do and damned if they don't" predicaments so that they can free their imaginations and gradually discover a third avenue along which to proceed, one which can transcend the concrete level of the problem (Ringstrom, 2005, p. 156). Structuring the problem in simple binary terms, according to Aron (2003), can obscure more than it clarifies, and ultimately impede the search for a constructive solution that reveals an aspect of truth in two incompatible positions. One may posit that several of the therapists, when contemplating the transgender phenomenon, situated at the interface between the individual and society, can lose the specificity of the therapeutic couple. It can further be hypothesized that several of the therapists' countertransferential intrusions or objections are being influenced by experiences of being stuck between opposing contradictory technical options or incompatible relational positions (Aron, 2003).

CHAPTER 5

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

The final chapter provides a summary of the research findings discussed in chapter 4. The chapter also outlines the possible limitations of the study and presents recommendations. Future areas of study are proposed that are aligned with the findings.

5.1 Conclusion: Summary of Main Findings

The foremost aim of the research was to explore psychotherapists' experiences and understandings of somatic phenomena, in relation to their own bodies, when treating clients with varying degrees of gender-related body dysphoria within the treatment setting. Additionally, it aimed to explore therapists' experiences and understandings of these somatic phenomena in relation to transference-countertransference dynamics, and with regard to the various defense mechanisms deployed in relation to these phenomena. The findings highlighted the role of the broader social currents in shaping therapists' experiences and also allowed for exploration of the reasons why psychotherapists may have resistance to working more closely with their own somatic countertransference.

The social context in which treatment is offered exerted an undeniable influence on the experiences of this group of psychotherapists. This context includes broader social activism around gender diversity and challenges to the theories that frame their therapeutic work. When asked about their understandings of transgenderism/transsexuality, all of the interviewed therapists challenged psychology's predominant need to investigate the genesis of transgenderism/transsexuality and they questioned the underlying motivations for embarking on such an approach. They endorsed, in lieu, a more trans-affirmative framework and an 'informed-consent' model of treatment when working with transgender and gender non-conforming patients, one which recognizes members of a non-binary gendered client population as generative agents who are rightly striving for and demanding parity as opposed to pathological entities. Each articulated an understanding of gender as a non-binary and fluid construct, positing that gender-identity development is multifaceted and involves biological, developmental, and cultural contexts. The vast majority of therapists drew attention to the existing theoretical and epistemological limitations or blindness which arise when thinking beyond accepted majoritarian cis-gendered norms and culture and, in very large

measure, castigated the apperception of psychological disturbance as espoused by psychoanalysis itself in the past towards homosexuals and more recently directed towards the trans community,. Notwithstanding the overarching trans-friendly consciously adopted stance demonstrated by the majority of analysts, it is important to acknowledge or, at least, be aware that the road to hell can often be paved with good intentions, and that the presence of 'transphilic biases' or of an unchecked desire to be an ideal 'complete container' to patients can be potentially counter-therapeutic.

The therapists agreed in unison that transgender phenomena are a challenge beyond the context of psychoanalytic theory. The majority of therapists appeared to renounce metapsychological efforts to better understand transgendered phenomena and explicitly eschewed normative assumptions of gender, as well as the attainment of implicit cis-normative goals and ideals in the therapeutic process. Each therapist acknowledged an uneasy tension in uncritically accepting a body of theories and a set of generalized notions, systematized and constructed on the basis of many individual transgender psychologies. The therapists collectively favoured an idiographic approach that considers patients' individual contexts. Coincidentally, this dilemma, as articulated by the therapists interviewed, seems to encapsulate the continuing polarity within psychoanalysis which ponders whether it is more efficacious to analyze the individual or to create metapsychological theories of sufficient scope and application.

The majority of therapists explored how a dichotomous conceptualization of trans phenomena inevitably pits psychic and social forces against each other. Therapists articulated how the incursion of a militant trans-activist milieu as well as an ambient global technosphere can have negative implications for therapists working with gender-diverse patients. Therapists explained how currently thoughtful engagement, as a means of making sense of gender dysphoria, can be treated as an enemy or perceived as unconscious expressions of transphobia. Despite therapists embracing more liberal minded and emancipatory discourses, they alluded to an encroaching sociopolitical environment which demands uncritical acceptance and which can tyrannically circumscribe therapists' motility and their freedom to think. Some therapists disclosed how the possession of non-binary gendered identities can implicitly confer an unquestioned higher authority upon individuals or bestow a sense of entitlement which serves to intimidate therapists and inhibit their degrees of relational freedom. The oppressive reproaches of the superego which manifest, in the context of the zeitgeist, appeared to inflict excessive feelings of guilt for many therapists. Consequently, therapists demonstrated how identity politics and the zeitgeist can both serve as obstacles

to how therapists position themselves, especially when, intrapsychically, the therapist's harsh superego is being unconsciously pitted against a commensurately benevolent ego-ideal to be a good therapist.

Therapists' experiences of somatic countertransference phenomena were varied and inconsistent. More than half of the therapists agreed that there is a preponderance of cerebration when working with countertransference which is used to the detriment of the sympathetic or autonomic system. More than half of the therapists reported the experiencing of sensations including nausea, headaches, restriction of the chest and experiences of drowsiness. Some therapists could not recall any experiences of somatic countertransference and demonstrated a tendency to minimize, deny or disavow the transference and countertransference intrusions especially when working with children and adolescents. Many of the therapists interviewed reported feelings of disembodiment. Some therapists gave expression to the distinct phenomena of kinesthetic empathy or mimesis, forms of empathic response.

Therapists understood their countertransferential reactions as unconscious communications, in the form of projective and introjective processes that move across the analytic couple. Some somatic countertransference reactions were conceived in terms that came from Klein's schizoid mechanisms of splitting and projective identification. Some transferential and countertransferential enactments or strangleholds came about when engaging with archaic or incompletely symbolized material or through coming into contact with unreachable, split parts of the psyche. Therapists also articulated the complexity of identifications, dis-identifications and desires which inevitably become stirred up in the therapeutic setting and which can lead to a denial or disavowal of transferential material. Several therapists ascribed experiences of somatic phenomena to unconscious processes of idealization and envy that gradually veered into the tangled vicissitudes of the doer–done to, perpetrator-victim split complementarities. Therapists acknowledged that their own internal processes and current complexes, as well as infantile complexes and desires, may become activated when working with gender-diverse clients. One therapist alluded to the powerful sense of the uncanny which can manifest when working with marginalised identifications. Primitive impingement by the 'Other', through alienating gender enigmatic assignments and enigmatic signifiers, as conceptualised by Laplanche, was also implicated, by one therapist, in somatic transferential and countertransferential phenomena.

In terms of resistance to somatic phenomena, the group of therapists was also found to be susceptible to an anxiety of regulation, further agitated by regulatory ideals and through being socially inserted and intricately embroiled in a quagmire, with respect to the phenomenon of gender transition. In adopting an intersectional perspective of sexuality and gender, it was suggested that therapists' tendency to valorise gender-binary categories and fixed identities may constitute a defense against the anxiety of polymorphic infantile drives or polymorphous sexuality, an anxiety which can be aroused by transgender bodies that are perceived to transgress socially constructed categories. Some therapists discussed how the polymorphic sexual excitation or excess of a trans body can lead to a disaggregation of gender from the sexual, and a destabilization of the gender system. It can be posited that there is a regulatory power to gender as a defense against the force of the sexual and the drive's excess. They also ascribed resistances in working through somatic phenomena to theories of internal objects and primitive failures in symbol formation. Specific transphobic countertransferential reactions were also understood as 'unthinkable anxieties', as propounded by Hansbury (2017). Therapists also appeared to experience disruptions or crises in their subjectivities, where not-me self-states were excluded or sequestered and dissociative processes or relational dynamics were likely to unfold. Therapists recounted multiple instances where subjective feelings of guilt and shame compromised, in the immediacy, their capacity to mentalize wherein therapeutic capacities were undermined by the presence of an 'anti-analytic third' or a 'trauma of morality', as conceptualized by Straker (2006).

Generally, therapists, who have worked with minors, advocated for a child-centered but adult-led approach with therapists outlining how an existing child-led approach, albeit affirmative, tends to stymy the treatment process. Several of these therapists recalled various experiences of being in the grip of regulatory anxiety and how increasingly anxious self-states have resulted in blocks in the working-through process of the countertransference. Such examples illustrated that it is not only patients but also therapists who are required to approach and confront the unbearable in order to re-galvanize the process of working-through in the countertransference.

Some therapists acknowledged feeling stranded between unacceptable postures within the analytic dyad, ensnared and suffocated by a closed world of clashing and opposing relational configurations and binary oppositions. It was concluded that a preoccupation with maintaining perfect balance, as a means of avoiding enactments, can be used defensively by patients and therapists alike, and can unduly impede growth and creative innovation, and foreclose the possibility of new experiences or states of mind. The

importance of engaging in reciprocal and improvisational dialogue as a means of easing these tensions and transcending dichotomous ways of thinking was explored. Therapists who displayed a capacity to imaginatively improvise and be interpersonally flexible with their clients appeared to chart a new, more viable and adaptive course whilst freeing themselves from old intractable constraints.

In a rather prescient commentary, given contemporary developments in gender identity theory, Kohut claimed, in 1975, that psychoanalysis was, similarly, on the threshold of a value and paradigm shift, and that psychoanalysis would be required to integrate its inherited value system into a revised worldview. He further predicted that psychoanalysis would enter a prolonged period of questioning its past, of struggling against the temptation to rebelliously discard its inheritance, followed by an examination of daring new paths into uncharted territories. Despite anticipating this as a period of great danger, of excited battles and debates, Kohut believed that analysis, in the process, would have "a chance to emerge from it, to go on to live and to thrive" (Kohut, 1975, p. 327). The striking parallels between this era in psychoanalysis and our present position are incontrovertible. Only when therapists can embrace intersubjective vulnerability in the treatment setting, including the shame which therapists bring to their encounter with the other, can they hope for the kind of healing that Kohut envisaged (Orange, 2009).

According to Goldner (2011), the trans phenomenon is "gender in free fall", with the author likening it to "gender theory on speed" (Goldner, 2011, p. 153). Psychologists, gender theorists, and social observers are still grappling with the Gordian knot of how to reconcile gender identity and the plane of anatomy. Despite latter-day epistemological breakthroughs in the psychoanalysis of gender and the formation of gender identity, a critical reckoning is still very much needed. Transgender phenomena continue to perplex and confound psychoanalytic theorists, whose subjective accounts sporadically disclose discombobulating and dissociative experiences when revisiting the Augean stables of the unconscious. The knowledge which has been acquired at this juncture may serve as departing points for ongoing conversations about gender and gender embodiment.

Notwithstanding a veneer of psychoanalytic sophistication which permeates our current understandings of *existing* psychological illnesses, psychoanalysis now faces a moving target owing to an increasingly rapid evolution in non-binary gendered identities. As such, new categories of patients, with new and distinct ways of inhabiting and presenting themselves, require new and generative ideas and ways of working; it is not only the

patient, but also the therapist, who has to confront the unknown and prepare to be confronted with it.

In conclusion, it is hoped that this particular body of research will serve as a springboard and as a generative force for ongoing exploration of how alternative expressions of gender and embodiment can manifest in the clinical setting. There is also a hope that it can inspire further commentary and cultivation of the themes outlined for the purposes of deepening and advancing the dialogue around the phenomena of somatic countertransference when working with a gender-variant population.

5.2. Limitations

It is important to outline the limitations of this study which should be considered when assessing the merits of the findings. Additionally, the limitations should be evaluated prior to contemplating the implementation of recommendations as well as appraising the direction of future research.

- The research study entailed conducting semi-structured interviews with thirteen participants. The participants varied in age as well as in years of respective experience as therapists in the field of psychology. However, a significant limitation of the study is the homogeneity of the sample in terms of race given that twelve of the thirteen participants were South African Caucasian and one was South African Indian. The recruitment method contributed to this limitation as recruited therapists recommended known colleagues who specialized in working with gender-diverse patients. The generalizability of findings is restricted in this respect as the accounts provided do not represent the broader population of South Africa and may dismiss the primacy of race in the emergence of gendered subjectivity and precisely how the multiple intersections of gender, race, culture and ethnicity can each inform the situatedness of subjective enunciation. Although the findings constitute compelling insights in relation to the research aims, it is important to gain a more representative view from a broader spectrum of the South African population in order to supplement and enrich existing findings.

- The sample size should be considered as a limitation as thirteen participants does make it difficult to generalize from the data. However, in qualitative research, smaller samples are usually relied on as the focus is more on the specific as opposed to the general. It was evident that many experiences were consistent even within the sample and that some of the observations may be transposable to other clinical settings.

- It is important to acknowledge that participants' assumptions and reasoning could not be tested against their patients' perceptual experiences of what may have transpired in the same situation, including subjective experiences of distinct stages of the treatment process. Notwithstanding, the examples offered by each participant did ostensibly appear to ground many of their observations in reasonably accurate reconstructions of events.

- Unfortunately, it was not possible to conduct any of these interviews face to face, owing to lockdown regulations and the institution of other strict COVID-19 protocols and restrictions. It would have offered a beneficial opportunity to reflect upon our own experiences of somatic transference and countertransference, during the interview process, as well as providing a means to comparatively assess and contrast experiences of somatic phenomena in both liberated and constrained settings.

- Only one of the therapists interviewed works exclusively in a public state hospital and does not treat patients in private practice. A notable difference was observed between this participant's experiences in the public system and the other therapists' experiences within private practice, which is beyond the scope of this research. However, the lack of participants working in the public system also limits the generalizability of the findings and a more balanced sample would enhance the overall findings.

5.3 Recommendations for Future Research

The following recommendations are proposed in line with the limitations discussed as well as the broader research topic.

A larger and more diversified, representative sample would be helpful in validating and ensuring the generalizability of the findings and in exploring whether differences in the positioning of participant's social identities might contribute to different kinds of interactions between therapists and their patients. An alternative method of recruiting participants may allow for access to a wider, more heterogenous group of participants

In order to fill further gaps in the literature, much more experience-near research is required in order to understand the experiences of both patients and therapists in therapeutic work with gender-diverse patients. Examples of studies that could be conducted include: examining the experiences of trans-identified therapists working with gender-diverse patients and whether processes of gender identification enhance or impede the treatment process; and, examining the subjective experiences of the therapeutic process from the perspective of transitioned transsexual patients. This study should emphasize the generative aspects of the treatment as well as factors which were felt to stymy or impede the process.

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APPENDIX A – D

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Dear potential participant,

My name is David Coleman and I am a Masters student in Clinical Psychology at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project which will be conducted under the supervision of Professor Katherine Bain. This research study will specifically explore therapists' experiences of somatic countertransference when treating clients dealing with issues pertaining to either gender-related body dysmorphia along with therapists' secondary experiences of working with transference and other defense mechanisms deployed by this same group of clients.

As part of this project I would like to invite you to participate in this study. If you agree to participate, this will involve being interviewed by me at a place and time that is convenient for you, outside of working hours, for approximately an hour. There is an option to hold the interview in person with strict adherence to government regulations concerning the corona pandemic which we can discuss in more detail if you have specific questions. Conversely, there is the option of conducting the interview online. With your permission I would like to video record the interview using a digital device for the purposes of transcription and also owing to the specific topic and the heavy emphasis on bodily gestures, facial expressions and particular patterns of movement.

The interview will cover your experiences of working with clients who have been treated for gender-related body dysphoric issues. You will also be asked about your own experiences of somatic countertransference and your understanding of transference and resistance behaviours exhibited by these clients. You will not be asked to give any specific details about your clients such as names. You may refuse to answer any

questions that you do not wish to answer, without any negative consequences. You may change your mind regarding participation and stop the interview at any time.

There will be no personal costs to you should you participate in this project nor will there be benefits (such as payment) and minimal risks. Your confidentiality will be protected through the use of pseudonyms and only the researcher will have access to the recordings. The interviews will be typed up but no information that may identify you or your clients will be included. The typed-up interviews transcripts will be stored securely in password protected files on the researcher's computer. Direct quotes from interviews will be used in the reporting of this study, but these will not be linked to any identifying information. The interview transcripts may be retained for use by other researchers for research purposes but will be stored on the password protected computer of the researcher and his supervisor. The video-recordings will be deleted after publication of the findings of the study.

The findings of the study may be reported in journal articles, which are published on the internet. If you would like a summary of the findings of the study, please include your email address on the consent form.
If you agree to participate, please complete the consent form provided.

If you would like any further information on the study, please contact me on 083 376 4779 or you can mail me at the following address 2071079@students.wits.ac.za. My supervisor can be contacted at 011 717 4513 or at the following email address katherine.bain@wits.ac.za

Kind regards,

David Coleman

David Coleman

EMTHONJENI CENTRE
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4513 • Fax: 011 717 4559 • E-mail:
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Consent to participate

Title of Research: Psychotherapists' experiences of working with somatic phenomena in the therapeutic setting when treating clients with gender-related body dysphoria.

Researcher Name: David Coleman

I _____
agree to participate in this research project. The research has been explained to me and I understand what my participation will involve.

(Please circle the appropriate response)

I agree that my participation will remain confidential. Only the researcher will know my name and he will keep this confidential.

YES NO

I agree that the researcher may use anonymous quotes in his research report.

YES NO

I agree that the interview may be video recorded.

YES NO

I agree that the information I provide may be kept by the researcher for future research use for a period of five years.

YES NO

I agree that I have read and understood the information sheet for the above study and have had the opportunity to ask questions which have been answered fully.

YES NO

_____ (participant signature)

_____ (name of participant)

_____ (date)

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Interview Schedule for Therapists

Please tell me a bit about your work as a psychotherapist and how you came to work with clients with gender-related body dysphoria.

Please tell me about your experiences, as a psychotherapist, in working with clients grappling with gender-related body dysphoria or body dysmorphic issues specifically relating to gender identity.

Have you noticed any particular experiences you have had of your client's body or your own in work with these patients? Please elaborate. Any bodily-felt sensations or visceral reactions evoked during the therapeutic encounter? Please could you give me some examples of such instances?

How much notice do you take of the client's body when you first encounter them in the therapeutic setting and how much weight or significance do you give to those initial perceptions?

(*Only if not provided sufficiently in preceding question*) Please discuss specific instances of somatic countertransference that you may have experienced and the various symptomatic manifestations.

How do you make sense of these experiences? (Explore understandings of the examples given).

In your therapeutic experience have you managed to formulate any working hypotheses about clients dealing with gender-related dysphoria relating to attachment in early development? If so, what have these been?

Have you had experiences, in working with such clients, where your relationship with your own body, sexuality or gender has come into focus? Please give me some examples.

Have you ever felt your body or the precise way in which you inhabit either your body or the consulting room been scrutinised when working with clients dealing with these issues? Please give me some examples.

Have you ever experienced the client making use of your physical body or the body of the consultation space that has felt somewhat intrusive? If so, what did this look like in the room and what meaning did you attribute to this behaviour?

Have you ever experienced anxieties being mobilized in clients dealing with body dysphoria when your physical appearance or the appearance of the consulting room has been altered? If so, what was happening and how did you manage it?

Have you had any experiences with these clients where hostility was evident in the transference? Please give me some examples. How did you understand the hostility?

Have any clients displayed evidence of a disruption in temporality such as clients arriving late to sessions and/or resistance to exploring and integrating the past? Please give me some examples. How have you made sense of this?

Have you communicated your experiences of somatic transference or countertransference to your clients as a means of working through issues? Please give me some examples.

How much notice do you take of the client's body when you first encounter them in the therapeutic setting and how much weight or significance do you give to those initial perceptions? Please give me an example.

How comfortable are you be in drawing direct attention to *sensitive* aspects of a client's body that warrant examination but which the resistant client is unwilling to address? Please give me an example.

What might be your initial concerns or reservations if a client were to present for therapy with the express therapeutic goal of expediting the process of transitioning gender?

Would there be additional concerns if there were clear indicators or evidence of client psychopathology?

Do you include information about your somatic countertransference in session notes?

How did you come to make sense of these things? Reading? Supervision? Training?

Do you think that there is too little emphasis presently in the therapeutic frame on the role of the body and that therapists need to work more at a more body-aware level?