



## The seventh penis: towards effective psychoanalytic work with pre-surgical transsexuals

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*Abstract:* The author reflects on his contrasting analytic work with two transsexual patients. He uses three previous psychoanalytic studies (Stoller, Morel and Lemma) to explore whether effective analytic work with the issues driving a person's determined wish for sex reassignment surgery (SRS) is possible. Particular consideration is given to how such work might navigate a path between traumatizing and pathologizing the patient on the one hand and avoiding important analytic material out of fear of so doing on the other. The author proceeds to ask whether it is possible to tell in advance, with any degree of reliability, who is and who is not likely to benefit from surgery. He considers certain diagnostic issues in relation to these questions. Illustrations are given of how, in practice, countertransference anxieties about psychopathologizing transsexual patients can contribute to significant difficulties in working clinically with them. It is argued that the understanding and containment of such anxieties could eventually lead to more effective analytic work, and that such work might be further facilitated by considering the contribution of mind-body dissociation to transsexualism.

*Key words:* countertransference, countertransference psychosis, father, gender, mind-body dissociation, psychosis, sex reassignment surgery

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Outside the operating room of the sex-change doctor, a tray of penises.

There is no blood. This is not Vietnam, Chile, Buchenwald. They were surgically removed under anaesthetic. They lie there neatly, each with a small space around it.

The anaesthetic is wearing off now. The chopped-off sexes lie on the silver tray.

One says *I am a weapon thrown down. Let there be no more killing.*

Another says *I am a thumb lost in the threshing machine.*

Bright straw fills the air. *I will never have to work again.*

The third says *I am a caul removed from his eyes. Now he can see.*

The fourth says *I want to be painted by Gericault, a still life with a bust of Apollo, a drape of purple velvet, and a vine of ivy leaves.*

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The fifth says *I was a dirty little dog, I knew he'd have me put to sleep.*  
The sixth says *I am safe. Now no one can hurt me.*  
*Only one is unhappy, He lies there weeping in terrible grief, crying out Father, Father!*

Outside the Operating Room of the Sex-Change Doctor (Sharon Olds 1989)

## Introduction

I do not consider myself an expert on transsexualism or transgendered states, as they should more properly be called. But, over the years, I have worked with (and supervised other therapists' work with) a small but significant number of people who have had, or intended to have, sex reassignment surgery (hereinafter SRS). All have had a powerful impact on me, but none more so than 'Chris', my first such patient. The views I attribute to him in this article are those he held at the time of our work together. They may well have changed since then.

## First clinical vignette

Chris was referred to me by his psychiatrist for analytical psychotherapy in the late 1980s. To begin with, we met weekly. This soon increased to twice, and eventually three times, a week. We saw each other for a total of four years. Chris had had male-to-female SRS, but wished to return to living as a man. As I struggled to process my shock at his story, my initial thought was that the best therapeutic outcome might well be for him to learn to accept himself as a woman. When his penis had been removed in the original operation, some of the foreskin and its associated nerve tissue had been fashioned into a kind of clitoris, and his scrotum into an artificial vagina. Unfortunately, there had been complications. He had suffered repeated urinary tract infections. The work of the original operation had broken down and the artificial vagina had had to be reconstructed using a piece of his gut. The clitoris did not seem to really work and he was unable to experience proper orgasms. Surgery could restore him a prosthetic penis, which however would never give him real sexual pleasure. A date had been fixed for an operation to have his breast tissue removed, and he had stopped taking the oestrogen routinely prescribed for male-to-female transsexuals.

Inwardly recoiling from all this surgery, I asked him why he wanted to revert to living as a man. He replied that he had come to realise that the original operation had not solved the problems he had hoped it would. A couple of years earlier, after living as a woman for nine years, a significant moment had occurred. He had introduced himself to a new psychiatrist who had told him 'But you are not a woman are you? You are a man who has had mutilating surgery'. I gasped involuntarily at what I regarded as this psychiatrist's

monumental insensitivity. But Chris held my gaze steadily and replied matter-of-factly that he had been right.

He went on to describe how his mother had dressed him in girl's clothing from an early age. She appeared to hate and denigrate all men, but especially his father, who had compounded matters by indulging in a series of histrionic, homicidal and suicidal drink-fuelled rages before leaving to join a circus when Chris was four. His father, it later transpired, had sexually abused Chris's elder brother and perhaps, Chris thought, himself as well, although he had no conscious memory of this. With the benefit of hindsight, Chris now believed that his wish to become a woman had been driven by the dual hope of winning his mother's love and avoiding identification with his 'mad', abusive father. Sadly, the operation had not cured his mother's narcissism; nor had it removed his fear of his own madness. 'When I woke up from the operation', he told me, 'the first thing I said was—"I feel as if all my anger has been cut out"'. Of course, it hadn't, as he soon discovered.

I began to be filled with a deep sense of admiration for this man who was so determined to face up to his mistakes, and from whom I learned so much. I started to feel rather ashamed of my earlier impulse to encourage him to cut his losses and live as a woman. Chris himself was full of rage with an 'industry' that he felt had sold him the illusion that having SRS would solve his psychological problems, 'It is as daft as if I were to go to a psychiatrist with the delusion that I was a kangaroo and he had said, "fine, if you can live in role as a kangaroo for a couple of years and come to a few counselling sessions over that period of time, then provided you still believe you are a kangaroo, I will refer you for an operation to have a pouch fitted"'. I could see his point. But why, I wondered, had his counsellor and psychiatrist so spectacularly failed to address the obvious psychological issues behind his wish for SRS prior to surgery, even if the number of sessions they could offer was perforce minimal?

Chris replied that it was not their fault. Even in those days, before the advent of the internet, nearly everyone wanting the sex change operation was familiar with all the relevant literature and knew exactly what the psychiatrists and counsellors 'wanted' to hear. A 'helpful' transsexual community had schooled him in what to say in these interviews. And he had thoroughly read and digested the works of Robert Stoller. All he had to do now was to show strong motivation and demonstrate the clear conviction that he had thought of himself as a girl from an early age, while avoiding divulging any information that might lead to an alternative 'diagnosis' such as homosexuality, transvestism or a 'paraphilia'; he carried this off with aplomb. Of course, some of these diagnostic criteria have since changed. He would no longer have to hide such things as his wish to live in a sexual relationship with a woman, for instance.

A detailed account of the analysis with Chris would detract from a consideration of the main themes of this article. But one important aspect of

our work together involved Chris gradually coming to terms with the pain of being let down by his father. This process was mediated by positioning me in the transference as the good father he never had. And eventually he was able to internalize a more positive experience of masculinity. From a Jungian perspective, we could say that the archetypal expectation of a father became de-integrated and eventually re-integrated through his relationship with me, in a way that had proved impossible with his own father (Fordham 1985).

### **Second clinical vignette**

Chris's post-surgical disillusion contrasts starkly with the hope with which 'John', a pre-surgical male-to-female transsexual client, came to see me over two decades later. While Chris has kindly granted me permission to use his material in this article, I am not in a position to request similar permission from John. So I will create a composite case, within which to frame a real 'critical incident' to which I wish to give particular attention. In doing this, I will aim to remain as true as I can to the dynamics of the original case without compromising client confidentiality. That task will be aided by the fact that I intend to focus on the countertransference.

'John' presented initially as a married man in his mid-life who was determined to have SRS. In the next session 'she' presented as 'Rachel', the woman she said she felt she really was and had always been. In both sessions John/Rachel made it clear that the role of therapy was to help him/her prepare for the transition to living permanently as a woman.

I am uncomfortably aware of the way that attempting to keep the issue of John/Rachel's gender open breaks up the flow of my writing. And so for simplicity's sake, without wishing to close that issue down, I will refer to him/her as 'John' and 'him', henceforth. Of course, John himself would probably object to that if he ever read this article. But my first introduction to him was as a man who had lived (outwardly at least) in the male role for the whole of his life to date. It is interesting to reflect, however, that language itself exerts a pressure on us to identify the other person as a unified individual of a fixed gender. Of course, there is the relatively familiar use of s/he which can help relieve this pressure. And there are also the less familiar non-gender specific pronouns *ze* (pronounced *zee*) and *hir* (pronounced like *here*). But these unfamiliar terms bring their own awkwardness and, even if I adopted them, I would still have the problem of whether to call *hir* John or Rachel or both.

It seemed to me in our first session that there were clear indications of serious issues from John's childhood that he had not worked through emotionally. He talked to me in a detached way about the violent rows he had had with his highly religious father, about the scout master who had become a father substitute but subsequently abused him, and about his mother leaving the family home when he was eight to live with a woman. I asked if he felt ok

about exploring the emotional impact of these experiences and their possible links to the wish for surgery. And he said he did, although he claimed to have dealt with them already.

Perhaps I accepted this 'yes' too readily. It offered me a way out of the double bind of being too confrontational on the one hand or clinically negligent by failing to explore important clinical material on the other. And, on John's side, perhaps his wish to escape being perceived as avoiding important psychological issues and therefore unlikely to benefit from surgery, led him to comply too easily with my wish to escape this double bind.

But I was sufficiently aware of this difficulty not seek to push him into full emotional contact with his traumatic childhood experiences in this, our first session (Rothschild 1999). As a result, he was able to talk about them without becoming overwhelmed. But he wondered why I was asking him about issues he had already 'worked through'. I explained that if his wish for surgery was being driven by unresolved psychological conflicts or traumas, he could end up regretting it. When he dismissed this possibility with a contemptuous laugh, I found myself saying that I had worked with someone who had regretted having male-to-female SRS. Upon reflection, I realize that this seems to have inadvertently exposed him to a level of anxiety that he found intolerable.

In his book, *The Last Hundred Days*, Patrick McGuinness (2011) describes life in Ceausescu's Romania at the end of the 1980s. One character, 'La Princesse', spends her time longing to leave the drudgery of her life as an ordinary Romanian citizen and return to Paris, where she had been feted as royalty in her youth. Eventually, a well-meaning friend manages to save enough money for her flight and secures the visa that allows her to go back to the city of her dreams. But she returns to Romania a month later a deranged and broken woman.

Madness is not living in a fantasy world—she has lived in her fantasy world quite happily for years, perhaps we all have. Madness is the space between the fantasy world and the real one, where you find yourself cut off from both. There's no way back from that.

(McGuinness 2011, p. 95)

Half an hour after the end of our session, John returned during my lunch break shaking and terrified, in what I can only describe as a psychotic state. He said he had felt an overwhelming fear of being attacked on the street after he left the session. He had come back looking for a place of safety, which I did my best to provide, offering him a cup of sweet tea and the chance to talk about what had happened to him. He left after about half an hour, saying he felt secure enough to go back out into the world. It was my wish to understand the psychodynamics of this critical incident that sparked the writing of this paper.

John returned the next week for his second and, as it turned out, final session. By then, his faith in surgery had been re-established, and he was at pains to

point out that he had thought of himself as Rachel all his/her life. Perhaps a well-meaning friend had told him/her in the interim that this was the way to secure his visa for surgery.

### Some reflections

Reflecting on these two contrasting clinical encounters, I recognized several underlying similarities. Both John and Chris had violent, abusive 'fathers'. Both seem to have had that negative image of men and masculinity reinforced by their mothers. And both faced issues of abandonment by their mothers. Chris felt he risked the loss of his mother's love if he identified himself as male, while John's mother actually left the family home for a woman. So it seems to be a real possibility that John, like Chris, was unconsciously seeking a sex change operation in order to avoid the pain of abandonment by his mother and identification of himself as male and therefore violent and abusive.

An obvious question then arises: could John and I have explored this possibility analytically? This question can be asked both generally regarding the analytic treatment of pre-surgical transsexuals and specifically in relation to John. And it leads to a further question regarding diagnosis: 'is it possible to tell in advance who is likely to benefit from SRS?'

I will not attempt a comprehensive review of the analytic literature on transsexualism. Instead, I will outline the views of three analysts whose contrasting views, I believe, will facilitate a discussion of these questions. I will re-examine the critical incident described above in the light of that discussion. And, out of these reflections, I hope to draw some tentative conclusions regarding possible ways forward in the analytic treatment and understanding of transsexuals.

### Three analytical views

#### Robert Stoller

The American psychoanalyst and professor of psychiatry, Robert Stoller, was widely regarded as the world's leading analytic authority on transsexualism before his premature death in a road traffic accident in 1991. Towards the end of a career that spanned over thirty years working, researching and writing on the subject, he wrote, 'I cannot find patients with massive gender disorders who want analysis. They wish only to change the outer world—their anatomy, the people they know, society.' (Stoller 1985, p. 6)

Indeed, Stoller regarded the inability to work analytically with the wish for SRS as virtually diagnostic of those he termed 'primary' as opposed to 'secondary' transsexuals. This is because, for him (Stoller, 1975), primary

transsexualism stems from a process of conditioning and imprinting from mother to infant that predates symbolization and is therefore not amenable to analysis. The male-to-female primary transsexual, according to Stoller, wishes to become the mother's idealized, feminized phallus. But this, he claims, does not make primary transsexualism pathological.

'Secondary transsexualism' can originate, according to Stoller, from a variety of sources. These include psychotic delusions, homosexuality, transvestism, paraphilias and neurotic conflicts around gender identity. Some, but by no means all, of these conditions might be amenable to analysis. He thought that primary transsexuals were likely to benefit from surgery, and that secondary transsexuals were likely to be harmed by it. But this was just his subjective impression. He acknowledged the poor quality of scientific research on the subject (Stoller 1985, p. 169) and therefore advised extreme caution before recommending surgery. We might well assume that, in Stoller's view, John would be regarded as a secondary transsexual, because he had lived his life to date in the male role and because the challenge to his wish for SRS precipitated a psychotic episode. But, of course, this would not guarantee that his wish for surgery could have been worked with analytically.

### A Lacanian view: Genevieve Morel

Lacanians (see, e.g., Morel 2011) seem to regard transsexualism as symptomatic of psychosis. Genevieve Morel illustrates this using her work with Ven, a female-to-male transsexual.

Female-to-male SRS can involve a variety of procedures, including: mastectomy and/or testosterone treatment, along with chest contouring, full hysterectomy, removal of the ovaries and fallopian tubes and genital reconstruction including the implantation of a prosthetic penis.

Morel's client 'Ven' was born female, lived as male and came to her because 'he' had been advised to see a 'shrink' before undergoing female to male SRS. What Ven really wanted, however, was for Morel to intervene with the authorities in support of surgery. Morel responded that she was unable to do this and that she doubted anyway that the operation would solve his problems.

What was the point of coming and talking to me, then, he retorted, if I couldn't help him obtain, through the operation, the 'proof of his being', the penis that would harmonize his body with his intimate conviction of his maleness? I replied quite simply: to find another solution to the 'proof of his being' than such a cruel operation.

(Morel 2011, p. 189)

Morel goes on to give an interesting analysis of the case, which she claims illustrates the underlying psychotic structure to Ven's psyche. This hinges on Ven's 'certainty' that she/he is male, itself a belief that, according to Morel, attempts to foreclose the terrible pain of abandonment by a mother who was faced with a 'Sophie's choice' scenario after her husband was sent to a

concentration camp in Pol Pot's Cambodia when Ven was three. Unable to look after both her children she had chosen to send Ven away and keep Ven's younger brother. 'I am male', Ven's unconscious thought seems to go, 'therefore she still loves me. All I need is the penis to prove it.' Interestingly, Ven claimed to be willing to forego all sexual pleasure in pursuit of this 'truth'.

This vignette hints at a contemporary Lacanian approach to working with transsexualism and hence psychosis. The psychotic symptom (in this case the conviction of being male) is regarded as an attempt at self-cure and is therefore not challenged directly. Morel is happy to treat Ven as a man, but does not support the wish for surgery.

Lacanian analyst, Darian Leader (2011), advocates a similar way of working in his recent book 'What is Madness'. There is, for him, a crucial distinction between having a psychotic structure—which is a condition that must be diagnosed but cannot be changed—and going mad, which the client, with the analyst's help, may be able to avert. But there is no set way to achieve this; each case is unique. It seems worth noting, however, that the Lacanian father plays a crucial role in the aetiology of the psychoses. It is to the father, as possessor of the phallus, that the infant imagines the absent mother has gone. His presence, as a function, thus structures the subject's psyche and enables symbolization in health. Interestingly, though perhaps not surprisingly, Stoller's infant's 'non-pathological' identification with the mother's phallus is, from a Lacanian perspective, indicative of psychosis. For such an infant, the father's possession of the phallus has been foreclosed. I refer readers who are interested in further discussion of Lacan and psychosis to Leader's book and to Lacan's (1955-6) seminar on the psychoses.

### **Another contemporary psychoanalytic view: Alessandra Lemma**

In a recent article in the *IJP*, Alessandra Lemma (2013) writes about her analytic treatment of 'Ms A', a male-to-female transsexual patient engaged in once weekly therapy over a period of five years as she goes through the process of transitioning. The article demonstrates how Lemma attempts to navigate a path between the twin dangers of pathologising or traumatising Ms A, on the one hand, and failing to work through the psychodynamics of her wish for surgery, on the other. Lemma does not get directly drawn into diagnosing her client or challenging her wish for surgery. Instead, she explores the dynamics of the transference/countertransference in the normal way and relates this to the traumas and conflicts of her childhood. In particular, Lemma hypothesizes that Ms A's mother was unable to accurately mirror the discomfort of growing up in the grip of a severe gender conflict. And she attempts to offer a more empathic mirroring of this in therapy, enabling Ms A to modify her internal working models. This implies that the gender conflict pre-dates such faulty mirroring. In line with this hypothesis, Lemma insists that Ms A's

transsexualism could have a biological origin. At the same time, however, she acknowledges that:

... a psychogenic account of her difficulties is compelling given the early history of emotional deprivation and especially the way the 'absence' of her mother, and the hatred for her father ... appeared to have been managed through a feminine identification that supported a fantasy of symbiotic fusion with the mother (Person & Ovesey, 1974) and obliterated the father.

(Lemma 2013, p. 288)

What Lemma says here, then, is that, from a psychodynamic perspective, Ms A's identification of herself as a woman can be readily understood as the result of wishes to simultaneously avoid the pain of abandonment by her mother and obliterate any identification with the hated father. This constellation is, of course, remarkably similar to that of my patient Chris and postulated for John.

Only after surgery did Ms A 'connect with the loss that ravaged her life' (ibid., p. 289). But it is hard not to wonder whether she would have felt the need for SRS if she had been able to do so pre-surgically. Nevertheless, Ms A felt happy with the outcome of surgery, according to Lemma, albeit after an initial period of intense post-surgical disappointment and fragmentation.

Summarising these three analysts' views on the possibility of effective analytic work with the wish for surgery, then:

Stoller did not think such work was possible with primary transsexuals;

Lemma did believe it was possible but, in practice, Ms. A still opted for surgery; and

Morel's account does not leave it exactly clear what analytic work she and Ven did together. However, unlike Lemma, she did not attempt to work directly with the wish for surgery as she believed this could expose Ven to a psychotic breakdown.

### Some diagnostic issues

Stoller's distinction between primary and secondary transsexuals was, as we have seen, an attempt to provide clear diagnostic grounds for discerning who is likely to benefit from surgery. But Stoller called for more scientific research into the effects of surgery before the practical value of his distinction could be determined.

Several studies (Moskowitz 2010, [www.lauras-playground.com](http://www.lauras-playground.com), etc.) suggest that over forty percent of transsexuals either attempt suicide or succeed in killing themselves post surgically. Some in the 'trans' community (e.g. [www.lauras-playground.com](http://www.lauras-playground.com)) ascribe this to society's intolerance. But one would expect this to be reduced after surgery as it became easier to pass as one's chosen gender. And yet the suicide rate for post-operative transsexuals is around twenty times higher than for a control group matched in terms of age, social position and psychological morbidity (Dhejne et al. 2011). It is not clear whether this is because of dissatisfaction with the operation or because

transsexuals as a group are already prone to suicide attempts and self-mutilation pre-surgically. Either way, this should ring alarm bells, rather than reinforce confidence in either Stoller's diagnostic categories or the benefits of surgery.

Morel believes that the wish for a sex change operation is generally indicative of psychosis and that surgery is therefore unlikely to be helpful. But, even if we accept Morel's analysis of the case, it still seems possible that SRS could have 'worked'. Ven might have felt happier in the position of the more loved brother with whom he was better able to identify postoperatively. This raises the ethical question, however, of whether such a 'solution' should be medically sanctioned, if, as seems likely, its therapeutic efficacy is based on reinforcing an imaginary identification. This seems to be essentially the same question that we face in relation to other placebo treatments. Recent research suggests, for instance, that most antidepressants (Antonuccio et al 2002) as well as homeopathy (Shang et al 2005) work for psychological, rather than physical, reasons. But should people be denied the therapeutic benefits of such treatments because of this?

Of course, it could be argued that these treatments do little or no harm, while cases like Chris's show SRS can permanently damage a person's bodily integrity, reproductive capacity and sexual pleasure. This, in turn, raises the question of whether therapists and surgeons have an ethical duty to try to prevent clients from harming themselves in this way and thus whether surgeons performing SRS are breaking the Hippocratic Oath. That certainly seems to be the reasoning behind the medical profession's refusal to remove the healthy limbs of sufferers of 'body integrity identity disorder' (see e.g. Furth & Smith 2000), who feel they will only be complete if they have a healthy limb amputated.

Lemma attempts to keep issues of causation, diagnosis and pathology open. She notes Ms A's wish to maintain an imaginary symbiotic fusion with her mother while obliterating her father, but insists on the possibility of a physical cause for Ms A's transsexualism.

She supports this with references to the same studies as those quoted by the 'Gender Identity Research and Education Society' (GIRES), which confidently advances a biological view of the aetiology of transsexualism:

Thus the experience of extreme gender variance is increasingly understood in scientific and medical disciplines as having a biological origin. The current medical viewpoint, based on the most up-to-date scientific research, is that this condition, which in its extreme manifestation is known as transsexualism, is strongly associated with unusual neurodevelopment of the brain at the foetal stage. Small areas of the brain are known to be distinctly different between males and females in the population generally. In those experiencing severe gender variance, some of these areas have been shown to develop in opposition to other sex characteristics and are, therefore, incongruent with the visible sex appearance.

(GIRES 2012, p. 3)

This sounds reassuringly plausible, but it seems worth pointing out that an examination of their references (Zhou et al 1995) reveals that GIREs's

conclusions are extremely speculative, to say the least. Not only is this 'most up-to-date scientific research' based on a pitifully small number of cases (six in the leading study quoted), but the brains of these six individuals were examined on autopsy, after they had been living for years as trans women, five without testes, all receiving hormone treatment (Breedlove 1996). So it seems a huge leap to assume that the 'unusual neurodevelopment of the brain' found on autopsy had indeed taken place in the womb. Remarkably, the same references and conclusions are repeated approvingly on a UK government web site offering information on transsexualism ([www.lcd.gov.uk](http://www.lcd.gov.uk)). And, even more strangely, these conclusions are endorsed by twenty internationally acclaimed professors and medical experts on the same web site though not, I hasten to add, by Lemma herself.

It may be unduly cynical to wonder whether some of these so-called 'experts' have a vested interest in the SRS 'industry' or are bowing to the forces of political correctness. If so, then perhaps this apparently uncritical determination to find a physical origin for transsexualism can be put down to the cultural prejudice that confuses the physical with the real. 'My condition is real,' this argument runs, 'so it must be caused physically, even if there is no clear evidence to support that conclusion'. And perhaps this position is entrenched by a further cultural confusion of the psychological with the conscious. 'And even if the psyche is real, I did not choose to be transsexual,' the argument continues, 'so my condition must still be physical in origin'. Without a notion of the unconscious, it seems natural to assume that psychopathology must either be imaginary or chosen, and therefore the individual's fault. This reinforces a stigmatization of mental illness, which probably originates in the historical conceptualization of it as demonic possession (see, e.g., Harrington 2008). And that stigmatization is paradoxically perpetuated by those who seek to save transsexuals from it, by insisting that their condition must have a physical origin.

Such conclusions and prejudices may be understandable in someone who is struggling with the feeling of being trapped in the 'wrong' body, in a culture that categorizes gender into the strict binaries of male and female and finds it hard to accept the existence of the unconscious. It is quite another thing for them to be endorsed by a panel of distinguished psychiatrists and academics.

It seems to me that there is a crucial difference between a child who identifies as female to defend against abandonment by mother and obliterate father, and one who is born with a male body but biologically female brain. In the latter case, surgery and empathic mirroring of the gender conflict might well produce significant relief. In the former, the fear of abandonment and sense of one's own monstrousness would have to be faced before would be possible to feel at home in one's own body, regardless of whether it had been surgically altered. Indeed, surgery would be likely to make that task more difficult. An uncomfortable question then arises: Lemma assumes that Ms A's mother failed empathically to mirror a pre-existing gender conflict; she thus implicitly

supports the hypothesis of a biological origin of her transsexualism. Is it possible that, in taking this stance, Lemma has inadvertently colluded with Ms A's psychological defences and unrealistic expectations of surgery by encouraging her to think of her problems as primarily physical?

### **Is it possible to tell in advance who will benefit from surgery?**

Despite Lemma's insistence on the possibility of a biological origin of transsexualism, there seems to be no good scientific evidence to support this hypothesis and certainly no related biological test to help identify in advance those likely to benefit from surgery. Research suggests that Stoller's distinction between primary and secondary transsexuals is less helpful than it originally seemed. Indeed, Mitchell (1976) argues convincingly that even Stoller's primary transsexuals are really psychotic and the DSM has dropped the distinction between primary and secondary transsexualism altogether, without replacing it with an equivalent differential diagnosis. Morel regards transsexualism as a form of psychosis and surgery as collusion with that psychosis. Therefore, none of these views offer much hope of identifying in advance who (if anyone) is likely to benefit from surgery, and yet many transsexuals claim it has positively transformed their lives.

Perhaps such claims should be taken with a pinch of salt, however. As my ex-patient Chris said, 'How many males having had their body and genitals radically altered by hormones and surgery will tell their story? Better to say nothing or cover everything up with self-justification, half-truths and rationalization.' But even if Chris were wrong and these claims are right, it seems hard to justify a surgical procedure with no reliable means of telling in advance who is likely to benefit from it. Analysts might argue that this is not their concern and that the responsibility for recommending surgery lies elsewhere. In practice, this is true. But, if we can agree that SRS is being used defensively—if it is being sought (for instance) in the unconscious hope of avoiding the pain of abandonment by mother and identification with a violent, abusive father—then, surely, it is the psychoanalyst's (rather than the surgeon's, psychiatrist's or doctor's) responsibility to attempt to work through these issues with the patient?

### **Some cultural considerations regarding pathology**

There seem to be significant cultural differences between the Lacanian and the Anglo-Saxon analytic worlds. The latter appears much more reluctant to pathologize transsexuals. DSM V, for instance, has dropped the term 'gender identity disorder' in favour of the less pathologising 'gender dysphoria', and it sees transsexualism as just an extreme form of this. But even that has led to the objections of certain sections of the 'trans' community, who oppose its

inclusion in a manual of ‘mental disorders’ on principle (see their petition at [www.change.org](http://www.change.org)).

And the United Kingdom Council for Psychotherapy (of which I am a member) reiterates this in a recent press release:

UKCP does not consider homosexuality, or bisexuality, or transsexual and transgendered states to be pathologies, mental disorders or indicative of developmental arrest. These are not symptoms to be treated by psychotherapists, in the sense of attempting to change or remove them. Homosexuality does not have ‘causes’. Society as a whole needs to stop the search for ‘causes’ and the inadvertent pathologization of what is neither immoral, unnatural nor pathological.

(UKCP 2012))

This statement seems designed to discourage UKCP members from exploring psychopathological aspects of the wish for SRS. And as a result, some therapists seem to see their primary role as affirming the wish for surgery (see, e.g., King 2012). But is it a mistake to bracket homosexuality and bisexuality, which do not need surgical treatment, together with transexualism, which ostensibly does? It certainly seems hard to reconcile the transsexuals’ perception that there is something wrong with their body which needs surgically correcting with the wish not to be pathologized.

These powerful cultural pressures not to traumatize John by pathologising his transexualism undoubtedly affected my countertransference. It should now be possible to reconsider the critical incident.

### **Some countertransference reflections regarding John and the critical incident**

In my wish to warn John of the possible dangers of surgery, I temporarily undermined his faith in its ability to solve his problems. From a Lacanian perspective, I challenged the psychotic symptom which was holding him together. When I did this, he fell apart. My desire not to pathologize him by thinking of him as psychotic, paradoxically contributed to bringing this about.

It will be recalled that, when I first mentioned the possibility that he might regret surgery, John laughed derisively, and I responded by telling him about my work with Chris. I can see, with the benefit of hindsight, that my feeling that John’s laughter was derisive probably led me to use my experience with Chris to attempt to force him to take me more seriously. The fact that this tipped him into a state of psychotic anxiety indicates that, from his point of view, it probably felt like a murderous attack. It could be argued that my attachment to my own penis (castration anxiety) prevented me from consciously identifying with John sufficiently to appreciate the effect of my remarks on him. However, I think it is probably more accurate to say that it was his wish for a concrete castration, rather than my neurotic difficulty accepting a symbolic castration, that made (consciousness of) this

identification so hard for me. I would have needed to be more aware of psychotic elements in myself to make it.

In his brilliant paper, 'Hate in the countertransference', Winnicott (1949a) writes about both the difficulty and the importance of being conscious of countertransference hatred in the analysis of psychotics. If I had been less worried about pathologising John by thinking of him as psychotic, I might have recognized the countertransference hatred behind my conscious concern for him. I remember feeling apprehensive before informing him about Chris, but I reassured myself that I was trying to prevent him from harming himself. I certainly was. But I was probably also dissociating from my countertransference hatred of him. (He had laughed in my face and I hated him for it). This appears to have set the scene for a co-created re-enactment of his internalized, unresolved childhood experiences.

For him, I believe, I had 'become' the monstrous father who claimed he wanted to 'save him' from himself, while actually trying to (metaphorically) kill him. Without John to ask, it is impossible to know the truth of this hypothesis for sure. Nor is it possible to know how he actually dealt with the murderous rows he and his father had in childhood. But it seems possible that he had attempted to cut himself off from this father—and, at the same time, his own reactive murderous rage—by identifying himself as female. Certainly, in the room with me, he seemed as cut off from his rage as I was from mine. But that rage seems to have returned to him as the paranoid fantasy of being attacked in the street after he left the session. With more awareness of my own identification with his (internalized) father in the countertransference (Bollas 1987), I might have been able to help him regulate the affect he had been unable to bear during the original experiences with his father and modify the resulting internal object relationships. From this perspective, our co-created re-enactment becomes a lost therapeutic opportunity.

If I had been less worried about pathologising John by thinking of him as psychotic, I might have made better use of this opportunity. And if I had drawn on Winnicott and Lacan's work on psychosis, I would have been quicker to acknowledge the hostile elements in my countertransference and less quick to challenge his wish for surgery. That would at least have had the advantage of keeping the therapeutic relationship alive until such time as I could recognize and understand my countertransference hatred well enough to use it therapeutically.

Of course, it is still impossible to know whether John would have been able to work through his traumatic childhood experiences and moderate his internal object relationships as a result. Even if he had been, there is no way of knowing for sure whether that would have modified his wish for surgery. I hope that it may now prove possible to use these reflections and speculations to draw some more general conclusions about potential ways forward in the analytic understanding and treatment of transsexual patients.

## Towards effective analysis

At first sight, it may appear that the analytic treatment of transsexualism simply devolves into a question of the analytic treatment of psychosis, or of psychotic elements in the psyche. Consideration of the critical incident above certainly suggests that this is important, but a search of the literature reveals remarkably few accounts of the analytic treatment of transsexuals (though see Stein 1995, Chiland 2000, and Quinodoz 1998, 2002). None, to my knowledge, involves the ‘successful’ analysis of a pre-surgical transsexual who is determined to have SRS. This is strange, given the numerous accounts of successful analytic work with paranoid schizoid (psychotic) phenomena. So perhaps the situation is not quite as straightforward as it appears.

Quinodoz (2002) wonders whether transsexualism constitutes a special case of what she calls ‘heterogeneity’, ‘I use the term heterogeneous patients specifically to denote those who fear that inner contradictions might lead to the loss of their sense of internal cohesion.’ (Quinodoz 2002, p. 784). While this certainly rings true of transsexuals, I am not sure if the term ‘heterogeneous’ really adds anything significant to the notion of psychotic material threatening the integrity of the container, as already outlined by Bion (1962) and others. One obvious feature of transsexualism does appear to be missing from the literature, however: the transsexual identifies with a mind of one gender while powerfully dissociating from a body of the other. So, could drawing on existing resources on mind-body dissociation, such as Winnicott (1949b, 1964), Ogden (2001), and Van der Kolk (1996)—who calls it ‘secondary dissociation’—help advance our clinical work and theoretical understanding?

Winnicott (1949b) describes a tendency for the psyche to get ‘seduced into the mind’ if an infant faces a trauma or environmental deficiency it is too immature to deal with. This can result, according to him, in the establishment of a precociously self-sufficient ‘false self’ or ‘head ego’ which is dissociated from the body. In Winnicott (1964), he describes how the feelings that led to this dissociation in the first place must be faced if the mind is to find its way back to its original psychosomatic integrity with that body.

Ogden (2001) movingly illustrates this process at work with a man who was both neglected and abused in childhood. His patient, ‘Mr S’, was unable to overcome the resultant, deeply entrenched mind-body dissociation. But after many years of analytic work several times a week, he ‘flashed-back’ to his abuse. Clearly distressed, he looked around the consulting room for points of reference in the here and now, ‘That’s a window, that’s a plant, that’s a rug’ (ibid. p. 165). He went on to tell Ogden that he was afraid he was going crazy and would never recover. At this point, Ogden found himself saying something spontaneous, authentic and surprising. He told Mr S that he wouldn’t let that happen. Ogden’s point is not that this constitutes good analytic practice, but that he was speaking from a profoundly embodied place with a deep understanding of Winnicott’s (1949b) work on mind-body dissociation. He

knew what he was doing. As a result, his comment—and especially the way he made it—provided the holding that enabled Mr S to contain his fear of fragmentation and eventually ‘re-mind his body’. Ogden’s state here contrasts strongly with my own apprehension when telling John about my work with Chris.

If I analyse what I mean by apprehension here, I think it is something like ‘dissociating from my own embodied sense of self and talking “head to head” with John’. This of course is precisely what a man who is dissociated from his own body does not need, but perhaps it points to the possibility that one of the necessary conditions for the ‘successful’ analysis of a pre-surgical transsexual is a therapist who speaks from a securely embodied place.

Another obvious factor that was present in Ogden’s work with Mr S, but absent at the time of the critical incident with John, was the containment of a long-established therapeutic relationship. Perhaps, then, such containment is another prerequisite for ‘successful’ analytic work with a pre-surgical transsexual.

Rothschild (1999) is a non-analytic trauma therapist who outlines some of the possible neuroscientific mechanisms behind phenomena such as Mr S’s flashback and the lodging of experiences in the body that cannot be recalled declaratively. She also describes the role of the hippocampus in laying down sequential, proprioceptive body memories. This function may be impeded if a person faces overwhelmingly traumatic experiences, and the defences of fight and flight are impossible. Under such circumstances, the body resorts to the ‘freeze’ response and what Van der Kolk (*ibid.*) calls ‘primary’ dissociation, in which reality takes on the quality of a dream. As a result, the traumatic experiences cannot be processed into sequential memory in the normal way, and do not become ordered in space and time. Instead, they are liable to return in such things as flashbacks and bodily symptoms that make no medical sense. From a psychoanalytic perspective, they remain as beta-elements (Bion 1962).

Clinically, Rothschild recommends a series of techniques designed to regulate the return of such raw unprocessed traumatic experiences to consciousness. I employed some of these in my first session with John and, if my speculations above are right, they returned anyway within the dynamics of the transference countertransference. They also seem to have been re-enacted, and in Ogden’s case worked through, in his relationship with Mr S. He describes, for instance, metaphorically ‘backing Mr S against the wall’ in the analysis, in a direct echo of his original abuse. Presumably, the transformation of beta into alpha elements that resulted from working this through in analysis would be paralleled by Mr S’s hippocampus (and eventually other brain areas and neural networks associated with declarative memory) becoming able to process his abuse and neglect for the first time (Bion 1962).

This formulation may help make sense of the fact that I was unable to help John through a similar process of transformation. The transsexual longs to be reunited with his/her body, but is so terrified of what they might find there that they feel the need surgically to alter it first. This is a step beyond the ordinary mind-body (secondary) dissociation talked about by Van der Kolk

(1996). In such circumstances, the analyst who speaks from and for the body must expect to be attacked too. The transsexual identifies the physical body itself, rather than the psychological and emotional experiences lodged there, as the hated enemy (see Rothschild 1999 and Withers 2003). Perhaps my own dissociation can be understood as a response to the fear of this attack.

It seems important for the sake of completeness to point out that this confusion of psyche and soma can also occur the other way round. My patient Chris and I worked for years on the assumption that a deep-rooted sense of deadness and depression, with which he struggled, was psychogenic. But towards the end of his analysis, when an endocrinologist finally recognized his need for the replacement testosterone his body could no longer produce, these feelings lifted. Chris was understandably very angry about the years he had spent suffering unnecessarily, as well as the time, money and energy he had wasted trying to tackle these physical problems psychologically. He decided to move away and end his analysis. Sadly, it was only on writing this paper that I realized the link between the timing of this and his father's departure when Chris was aged four. On a happier note, he informed me recently that his capacity for orgasm had returned with the testosterone treatment, albeit in a very 'male' way involving the ejaculation of prostatic fluid through a 'phantom penis'. He said that this had also been his experience of orgasm while living in the female role taking oestrogen.

I hope that the above ideas can offer some hints concerning possible ways forward in the analytic treatment of transsexual patients, but I am aware that they are just a beginning and that I have left several important areas unexplored. One of these concerns the role of sado-masochism in the transsexual's attack upon their body. Another concerns the role of dissociation between the male and female elements of the psyche in transsexualism. Winnicott (1966) writes about this dissociation in a paper which describes his successful analytic work with a patient who might today have identified himself as transsexual. Winnicott's success seems to hinge on his ability to identify and understand the meaning of a psychotic element in his own countertransference. He suddenly has the powerful and surprising impression that he is not talking to a man but to a little girl. And he comes to understand this as the result of his countertransference identification with a 'mad' mother who could only see a little girl when her son was born. Could some of the therapists, doctors, and surgeons who also see this little girl in their male patients be making a similar identification without realising it?

### **Treatment in search of a diagnosis?**

This leads to another important theme that I can do little more than touch on here. It concerns the role of culture in the creation and resolution of the

transsexual's gender conflict. Transsexualism and SRS are diagnostic and treatment options that were unavailable in Winnicott's day, so perhaps transsexualism could be regarded as part of a general contemporary proliferation of psychiatric diagnoses that seems to owe more to an increase in treatment options than actual mental disorders (Whitaker 2010, Leader 2011).

Male-to-female SRS is five times more popular than its opposite in Britain (see, e.g., NHS Choices website). It also seems likely that social factors, such as a lack of positive paternal role models, coupled with a cultural denigration of men, play a role.

In traditional Samoan culture, the Fa'afafine can live in both male and female roles, enjoying a respected place in their society (Vanessa 2007). Does the lack of such a respected place in our culture contribute to pressure on the transsexual to resolve their gender identity conflict through surgery rather than find a way to live with it creatively? Further development of this and other related themes lies beyond the scope of this paper.

## Conclusion

In this paper, I have attempted to understand the psychodynamics of a critical incident during my work with a pre-surgical transsexual patient. I have gone on to consider whether effective analytic work with pre-surgical transsexuals is possible in a more general sense. I have concluded that fears of psychopathologising my patient contributed to the critical incident, by leading me to overlook psychotic elements in both him and my own countertransference. Such fears seem to be fairly ubiquitous, especially in the Anglo Saxon analytic world, and I would argue that their recognition and containment is an essential feature of effective future analytic work.

Winnicott (1966) described the successful analytic treatment of a man who might have identified himself as transsexual in today's cultural climate. Here, too, recognition of a psychotic element in the countertransference proved crucial.

At various points in the paper, I have examined the role of cultural factors in the conceptualization, diagnosis and treatment of transsexualism. I have also suggested that a consideration of the role of extreme mind-body dissociation in transsexualism might improve our capacity to work analytically with it.

I will leave the final word to Chris:

Looking back I rather wish the diagnosis of transsexual had never been coined. I think it has robbed many individuals of their unique and talented humanity, handing it over to the waiting rooms and operating theatres of a psycho-sexual empire whose role now seems, to me, to place the individual confused with their 'gender identity' into a third stereotype little better than the two we were once tethered to.

(Chris, personal communication 2001)

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 TRANSLATIONS OF ABSTRACT
 

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L'auteur partage ses réflexions sur le travail analytique contrasté avec deux patients transsexuels. Il s'appuie sur trois études psychanalytiques antérieures (Stoller, Morel et Lemma) pour examiner si un travail analytique efficace, avec les questions que pose l'accompagnement d'une personne résolue à changer de sexe chirurgicalement, est possible. Une attention particulière est donnée au fait que ce travail peut ouvrir une voie entre traumatisation ou pathologisation du patient, d'une part, et évitement de matériel analytique important sans crainte de le faire, de l'autre. L'auteur poursuit en se demandant s'il est possible de dire à l'avance, avec une certaine fiabilité, qui a ou n'a pas de chances de tirer profit de la chirurgie. Il considère les problèmes de certains diagnostics par rapport à ces questions.

Des illustrations montrent comment, en pratique clinique, les angoisses contre-transférentielles autour de la psycho-pathologisation des patients transsexuels peuvent ajouter des difficultés significatives dans le travail clinique avec eux. L'auteur soutient que la compréhension et le fait de contenir ces angoisses peut éventuellement permettre un travail analytique plus efficace, et que ce travail pourrait être davantage facilité en prenant en compte la part de la dissociation corps-esprit dans la genèse du transsexualisme. *Mots-clés:* Changement de sexe chirurgical, contre-transfert, dissociation corps-esprit, genre, père, psychose, psychose du contre-transfert

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Der Autor berichtet über seine gegensätzliche analytische Arbeit mit zwei transsexuellen Patienten. Er zieht drei vorausgegangene psychoanalytische Studien (Stoller, Morel und Lemma) heran um zu untersuchen, ob eine effektive analytische Arbeit an den Themen möglich ist, die dem dringenden Wunsch einer Person zugrundeliegen, sich einer chirurgischen Geschlechtsumwandlung (sex reassignment surgery, SRS) zu unterziehen. Besondere Aufmerksamkeit gilt der Art und Weise, auf die eine solche Arbeit einem Pfad folgen kann, der zwischen einerseits Traumatisierung und Pathologisierung des Patienten und andererseits der Aussparung von diese Gefahr mit sich bringendem wichtigen analytischen Material entlangführt. Der Autor fährt mit der Frage fort, ob es im voraus möglich ist, mit einigermaßen vorhandener Sicherheit anzugeben, wer von einem solchen Eingriff profitieren wird und wer nicht. Er betrachtet bestimmte diagnostische Fragen in Bezug auf diese Fragen.

Es werden Veranschaulichungen geboten, wie in der Praxis Gegenübertragungängste vor einer Pathologisierung von transsexuellen Patienten zu bedeutsamen Schwierigkeiten in der klinischen Arbeit mit diesen beitragen können. Es wird postuliert, daß das Verstehen und Containen solcher Ängste möglicherweise zu einer effektiveren analytischen Arbeit führen könnte und daß eine solche Arbeit weiterführend gestützt werden mag durch die Beachtung des Beitrages einer Körper-Geist-Dissoziation zum Transsexualismus.

*Schlüsselwörter:* chirurgische Geschlechtsumwandlung, Geschlecht, Psychose, Gegenübertragung, Gegenübertragungspsychose, Geist-Körper-Dissoziation, Vater

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L'autore riflette sul suo contrastato lavoro analitico con due pazienti transessuali. Egli usa tre precedenti studi psicoanalitici (Stoller, Morel e Lemma) per cercare di capire se sia possibile un vero lavoro analitico con la finalità di guidare il determinato desiderio

della persona per un intervento chirurgico di cambiamento sessuale. Viene data particolare attenzione al come un tale lavoro possa muoversi su un sentiero tra la traumatizzazione e la patologizzazione del paziente da una parte e dall'altra parte l'evitare materiale analitico importante per paura di farlo. L'autore procede con il chiedersi se sia possibile dire in anticipo, con un qualche grado di affidabilità, chi sia e chi non sia adatto per beneficiare dell'operazione. Egli considera certi risultati diagnostici in relazione a tali questioni.

Vengono portati degli esempi di come, nella pratica, le ansie controtransferali su una eventuale patologizzazione del paziente transessuale possano contribuire a significative difficoltà nel lavoro clinico con loro. Si sostiene che il comprendere e contenere tali ansie potrebbe finalmente portare a un lavoro più effettivamente analitico e che tale lavoro potrebbe essere ulteriormente facilitato prendendo in considerazione il contributo di una dissociazione mente-corpo verso il transessualismo.

*Parole chiave:* Operazioni chirurgiche di cambiamento sessuale, genere, psicosi, controtransfer, psicosi controtransferale, dissociazione mente-corpo, padre

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Автор размышляет о контрастных результатах своей работы с двумя транссексуальными пациентами. Он использует три ранее проведенных психоаналитических исследования (Столлер, Морель и Лемма) для изучения того, возможна ли эффективная аналитическая работа с темами, подталкивающими намеренную волю человека к желанию провести хирургическую коррекцию пола (ХКП). Особое внимание уделяется тому, как такая работа может проложить дорожку между травматизацией и патологизацией пациента, с одной стороны, и избеганием важного аналитического материала из страха этой травматизации, с другой. Далее автор спрашивает, а можно ли заранее предположить, с какой бы то ни было долей достоверности, кто выиграет, а кто, скорее, не выиграет от хирургического вмешательства. Он рассматривает некоторые диагностические темы, имеющие отношение к этим вопросам.

Приведенные иллюстративные материалы показывают, как на практике контрпереносная тревога о психопатологизировании транссексуальных пациентов может внести вклад в приумножение значительных трудностей клинической работы с этими людьми. Доказывается, что понимание и контейнирование таких тревог может, фактически, привести к более эффективной аналитической работе, и что, если учитывать вклад диссоциации ума и тела в формирование транссексуальности, это значительно облегчает такую работу.

*Ключевые слова:* хирургическая коррекция пола, пол, психоз, контрперенос, контрпереносный психоз, диссоциация ума и тела, отец

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El autor reflexiona sobre su trabajo analítico contrastante con dos pacientes transexuales. El autor utiliza tres estudios psicoanalíticos previos (Stoller, Morel y Lemma) para explorar si es posible un trabajo analítico efectivo para tratar aquellos temas que conducen a una persona, a desear una cirugía de reasignación sexual. Se considera particularmente cómo semejante trabajo podría navegar un camino entre la traumatización y la patologización del paciente por un lado, y por otro lado, la

evitación de importante material analítico debido al miedo. El autor continúa preguntando si es posible decir de antemano, con algún grado de fiabilidad, quien podría beneficiarse de una cirugía, y quien no. Considera algunos puntos diagnósticos en relación a estas cuestiones.

El escrito ilustra cómo, en la práctica, las ansiedades contratransferenciales respecto de patologizar a pacientes transexuales, puede contribuir a crear dificultades significativas en el trabajo clínico. Se argumenta que la comprensión y contención de semejantes ansiedades podría eventualmente conducir a un trabajo analítico más efectivo; y semejante trabajo podría a su vez ser facilitado si se considera la contribución de la disociación mente-cuerpo al transexualismo.

*Palabras clave:* cirugía de reasignación sexual, género, psicosis, contratransferencia, contratransferencia psicosis, disociación mente-cuerpo, padre

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### **Acknowledgments**

Heartfelt thanks are due to all the people who have contributed in numerous ways to the writing of this article, but especially Russell Rose, Heather Mills, Joy Schaverien, Anne Scott, Marcus West, Francis Hope and, of course, Chris.